blue CALIFORNIA

Evidence of Coverage

Your medicare health benefits and services and prescription drug coverage as a member of Blue Shield of 65 Plus (HMO)

Riverside County

January 1, 2026 - December 31, 2026

Blue Shield of California is an independent member of the Blue Shield Association
MA026-EOC-RV-1025

January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services and Drug Coverage as a Member of Blue Shield 65 Plus (HMO)

This document gives the details of your Medicare health and drug coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place.**

This document explains your benefits and rights. Use this document to understand:

- Our plan premium and cost sharing
- Our medical and drug benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Customer Service at (800) 776-4466 (TTY users call 711). Hours are 8 a.m. to 8 p.m. PT, seven days a week. This call is free.

This plan, Blue Shield 65 Plus, is offered by California Physicians' Service (dba Blue Shield of California). (When this Evidence of Coverage says "we," "us," or "our," it means California Physicians' Service (dba Blue Shield of California). When it says "plan" or "our plan," it means Blue Shield 65 Plus.)

This document is available for free in Spanish.

This information may be available in a different format, including Braille, large print, audio cd and data cd. Please call Customer Service at the number above if you need plan information in another format. If you would like to receive your plan materials via email, log in at blueshieldca.com/login and go to your profile page by clicking "Edit profile" on your myblueshield dashboard and then select Yes, save paper, Send by Email as your delivery preference under communication preferences. If you do not have an account, click on Create account, and select email as your delivery preference during the registration process.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2027.

Our formulary, pharmacy network, and/or provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

OMB Approval 0938-1051 (Expires: August 31, 2026)

Blue Shield of California's pharmacy network includes limited lower-cost, pharmacies with preferred cost sharing in certain counties in California. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost pharmacies with preferred cost sharing in your area, please call (800) 776-4466 [TTY: 711], 8 a.m. to 8 p.m. PT, seven days a week or consult the online pharmacy directory at **blueshieldca.com/medpharmacy2026**.

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CHAPTER 1:
Get started as a member

SECTION 1 You're a member of Blue Shield 65 Plus

Section 1.1 You're enrolled in Blue Shield 65 Plus, which is a Medicare HMO

You're covered by Medicare, and you chose to get your Medicare health and your drug coverage through our plan, Blue Shield 65 Plus. Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

Blue Shield 65 Plus is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Blue Shield 65 Plus covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs* (formulary), and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called riders or amendments.

The contract is in effect for the months you're enrolled in Blue Shield 65 Plus between January 1, 2026 and December 31, 2026.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of Blue Shield 65 Plus after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve Blue Shield 65 Plus each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B.
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.
- You're a United States citizen or lawfully present in the United States.

Section 2.2 Plan service area for Blue Shield 65 Plus

Blue Shield 65 Plus is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is described below.

Our service area includes this county in California: Riverside County.

If you move out of our plan's service area, you can't stay a member of this plan. Call Customer Service at (800) 776-4466 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

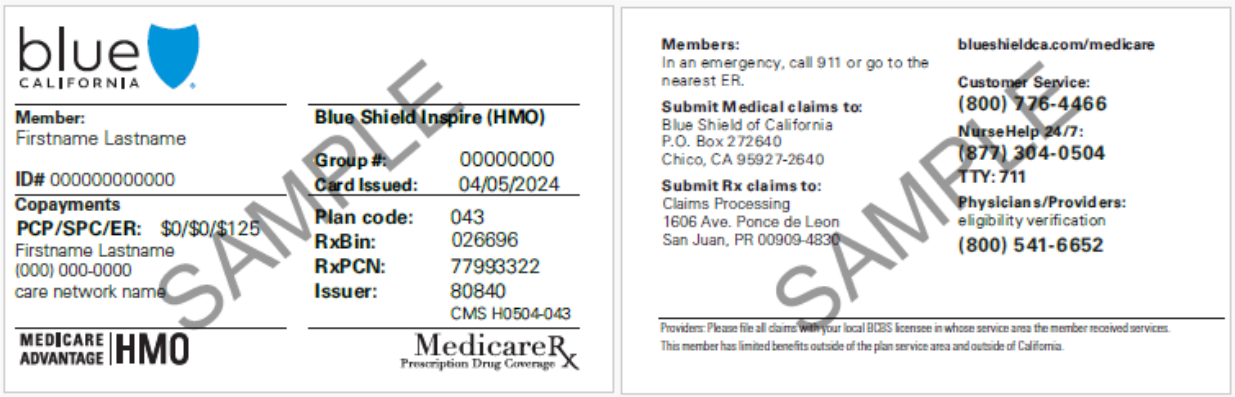
Section 2.3 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Blue Shield 65 Plus if you're not eligible to stay a member of our plan on this basis. Blue Shield 65 Plus must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if you have one. Sample plan membership card:



DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your Blue Shield 65 Plus membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials).

If your plan membership card is damaged, lost, or stolen, call Customer Service at (800) 776-4466 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* (**blueshieldca.com/find-a-doctor**), lists our current network providers. **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization, you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is, situations when it's unreasonable or not possible to get services in network), out-of-area dialysis services, and cases when Blue Shield 65 Plus authorizes use of out-of-network providers.

Get the most recent list of providers on our website at **blueshieldca.com/find-a-doctor**.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Customer Service at (800) 776-4466 (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

Section 3.3 Pharmacy Directory

The *Pharmacy Directory* (**blueshieldca.com/medpharmacy2026**), lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 5, Section 2.5 for information on when you can use pharmacies that aren't in our plan's network.

The *Pharmacy Directory* also shows which pharmacies in our network have preferred cost sharing, which may be lower than the standard cost sharing offered by other network pharmacies for some drugs.

If you don't have a *Pharmacy Directory*, you can ask for a copy from Customer Service at (800) 776-4466 (TTY users call 711). You can also find this information on our website at **blueshieldca.com/medpharmacy2026** or call Customer Service.

Section 3.4 Drug List (formulary)

Our plan has a *List of Covered Drugs* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in Blue Shield 65 Plus. The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced as described in Chapter 5, Section 6. Medicare approved the Blue Shield 65 Plus Drug List.

The Drug List also tells if there are any rules that restrict coverage for a drug.

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit **blueshieldca.com/medformulary2026** or call customer service at (800) 776-4466 (TTY users call 711).

SECTION 4 Summary of Important Costs

	Your Costs in 2026
Monthly plan premium* *Your premium can be higher than this amount. Go to Section 4.1 for details.	**$0**
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1 for details.)	**$2,800**
Primary care office visits	**$0 copayment per visit**
Specialist office visits	**$0 copayment per visit**
Inpatient hospital stays	**For each Medicare-covered stay in a network hospital you pay:** • **$75 per day for days 1 to 5** • **$0 per day for days 6 and over**
Part D drug coverage deductible (Go to Chapter 6 Section 4 for details.)	**$340 for Tier 3 through Tier 5 drugs, except for covered insulin products and most adult Part D vaccines.**
Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	**Copayment/Coinsurance during the Initial Coverage Stage:** **Drug Tier 1: $0 or $5*** **Drug Tier 2: $10 or $18*** **Drug Tier 3: 20% coinsurance** **You pay the lesser of $35 or 20% coinsurance per month supply of**

	Your Costs in 2026
	each covered insulin product on this tier. **Drug Tier 4: 25% coinsurance** **You pay the lesser of $35 or 25% coinsurance per month supply of each covered insulin product on this tier.** **Drug Tier 5: 29% coinsurance** *** The first amount listed is what you will pay if you use a network pharmacy with preferred cost sharing.** **The second amount listed is what you will pay if you use a network pharmacy with standard cost sharing.** **Catastrophic Coverage Stage:** **During this payment stage, you pay nothing for your covered Part D drugs.**

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Optional Supplemental Benefit Premium (Section 4.3)
- Part D Late Enrollment Penalty (Section 4.4)
- Income Related Monthly Adjusted Amount (Section 4.5)
- Medicare Prescription Payment Plan Amount (Section 4.6)

Section 4.1 Plan premium

You don’t pay a separate monthly plan premium for Blue Shield 65 Plus.

If you *already* get help from one of these programs, **the information about premiums in this *Evidence of Coverage* may not apply to you**. We sent you a separate document, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Customer Service at (800) 776-4466 (TTY users call 711) and ask for the *LIS Rider*.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

Section 4.3 Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called *optional supplemental benefits*, you pay an additional premium each month for these extra benefits. Go to Chapter 4, Section 2.1 for details.

Blue Shield 65 Plus is offering two optional supplemental dental plans: dental HMO and dental PPO. The monthly premium for the optional supplemental dental HMO plan is **$16.00**, and the monthly premium for the optional supplemental dental PPO plan is **$49.00**.

If you have any questions about your plan premiums, please call Customer Service (phone numbers are printed on the back cover of this document).

Section 4.4 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable drug coverage. Creditable drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable drug coverage. You'll have to pay this penalty for as long as you have Part D coverage.

When you first enroll in Blue Shield 65 Plus,we let you know the amount of the penalty. If you don't pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from that plan. Keep this information because you may need it if you join a Medicare drug plan later.
    - **Note:** Any letter or notice must state that you had creditable prescription drug coverage that's expected to pay as much as Medicare's standard drug plan pays.
    - **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here's how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage. The penalty is 1% for every month you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026, this average premium amount is $38.99.
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round it to the nearest 10 cents. In the example here, it would be 14% times $38.99, which equals $5.458. This rounds to $5.46. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty**.

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year** because the national base beneficiary premium can change each year.
- **You'll continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must ask for this review **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you may not have another chance to ask for a review of that late enrollment penalty.

Important: Don't stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay our plan premiums.

Section 4.5 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit www.Medicare.gov/health-drug-plans/part-d/basics/costs.

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay our plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out how to do this, call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 4.6 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay our plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

SECTION 5 More information about your monthly plan premium

Section 5.1 How to pay your Part D late enrollment penalty

There are three ways you can pay the penalty.

We will assume you are using Option 1 and bill you monthly, unless you selected a different option on your plan enrollment form when you first enrolled, or if you contact us to make a change to one of the other options listed below.

Option 1: Pay by check

Your Part D late enrollment penalty is due monthly and should be paid with a check by the last day of the month prior to your coverage period month. Please mail all payments by check using the business reply envelope included in your monthly bill. If you misplace your business reply envelope the address to mail to is:

Blue Shield of California – Medicare Advantage
P.O. Box 745843
Los Angeles, CA 90074-5843

Please make all checks payable to “Blue Shield of California.”

Option 2: Electronic Payments

Instead of paying by check, you can pay your Part D late enrollment penalty online or by phone via your credit/debit card or bank account for one-time payments, or you can enroll in AutoPay (automatic payment service). Enrolling in AutoPay is easy and will draft automatic payment from your credit/debit card or bank account monthly. To learn more about your payment options and how to enroll in AutoPay, visit us at **blueshieldca.com/medicarewaystopay** or call the Customer Service number on the back of your ID card.

Option 3: Have Part D late enrollment penalties deducted from your monthly Social Security check

Changing the way you pay your Part D late enrollment penalty. If you decide to change how you pay your Part D late enrollment penalty, it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you’re still responsible for making sure your Part D late enrollment penalty is paid on time. To change your payment method, please call Customer Service at the number on the back of this document.

If you have trouble paying your Part D late enrollment penalty

Your Part D late enrollment penalty is due in our office by the last day of the month prior to your coverage period month. If we don't get your payment by the last day of the month prior to your coverage period month, we'll send you a notice letting you know our plan membership will end if we don't get your Part D late enrollment penalty, if owed, within the 3-month grace period. If you owe a Part D late enrollment penalty, you must pay the penalty to keep your drug coverage.

If you have trouble paying your Part D late enrollment penalty, if owed, on time, call Customer Service at (800) 776-4466 (TTY users call 711) to see if we can direct you to programs that will help with your costs.

If we end your membership because you didn't pay your Part D late enrollment penalty, if owed, you'll have health coverage under Original Medicare. You may not be able to get Part D drug coverage until the following year if you enroll in a new plan during the Open Enrollment Period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for unpaid penalties. We have the right to pursue collection of the amount you owe. If you want to enroll again in our plan (or another plan that we offer) in the future, you'll need to pay the amount you owe before you can enroll.

If you think we wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance out of your control that made you unable to pay your Part D late enrollment penalty, if owed, within our grace period, you can make a complaint. For complaints, we'll review our decision again. Go to Chapter 9 to learn how to make a complaint or call us at (800) 776-4466 between 8 a.m. to 8 p.m. PT, seven days a week. TTY users call 711. You must make your complaint no later than 60 calendar days after the date your membership ends.

Section 5.2 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

However, in some cases, you may be able to stop paying a late enrollment penalty, if you owe one, or you may need to start paying a late enrollment penalty. This could happen if you become eligible for Extra Help or lose your eligibility for Extra Help during the year.

- If you currently pay a Part D late enrollment penalty and become eligible for Extra Help during the year, you'd be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the Part D late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Find out more about Extra Help in Chapter 2, Section 7.

SECTION 6 Keep our plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary Care Physician/Medical Group/IPA.

The doctors, hospitals, pharmacists, and other providers in our plan's network **use your membership record to know what services and drugs are covered and your cost-sharing amounts**. Because of this, it's very important you help to keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you participate in a clinical research study (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Customer Service at (800) 776-4466 (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read over this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call customer service at (800) 776-4466 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first ("the primary payer") pays up to the limits of its coverage. The insurance that pays second ("secondary payer") only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
    - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2:
Phone numbers and resources

SECTION 1 Blue Shield 65 Plus contacts

For help with claims, billing, or member card questions, call or write to Blue Shield 65 Plus Customer Service. We'll be happy to help you.

Customer Service – Contact Information	
Call	(800) 776-4466 Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day. Customer Service [(800) 776-4466 (TTY users call 711)] also has free language interpreter services for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
Fax	(877) 251-6671
Write	Blue Shield 65 Plus P.O. Box 927 Woodland Hills, CA 91365-9856
Website	**blueshieldca.com/medicare**

How to ask for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care, go to Chapter 9.

Coverage Decisions for Medical Care – Contact Information	
Call	(800) 776-4466 Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day. Customer Service [(800) 776-4466 (TTY users call 711)] also has free language interpreter services for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
Fax	(877) 251-6671
Write	Blue Shield 65 Plus P.O. Box 927 Woodland Hills, CA 91365-9856
Website	**blueshieldca.com/medicare**

How to ask for a coverage decision about your Part D drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your Part D drugs. For more information on how to ask for coverage decisions or appeals about your Part D drugs, go to Chapter 9.

Coverage Decisions for Part D Prescription Drugs – Contact Information	
Call	(800) 776-4466 Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day. Customer Service [(800) 776-4466 (TTY users call 711)] also has free language interpreter services for non-English speakers.
TTY	711

	This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
Fax	(888) 697-8122
Write	Blue Shield 65 Plus P.O. Box 2080 Oakland, CA 94604-9716
Website	**blueshieldca.com/medicare**

How to ask for an appeal about your medical care or your Part D drugs

An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care or Part D drugs, go to Chapter 9.

Appeals for Medical Care or Part D Prescription Drugs – Contact Information	
Call	(800) 776-4466 Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day. Customer Service [(800) 776-4466 (TTY users call 711)] also has free language interpreter services for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
Fax	(916) 350-6510

Write	Blue Shield 65 Plus Appeals & Grievances Department P.O. Box 927 Woodland Hills, CA 91365-9856
Website	**blueshieldca.com/medappeals**

How to make a complaint about your medical care or Part D drugs

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care or Part D drugs, go to Chapter 9.

Complaints about Medical Care or Part D Prescription Drugs – Contact Information	
Call	(800) 776-4466 Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day. Customer Service [(800) 776-4466 (TTY users call 711)] also has free language interpreter services for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
Fax	(916) 350-6510
Write	Blue Shield 65 Plus Appeals & Grievances Department P.O. Box 927 Woodland Hills, CA 91365-9856
Medicare website	To submit a complaint about Blue Shield 65 Plus directly to Medicare, go to www.Medicare.gov/my/medicare-complaint.

How to ask us to pay our share of the cost for medical care or a drug you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9 for more information.

Payment Requests – Contact Information	
Call	(800) 776-4466 Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day. Customer Service [(800) 776-4466 (TTY users call 711)] also has free language interpreter services for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
Payment Requests for Medical Care – Contact Information	
Fax	(877) 251-6671
Write	Blue Shield 65 Plus P.O. Box 927 Woodland Hills, CA 91365-9856
Payment Requests for Part D Prescription Drugs – Contact Information	
Write	Claims Processing 1606 Ave. Ponce de Leon San Juan, PR 00909-4830
Website	**blueshieldca.com/medicare**

SECTION 2 Get help from Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at www.Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	www.Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about Blue Shield 65 Plus.

	To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In California, the SHIP is called Health Insurance Counseling and Advocacy Program (HICAP).

HICAP is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

HICAP counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. HICAP counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

HICAP (California's SHIP) – Contact Information	
Call	(800) 434-0222
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	California Department of Aging 2880 Gateway Oaks Dr, Suite 200, Sacramento, CA 958333
Website	**https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/**

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For California, the Quality Improvement Organization is called Commence Health (formerly Livanta).

Commence Health has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. Commence Health is an independent organization. It's not connected with our plan.

Contact Commence Health in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

Commence Health (California's Quality Improvement Organization) – Contact Information	
Call	(877) 588-1123 9 a.m. to 5 p.m., Monday through Friday; 10 a.m. to 4 p.m., Saturday, Sunday and holidays. 24-hour voicemail service available..
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23450
Website	**www.livantaqio.cms.gov**

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment. Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, contact Social Security to let them know.

Social Security– Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
Website	www.SSA.gov

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and Medicare Savings Programs, contact Medi-Cal office or the California Department of Health Care Services.

California Department of Health Care Services – Contact Information	
Call	(800) 541-5555 Available 8:00 am to 5:00 pm, Monday through Friday.

TTY	(866) 784-2595 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	California Department of Health Care Services P.O. Box 997413, MS 4400 Sacramento, CA 95899-7413
Website	**www.dhcs.ca.gov**

SECTION 7 Programs to help people pay for prescription drugs

The Medicare website (www.Medicare.gov/basics/costs/help/drug-costs) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly plan premium, yearly deductible, and copayments. Extra Help also counts toward your out-of-pocket costs.

If you automatically qualify for Extra Help, Medicare will mail you a purple letter to let you know. If you don't automatically qualify, you can apply anytime. To see if you qualify for getting Extra Help:

- Visit https://secure.ssa.gov/i1020/start to apply online
- Call Social Security at 1-800-772-1213. TTY users call 1-800-325-0778.

When you apply for Extra Help, you can also start the application process for a Medicare Savings Program (MSP). These state programs provide help with other Medicare costs. Social Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

If you qualify for Extra Help and you think that you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of the right copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- For assistance in obtaining evidence of your proper copayment level, you may call Customer Service (phone numbers are printed on the back cover of this document)

and we can either mail or fax you a list of acceptable documents of evidence or read you the list over the phone. Once you obtain the evidence, or if you already have it, you may send it to us either by fax (877) 251-6671) or by mail (Blue Shield 65 Plus,P.O. Box 927, Woodland Hills, CA 91365-9856).

- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make the payment directly to the state. Call Customer Service at (800) 776-4466 (TTY users call 711) if you have questions.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the California ADAP. For more information, contact the California ADAP at (844) 421-7050, 8 a.m. to 5 p.m., Monday through Friday, or by visiting their website at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_eligibility.aspx.

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call the California ADAP at (844) 421-7050, 8 a.m. to 5 p.m., Monday through Friday or visit their website at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_eligibility.aspx.

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** To learn more about this payment option, call Customer Service at (800) 776-4466 (TTY users call 711) or visit www.Medicare.gov.

Medicare Prescription Payment Plan – Contact Information	
Call	(833) 696-2087 Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week.
Fax	(440) 557-6585
Write	SimplicityRx Blue Shield 65 Plus Medicare Prescription Payment Program Election Department 13900 N. Harvey Ave. Edmond, OK 73013
Website	**Activate.RxPayments.com**

SECTION 8 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press "1" to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.

TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.
Website	https://RRB.gov

SECTION 9 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Customer Service at (800) 776-4466 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator.** The benefits administrator can help you understand how your current drug coverage will work with our plan.

CHAPTER 3:
Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, Blue Shield 65 Plus must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

Blue Shield 65 Plus will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network primary care physician (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 for more information).
    - In most situations, your network PCP must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3.
    - You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.
- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means you have to pay the provider in full for services you get. Here are 3 exceptions*:*
    - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.
    - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. In this situation, you pay the same as you'd pay if you got the care from a network provider. Be sure you get a referral (approval in advance) from your PCP before you use an out-of-network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
    - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider that's outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

SECTION 2 Use providers in our plan's network to get medical care

Section 2.1 You must choose a Primary Care Physician (PCP) to provide and oversee your medical care

What is a PCP and what does the PCP do for you?

When you become a member of Blue Shield 65 Plus, you must choose a network provider to be your PCP. Your PCP is a healthcare professional who meets state requirements and is trained to give you basic medical care. PCPs generally fall into one of four categories as listed in the Blue Shield 65 Plus *Provider Directory*: Family Practice, General Practice, Internal Medicine, and OB/GYN.

As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a plan member. For example, in order for you to see a specialist, you usually need to get your PCP's approval first (this is called getting a referral to a specialist).

Coordinating your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval) from us or your physician group. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

How to choose a PCP?

When you join Blue Shield 65 Plus, you will have access to a provider directory that shows the physicians who provide care for our members, along with the physician group and affiliated specialists. The provider directory also includes the network hospital or hospitals at which you may receive care.

You choose your PCP from this list of providers and write the physician's name and ID number on your enrollment form.

When you choose your PCP, you are also choosing the hospitals and specialty network associated with your PCP. If there is a particular network specialist or hospital you want to use, check first to be sure your PCP makes referrals to that specialist or uses that hospital.

Once you are enrolled in the plan, we send you a Blue Shield 65 Plus member ID card. The name and office telephone number of your PCP is printed on your Blue Shield 65 Plus member ID card.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP. Note that changing your PCP may result in being limited to specific specialists or hospitals to which that PCP refers (i.e., sub-network, referral circles).

To change your PCP, call Customer Service. If you call by the 15th of the month, your transfer to a new PCP will be effective on the first day of the following month.

When you call, be sure to tell Customer Service if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Customer Service will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Customer Service will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect.

They will also send you a new Blue Shield 65 Plus member ID card that shows the name and phone number of your new PCP.

Section 2.2 Medical care you can get without a PCP referral

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Customer Service at (800) 776-4466 (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. For example:

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions

When your PCP thinks that you need specialized treatment, they will request a referral (approval in advance) to see a plan specialist or certain other providers. For some types of referrals, your PCP may need to get approval in advance from our plan (this is called getting prior authorization). For more information about which services require prior authorization, see Chapter 4, Section 2.1 of this document.

It is very important to get a referral (approval in advance) from your PCP before you see a plan specialist or certain other providers (there are a few exceptions, including routine women's health care that we explain later in this section). If you don't have a referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself.

If the specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your PCP for the first visit covers more visits to the specialist.

When you choose your PCP, you are also choosing the hospital and specialty network associated with your PCP.

If there are specific specialists you want to use, find out whether your PCP sends patients to these specialists. Each network PCP has certain plan specialists they use for referrals. This means that the PCP you select may determine the specialists you may see. You may generally change your PCP at any time if you want to see a plan specialist that your current PCP can't refer you to. Earlier in this chapter, in Section 2.1 under How to change your PCP, we tell you how to change your PCP. If there are specific hospitals you want to use, you must first find out whether your PCP uses these hospitals. Note that changing your PCP may result in being limited to specific specialists or hospitals to which that PCP refers (i.e., sub-network, referral circles).

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors, and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.

  - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
  - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. Depending on the covered benefit, prior authorization may be required and is the responsibility of your provider.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

Section 2.4 How to get care from out-of-network providers

If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. If this happens, your PCP will refer you to the out-of-network provider. Be sure you get a referral (approval in advance) from your PCP before you use an out-of-network provider.

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a

bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network. Our plan covers emergency care and urgently needed services outside of the United States and its territories with a $10,000 combined annual dollar limit. See *Emergency care* and *Urgently needed services* in the Medical Benefits Chart in Chapter 4 of this document for more information on how much you pay.

- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call is on the back of your Blue Shield 65 Plus member ID card.

Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors giving you emergency care will decide when your condition is stable and when the medical emergency is over.

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

If your emergency care is provided by out-of-network providers, we'll try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—and the doctor may say that it wasn't a medical emergency after all. If it turns out that it wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, we'll cover additional care *only* if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care, or
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

Section 3.2 Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits such as annual checkups aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

For an up-to-date list of urgent care centers affiliated with your physician group, please contact your PCP. You can also search for urgent care centers in your area by going to **blueshieldca.com/find-a-doctor**.

Our plan covers worldwide emergency care and urgently needed services outside the United States and its territories with a $10,000 combined annual dollar limit. See Emergency care and Urgently needed services in the Medical Benefits Chart in Chapter 4 of this document for more information on how much you pay.

Section 3.3 Get care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit **blueshieldca.com/emergencypolicy** for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing. If you can't use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.5.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

Blue Shield 65 Plus covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan or you get services out-of-network without authorization, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. Once a benefit limit has been reached, whatever you pay for services will not count toward your out-of-pocket maximum. See Chapter 4 for more information on benefit limits and out of pocket maximums.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, you're only responsible for the in-network cost sharing for the services in that trial. If you paid more—for example, if you already paid the Original Medicare cost-sharing amount—we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain

benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 7 for more information on submitting requests for payments.

> *Example of cost sharing in a clinical trial:* Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation, (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you'd pay under our plan's benefits.

When you're in a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.

- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free of charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies,* available at www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf. You can also call 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.

SECTION 6 Rules for getting care in a religious non-medical health care institution

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.

- If you get services from this institution provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - *– and –* you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

Medicare Inpatient Hospital coverage limits apply (see Chapter 4 for more information on Medicare Inpatient Hospital coverage limits).

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of Blue Shield 65 Plus, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan**. You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we'll transfer ownership of the DME item to you. Call Customer Service at (800) 776-4466 (TTY users call 711) for more information.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count. You'll have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage Blue Shield 65 Plus will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Blue Shield 65 Plus or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:
Medical Benefits Chart
(what's covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of Blue Shield 65 Plus. This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments, or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Medicare Advantage Plans have limits on the total amount you have to pay out of pocket each year for in-network medical services covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2026 the MOOP amount is $2,800.**

The amounts you pay for copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for Part D drugs don't count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are

marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of $2,800, you won't have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Providers aren't allowed to balance bill you

As a member of Blue Shield 65 Plus, you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service, and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
    - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
    - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or for urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Customer Service at (800) 776-4466 (TTY users call 711).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services Blue Shield 65 Plus covers and what you pay out of pocket for each service (Part D drug coverage is in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these are met:

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered, unless it's emergency or urgent care or unless our plan or a network provider gave you a referral. This means you pay the provider in full for out-of-network services you get.
- You have a primary care physician (a PCP) providing and overseeing your care. In most situations, your PCP must give you approval in advance (a referral) before you can see other providers in our plan's network.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart in italics.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at

www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.)

- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.

This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.	You pay $0 for all Medicare-covered services.

Covered Service	What you pay
Acupuncture for chronic low back pain (cont'd) Treatment must be discontinued if the patient is not improving or is regressing. **Provider Requirements:** Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. Covered services are provided through a contract with American Specialty Health Plans of California, Inc. (ASH Plans) participating providers. For more information, or to locate an ASH Plans participating provider you may call ASH Plans at (800) 678-9133 [TTY: 711], Monday through Friday, 5 a.m. to 8 p.m. PT, April 1st through September 30th and Sunday through Saturday, 8 a.m. to 8 p.m. PT, October 1st through March 31st. You can also call Blue Shield 65 Plus Customer Service or go to **blueshieldca.com/find-a-doctor** to locate an ASH Plans participating provider.	
Additional telehealth services* Teladoc Health provides Physician consultations by phone or video 24/7/365. Teladoc Health Physicians can diagnose and treat basic medical conditions and can also prescribe certain	You pay $0.

Covered Service	What you pay
Additional telehealth services* (cont'd) medication. Teladoc Health is a supplemental service that is not intended to replace care from your Primary Care Physician. Please log into **blueshieldca.com/teladochealth** or the Blue Shield of California app to request a visit. If you have questions, you may contact Teladoc Health by phone at 1-800-Teladoc (1-800-835-2362) [TTY: 711], 24 hours a day, 7 days a week, 365 days a year. *Services do not apply to the plan's maximum out-of-pocket limit.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. *Prior authorization may be required and is the responsibility of your provider.*	You pay $250 per trip, each way for Medicare-covered ground ambulance services. You pay 20% coinsurance per trip, each way for Medicare-covered air ambulance services. Although most providers collect the applicable cost-sharing at the time of service, this may not occur for ambulance services. You may receive a bill for the entire cost of the ambulance service. If this occurs, simply submit your bill to: Blue Shield 65 Plus Customer Service

Covered Service	What you pay
Ambulance services (cont'd)	P.O. Box 927 Woodland Hills, CA 91365-9856 Blue Shield will reimburse you for the cost of the covered services, less the applicable cost-sharing. You will receive a separate bill from the provider for the applicable cost-sharing.
Annual physical exam* You are covered for one routine physical exam every 12 months in addition to your annual wellness visit. This visit includes a comprehensive review of your medical and family history, a detailed head-to-toe assessment and other services, referrals and recommendations that may be appropriate. Any labs, diagnostic procedures, or other types of services ordered are not covered under this benefit and you pay your plan cost-sharing amount for each of those services separately. *Services do not apply to the plan's maximum out-of-pocket limit.	You pay $0.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.

Covered Service	What you pay
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	You pay $30 per visit.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.

Covered Service	What you pay
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services (Medicare covered) Covered services include: • We cover only manual manipulation of the spine to correct subluxation *A referral may be required and is the responsibility of your provider.*	You pay $0 per visit for all Medicare-covered services.
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning. *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	Cost sharing for this service will vary depending on individual services provided under the course of treatment. Please see the following sections of the Medical Benefits Chart for more information on cost sharing and benefit limitations: • Acupuncture for chronic low back pain • Chiropractic services • Depression screening

Covered Service	What you pay
Chronic pain and management and treatment services (cont'd)	• Medicare Part B drugs • Opioid treatment program services • Outpatient mental health care • Outpatient rehabilitation services • Outpatient substance use disorder services • Partial hospitalization services and Intensive outpatient services • Physician/Practitioner services, including doctor's office visits • Screening and counseling to reduce alcohol misuse • For Medicare Part D drugs, refer to Chapters 5 and 6 for more information on cost sharing and limitations.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and is subject to copays for physician services and

Covered Service	What you pay
Colorectal cancer screening (cont'd) last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connect with, as a result of, and in the same clinical encounter as the screening test.	services in a hospital outpatient setting or ambulatory surgical center. See the *Physician/Practitioner* services, including doctor's office visits section and the *Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* section later in this Medical Benefits Chart.
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's	For Medicare-covered dental services, please see the *Physician/Practitioner services, including doctor's office visits* section of the Medical Benefits Chart.

Covered Service	What you pay
Dental services (cont'd) primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. *A referral may be required and is the responsibility of your provider.*	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with	You pay $0 for diabetes supplies (except blood glucose monitors and continuous glucose monitors), diabetic services and diabetes self-management training. For blood glucose monitors and continuous glucose monitors, please

Covered Service	What you pay
Diabetes self-management training, diabetic services, and supplies (cont'd) such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. For test strips and blood glucose monitors, the preferred manufacturer is Roche Diagnostics. ACCU-CHEK® (made by Roche Diagnostics) test strips and blood glucose monitors will not require your doctor to get approval in advance (sometimes called prior authorization) from the plan. Test strips and blood glucose monitors from all other manufacturers will require your doctor to get approval in advance (sometimes called prior authorization) from the plan. Continuous glucose sensors/receivers from preferred and non-preferred manufacturers will require medical rationale submitted via the plan's prior authorization process. *Prior authorization may be required and is the responsibility of your provider.*	see the *Durable medical equipment and related supplies* section of this Medical Benefits Chart.
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3.) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	You pay 20% coinsurance for each Medicare-covered item, including Medicare oxygen equipment. Blood glucose monitors: • You pay $0 for ACCU-CHEK® blood glucose monitors. • You pay 20% coinsurance for blood glucose monitors from all other manufacturers.

Covered Service	What you pay
Durable medical equipment (DME) and related supplies (cont'd)	Continuous glucose monitors: • You pay $0 for Dexcom and Freestyle Libre continuous glucose monitors. • You pay 20% coinsurance for continuous glucose monitors from all other manufacturers. See the *Medicare Part B Prescription Drugs* section of this Medical Benefits Chart for more information on drugs you take using durable medical equipment.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.	You pay $150 per visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition). If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital.

Covered Service	What you pay
Emergency care Worldwide coverage* *Services do not apply to the plan's maximum out-of-pocket limit.	$150 copay for each visit to an emergency room or urgent care center that is outside the United States and its territories (waived if you are admitted to the hospital within one day for the same condition). You have a $10,000 combined annual limit for covered emergency care or urgently needed services outside the United States and its territories. Services outside the United States and its territories do not apply to the plan's maximum out-of-pocket limit.
Health and wellness education programs* **NurseHelp 24/7** Have a confidential one-on-one online dialogue with a registered nurse, 24 hours a day. When you have a medical concern, one call to our toll-free hotline puts you in touch with a registered nurse who will listen to your concerns and help you toward a solution. Call 1-877-304-0504 (TTY: 711) 24 hours a day, 7 days a week.	You pay $0.
SilverSneakers® Fitness • A nationwide network of participating gyms and community locations with group fitness classes and amenities at select locations – enroll in as many locations as you like	You pay $0.

Covered Service	What you pay
Health and wellness education programs* (cont'd) • Live online classes and workshops through SilverSneakers LIVE™ 7 days/week, morning, afternoon, and evening • On-demand online workouts, wellness and exercise program videos through SilverSneakers On-Demand™ 24 hours a day, 7 days a week • Mobile app access to fitness programs, activity tracking, and your Member ID through SilverSneakers GO™ 24 hours a day, 7 days a week • Community connection and wellbeing support in-person and virtually through SilverSneakers Community and Burnalong® To start using the benefit, find your SilverSneakers ID number, fitness locations, and classes at silversneakers.com. If you have additional questions about your benefit, call 1-888-423-4632 [TTY: 711] Monday through Friday, 5 a.m. to 5 p.m. PT. When you go to the participating fitness location of your choice, the staff will enroll you in their system using your SilverSneakers ID number. You may also ask for a tour of the location to see all the amenities and where the classrooms are located. At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound. Always talk with your doctor before starting an exercise program. *Services do not apply to the plan's maximum out- of-pocket limit.	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. *A referral may be required and is the responsibility of your provider*	You pay $0.

Covered Service	What you pay
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months. If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy.	There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies • *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	You pay $0.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care	You pay $0.

Covered Service	What you pay
Home infusion therapy • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Blue Shield 65 Plus.

Covered Service	What you pay
Hospice care (cont'd) **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare **For services covered by Blue Shield 65 Plus but not covered by Medicare Part A or B:** Blue Shield 65 Plus will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your **For drugs that may be covered by our plan's Part D benefit:** terminal prognosis. You pay our plan cost-sharing amount for these services. If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4). **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	You pay $0 for the hospice consultation services (one time only).

Covered Service	What you pay
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 7 for more information.	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. There is no limit to the number of days per hospital stay. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services	For each Medicare-covered stay in a network hospital, you pay: • $75 per day for days 1 to 5. • $0 per day for days 6 and over If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you'd pay at a network hospital.

Covered Service	What you pay
Inpatient hospital care (cont'd) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Blue Shield 65 Plus provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'llarrange or pay for appropriate lodging and transportation costs for you and a companion.† • Blood - including storage and administration. Coverage of whole blood, packed red cells and all other components of blood begins with the first pint used • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. †Transplants are covered only if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from us. *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	

Covered Service	What you pay
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. Medicare covers up to 90 days of medically necessary hospitalization. Medicare also covers up to 60 additional lifetime reserve days that can be used only once during your lifetime for care provided in either an acute care hospital or a psychiatric hospital. Medicare covers up to 40 additional days in a Psychiatric hospital. The 40 additional Psychiatric days are offered once during your lifetime. Payment may not be made for more than a total of 190 days of inpatient psychiatric care in a freestanding psychiatric hospital during your lifetime. Prior usage under Medicare is included in the lifetime maximum (this includes our plan, any other Medicare Advantage plan, or Original Medicare). *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	For each Medicare-covered stay in a network hospital, you pay: • $900 for days 1 to 150 • 100% of the cost for days 151 and over.
Inpatient stay: Covered services you get in a SNF during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) X-ray, radium, and isotope therapy including technician materials and services	• You pay $0. • You pay $0. • See the *Outpatient diagnostic tests and therapeutic services and supplies* section below.

Covered Service	What you pay
Inpatient stay: Covered services you get in a SNF during a non-covered inpatient stay (cont'd) • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	• You pay $0 for items covered by Medicare. • You pay $0 for items covered by Medicare. • You pay 20% coinsurance. • You pay 20% coinsurance. • You pay $25 per visit.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Covered Service	What you pay
Medicare Diabetes Prevention Program (MDPP) **MDPP services are covered for eligible people under all Medicare health plans.** MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B drugs **These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them. • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-	You pay 0% to 20% coinsurance. For your exact cost, you may call Customer Service at the number on your plan ID card. Members may pay 0% to 20% coinsurance for select Medicare Part B drugs which can change each quarter as established by CMS. Insulin obtained under Part B (when taken with an insulin pump) will not exceed a $35 copay for a one-month supply.

Covered Service	What you pay
Medicare Part B drugs (cont'd) menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision. • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug. • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta). • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube	

Covered Service	What you pay
Medicare Part B drugs (cont'd) feeding) We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit. Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6. *Prior authorization may be required and is the responsibility of your provider.*	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	You pay $15 per visit.

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood, packed red cells and all other components of blood begins with the first pint used • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. • Other outpatient diagnostic tests *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	What you pay depends on the type of services obtained. 1) You pay $0 for basic diagnostic tests, X-ray services, EKGs, supplies, blood and laboratory services. 2) You pay $30 for each diagnostic radiology service. Diagnostic radiology services include, but are not limited to, ultrasound, MRI scans, PET scans, nuclear medicine studies, CT scans, cardiac stress tests, SPECT, myelogram, cystogram, and angiogram. The copay is applicable to the global, technical and professional components of the diagnostic radiology services only. 3) You pay 20% coinsurance for therapeutic radiology services. Therapeutic radiology services include, but are not limited to, radiation therapy, radium and isotope therapy. The 20% coinsurance is applicable to the global, technical and professional components of the

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies (cont'd)	therapeutic radiology services.
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. *A referral may be required and is the responsibility of your provider.*	You pay $0.
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	• You pay $150 per visit to an emergency room (waived if you are admitted to the

Covered Service	What you pay
Outpatient hospital services (cont'd)	hospital within one day for the same condition). You pay $200 per visit to an outpatient hospital facility. You pay $0 for Medicare-covered observation services.
• Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it	• You pay $0. • You pay $30 per outpatient mental health visit. You pay $55 per partial hospitalization visit.
• X-rays and other radiology services billed by the hospital	• See the *Outpatient diagnostic tests and therapeutic services* section above.
• Medical supplies such as splints and casts	• You pay $0 for items covered by Medicare.
• Certain drugs and biologicals you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	• You pay 20% coinsurance.

Covered Service	What you pay
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	You pay $30 for each individual or group therapy visit.
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	You pay $25 per visit.
Outpatient substance use disorder services Coverage under Medicare Part B is available for treatment services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance use disorder or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	You pay $30 for each individual or group therapy visit.

Covered Service	What you pay
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	You pay $50 per visit to an ambulatory surgical center. You pay $200 per visit to an outpatient hospital facility.
Partial hospitalization services and Intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization. *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	You pay $55 per visit.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical	For all covered services: You pay $0 (visits to your PCP do NOT require prior authorization).

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits (cont'd) center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: physician services to treat non-emergency conditions such as cold and flu symptoms, allergies, bronchitis, respiratory infection, sinus problems, rash, eye infection, migraine, and more. o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. o Refer to the *Additional telehealth services* section in the Medical Benefits Chart for more information. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while getting these telehealth services o Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers	For telehealth services related to outpatient substance use disorder, please see the *Outpatient substance use disorder services* section of the Medical Benefits Chart. For telehealth services related to mental health disorders or visits, please see the *Outpatient mental health care* section of the Medical Benefits Chart.

Covered Service	What you pay

Physician/Practitioner services, including doctor's office visits (cont'd)
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:
  ○ You're not a new patient **and**
  ○ The check-in isn't related to an office visit in the past 7 days **and**
  ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:
  ○ You're not a new patient **and**
  ○ The evaluation isn't related to an office visit in the past 7 days **and**
  ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
• Consultation your doctor has with other doctors by phone, internet, or electronic health record
• Second opinion by another network provider prior to surgery
A referral may be required and is the responsibility of your provider.	

Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs *A referral may be required and is the responsibility of your provider.*	You pay $0 for each Medicare-covered visit.
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we	There is no coinsurance, copayment, or deductible for the PrEP benefit.

Covered Service	What you pay
Pre-exposure prophylaxis (PrEP) for HIV prevention (cont'd) cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening.	
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test You can get these services on your own, without a referral from your PCP, as long as you get the service from a network provider.	There is no coinsurance, copayment, or deductible for an annual PSA test or digital rectal exam.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to Vision Care later in this table for more detail. *Prior authorization may be required and is the responsibility of your provider.*	You pay 20% coinsurance for Medicare-covered prosthetic and orthotic devices and related supplies.

Covered Service	What you pay
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	You pay $30 per visit.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. **Eligible members are** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

Covered Service	What you pay
Screening for lung cancer with low dose computed tomography (LDCT) (cont'd) cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Covered Service	What you pay
Services to treat kidney disease Covered services include:	
• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime	• You pay $0.
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)	• You pay 20% coinsurance for each treatment billed by a qualified, Medicare-approved dialysis provider. You pay 20% coinsurance for any drugs used during the procedure.
• Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)	• Included in your costs for Inpatient hospital care. Please see the *Inpatient hospital care* section of this chart for more information about what you must pay.
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	• You pay 20% coinsurance for self-dialysis training.
• Home dialysis equipment and supplies	• You pay 20% coinsurance.
• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	• You pay 20% coinsurance.
Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table**.**	
Prior authorization and/or a referral may be required and is the responsibility of your provider.	

Covered Service	What you pay
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech therapy • Drugs administered to you as part of our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood, packed red cells and all other components of blood begins with the first pint used • Medical and surgical supplies ordinarily provided by SNFs Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	For each stay in a Medicare-certified skilled nursing facility, you pay: • $0 per day for days 1 to 20. • $120 per day for days 21 to 100. If you go over the 100-day limit, you will be responsible for all costs. When a network provider coordinates your admission, Blue Shield 65 Plus waives the 3-day prior hospital stay required by Medicare to qualify for coverage.

Covered Service	What you pay
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. *Prior authorization and/or a referral may be required and is the responsibility of your provider.*	You pay $30 per visit.

Covered Service	What you pay
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. Worldwide coverage* *Services do not apply to the plan's maximum out-of-pocket limit.	You pay $0 per visit to a network urgent care center within your plan service area. You pay $0 per visit to an urgent care center outside of your plan service area but within the United States and its territories. You pay $150 for each visit to an emergency room outside of your plan service area but within the United States and its territories (waived if you are admitted to the hospital within one day for the same condition). You pay $150 for each visit to an emergency room or urgent care center that is outside of the United States and its territories (waived if you are admitted to the hospital within one day for the same condition). You have a $10,000 combined annual limit for covered emergency care or urgently needed services outside the United States and its territories.

Covered Service	What you pay
Urgently needed services (cont'd)	Services outside the United States and its territories do not apply to the plan's maximum out-of-pocket limit.
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. *Prior authorization may be required and is the responsibility of your provider.*	• You pay $0. • You pay $0. • You pay $0. • You pay $0.
Vision care, non-Medicare covered (obtained from a network provider)* Covered services include: • Routine eye exam, including refraction and prescription for eyeglass lenses. If the provider recommends additional procedures, you are responsible for paying the additional costs. Contact	• You pay $10 for one exam every year when you use a network provider.

Covered Service	What you pay
Vision care, non-Medicare covered (obtained from a network provider)* (cont'd) lens exams require additional fees. You are responsible for paying the additional cost. • Eyeglass frames • Eyeglass lenses or contact lenses. If you choose eyeglass lenses, you may elect single, lined bifocal, lined trifocal, or lenticular lenses. If you opt for other lens types not listed or add-on treatments, you will be responsible for paying the additional costs, even if the total costs remain within the allowance. **Note:** You may obtain either eyeglass lenses or contact lenses (but not both) from either an in-network or an out-of-network provider (but not both) every year. Please note that services, eyeglass lenses, and lens treatments not listed are not covered. Prior authorization (approval in advance) is NOT required. Use the Vision Directory or go to **blueshieldca.com/find-a-doctor** to locate a provider participating in the Vision Service Plan (VSP) (Blue Shield Vision Plan Administrator) network. *Services do not apply to the plan's maximum out- of-pocket limit.	• You pay $20 for eyeglass frames (priced up to a regular retail value of $195) every 2 years when you use a network provider. If you choose eyeglass frames priced above $195, you are responsible for the difference. • You pay $20 for either one pair of prescription eyeglass lenses (regardless of size or power) **OR** for contact lenses (priced up to $195 for contact lens services and materials) every year when you use a network provider. If the service and materials price above $195, you are responsible for the difference.
Vision care, non-Medicare covered (obtained from a non-network provider)* • Routine eye exam, refraction and prescription for eyeglass lenses. • Eyeglass frames, Eyeglass lenses or contact lenses. If you choose eyeglass lenses, you may elect single, lined bifocal,	• You are reimbursed up to $30 for one exam every year. • You are reimbursed up to $35 for one pair of

Covered Service	What you pay
Vision care, non-Medicare covered (obtained from a non-network provider)* (cont'd) lined trifocal, or lenticular lenses. If you opt for other lens types not listed or add-on treatments, you will be responsible for paying the additional costs, even if the total costs remain within the allowance. **Note:** You may obtain either eyeglass lenses or contact lenses (but not both) from either an in-network or an out-of-network provider (but not both) every year. You may, if you choose, see an optometrist or an optician who is not a Blue Shield 65 Plus network provider. However, you may not obtain the same services from both a network and a non-network provider. If you choose a non-network provider, you are eligible for a partial reimbursement for the services rendered, unless you've already reached your benefit limit for the vision service you are seeking. Call Customer Service to request a reimbursement form and for more information on requesting a reimbursement. Prior authorization is NOT required. *Services do not apply to the plan's maximum out-of-pocket limit.	eyeglass frames every 2 years. • You are reimbursed up to $35 for either one pair of prescription eyeglass lenses (regardless of size or power) **OR** for contact lenses every year.
Welcome to Medicare preventive visit Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit.	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.

Section 2.1 Extra optional supplemental benefits you can buy

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package. These extra benefits are called Optional Supplemental Benefits. If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

Blue Shield offers two optional supplemental dental plans to Blue Shield 65 Plus Members. Members can choose between an optional supplemental dental HMO plan and a dental PPO plan. Not sure which plan to choose? Below is a brief description of the two plan options:

- The HMO plan has a lower monthly Premium of **$16.00** and offers defined Member out-of-pocket costs; while,
- The PPO plan lets you choose from in- and out-of-network dentists, but you will pay a higher monthly Premium of **$49.00**.

Tip: There are several ways you can pay your Premium. You can pay in all the same ways listed in Chapter 1, Section 5.1.

Blue Shield 65 Plus optional supplemental Dental HMO and PPO plans

The Blue Shield 65 Plus optional supplemental dental HMO and PPO plans are administered by a contracted Dental Plan Administrator (DPA), an entity that contracts with Blue Shield to administer the delivery of dental services through a network of contracted dentists. The DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from in- and out-of-network dentists.

Enrolling in a Blue Shield 65 Plus optional supplemental Dental HMO or PPO plan

To enroll in either the optional supplemental dental HMO or PPO plan, you should have indicated your choice to purchase one of the plans on your enrollment form at the time of enrollment in Blue Shield 65 Plus. For the optional supplemental dental HMO plan, you should have also selected a network dentist from the list of dentists located in the Provider Directory and indicated your choice on your enrollment form at the time of enrollment. With the optional supplemental dental PPO plan, you don’t have to select a network dentist in order to enroll. If you are already a Blue Shield 65 Plus Member, you may add either the optional supplemental dental HMO or PPO coverage simply by calling Customer Service at the number on the back cover of this document to receive an enrollment form. You may add this coverage for the first time at any time during the year.

Switching enrollment between the Blue Shield 65 Plus optional supplemental dental HMO or PPO plans

If you are currently enrolled in a Blue Shield 65 Plus optional supplemental dental plan, you have the option to switch to another Blue Shield optional supplemental dental plan. During the annual enrollment period (AEP), October 7 to December 15, you may make your switch from the optional supplemental dental HMO plan to the optional supplemental dental PPO plan, or from the optional supplemental dental PPO plan to the optional supplemental dental HMO plan, for a January 1 effective date.

To switch your enrollment outside of the AEP, you must follow these guidelines:

- To switch to the Blue Shield 65 Plus optional supplemental dental PPO plan outside of the AEP, you must have six (6) months of continuous enrollment in the optional supplemental dental HMO plan, remain enrolled in Blue Shield 65 Plus, and continue to pay your monthly optional supplemental dental plan Premium. You must complete and submit a new application for the optional supplemental dental PPO plan.
- To switch to the Blue Shield 65 Plus optional supplemental dental HMO plan outside of the AEP, you must have twelve (12) months of continuous enrollment in the optional supplemental dental PPO plan, remain enrolled in Blue Shield 65 Plus, and continue to pay your monthly optional supplemental dental plan Premium. You must complete and submit a new application for the optional supplemental dental HMO plan.

If you have questions about enrolling in an optional supplemental dental plan or switching from one optional supplemental dental plan to another, please call Customer Service (phone numbers are printed on the back cover of this document).

Disenrolling from the Blue Shield 65 Plus optional supplemental Dental HMO or PPO plan

You can disenroll from the optional supplemental dental HMO or PPO plan at any time during the year. You may mail or fax to us a signed letter requesting disenrollment from the optional supplemental dental HMO or PPO plan, or you may call Customer Service to request a disenrollment form. Your letter must clearly state that you wish to disenroll from the optional supplemental dental HMO or PPO plan, and include your printed name and membership ID number located on your Member ID card. Disenrollment requests received by the last day of the month will be effective the first day of the following month. Members will be responsible for their optional supplemental dental HMO or PPO plan Premium payment if the disenrollment request is received after the last day of the month.

You can be disenrolled from the optional supplemental dental HMO or PPO plan for failure to pay the required monthly Premium, when due. Your plan Premium is due by the last day of

the month prior to your coverage period month. If we have not received your Premium by the last day of the month, we will send you a notice telling you that your optional supplemental dental HMO or PPO plan membership will end if all Premium payments due are not received within a 3-month grace period. You will be liable for the Premium accrued during this 3-month grace period.

At the time we end your membership in the optional supplemental dental HMO or PPO plan, you may still owe us for Premiums you have not paid. You will need to pay the amount you owe before you can re-enroll in that plan.

Within ten (10) calendar days of your disenrollment date, we will mail you a notice confirming termination of coverage with the specific date when coverage ended.

Disenrollment from the optional supplemental dental HMO or PPO plan will not result in disenrollment from Blue Shield 65 Plus. Non-payment of plan Premiums for your optional supplemental dental HMO or PPO plan will not result in disenrollment from Blue Shield 65 Plus, only the loss of the optional supplemental dental HMO or PPO plan.

Re-enrolling

If you disenroll from the optional supplemental dental HMO or PPO plan, you must wait six (6) months before you will be allowed to re-enroll.

Refund of Premium

Members enrolled in the optional supplemental dental HMO or PPO plan have a monthly plan Premium and are entitled to a refund for any overpayments of plan Premiums made during the course of the year or at the time of disenrollment. Overpayments of optional supplemental dental HMO or PPO plan Premiums will be refunded upon request or disenrollment. We will refund any overpayments within 30 business days of notification.

Optional supplemental Dental HMO and PPO benefits chart (what is covered and what you pay)

The following ***Summary of Benefits Chart*** shows the specific dental procedures covered by the optional supplemental dental HMO and PPO plans and what you will pay for those procedures. The services listed are covered benefits when provided by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice. Additionally, specific to the optional supplemental dental HMO plan, referral to a dental specialist is limited to only those procedures that cannot be performed by a contracted general dentist as determined by the Dental Director prior to service. As a Member of the optional supplemental dental PPO plan, you can go directly to a dental specialist without a referral.

Important: Please note that procedures not listed are not covered.

Not all procedures may be appropriate for everyone. In cases where there may be more than one appropriate procedure or option to address a dental condition, an Alternate Benefit Provision (ABP) may be applied.

An ABP may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist. For example, an alternate benefit of a partial denture will be applied when there are bilaterally missing teeth or more than 3 teeth missing in one quadrant or in the anterior region. The ABP does not commit the Member to the less costly treatment. However, if the Member and the dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed for the ABP.

Important: Some dental services are not covered by the optional supplemental dental HMO or PPO plans under any conditions (also known as Exclusions), and some dental services are only covered under specific conditions (also known as Limitations). Please refer to the "General Limitations" column in the ***Summary of Benefits Chart*** below and to the "General exclusions" listed after the ***Summary of Benefits Chart*** for more information.

Important: Any frequency limits listed in the General Limitations column of the ***Summary of Benefits Chart*** below that do not specify per plan year or per lifetime are based on the last date of service. For example, a limit of 1 every 6 months means that you may receive the listed service once every six months from the date you last received that same service. So, if you receive your first service on January 1st, you will be eligible for that same service again on July 1st. If you receive your first service on July 1st, you will not be eligible for that service until January 1st of the next plan year. Services with no frequency limit listed are unlimited when necessary and customary as determined by the standards of generally accepted dental practice.

When there is documentation that any of the conditions below existed at the time treatment was begun, or emergent conditions existed during preparation of a specific tooth, the treatment is subject to review of documentation by a Plan dental director.

Benefits will be provided for specific dental procedures necessary to treat specified emergent, painful or infective acute dental conditions in a manner consistent with professionally recognized standard of care. The Plan reserves the right to administratively review, by a Plan dental director, the submitted documentation of the above conditions for coverage determination.
Conditions characterized by acute pain or infection include the following:

- Acute pain requiring immediate root canal;
- Acute pain requiring tooth extraction or removal and/or incision and drainage;

- Acute periodontal abscess requiring emergency periodontal procedures.

Emergent restorative conditions include the following:

- A tooth that is undergoing restoration that was begun as a (Basic Restorative) filling, but due to the extent of decay/fracture found during the course of its restoration, is now required to have a (Major Restorative) cast crown placed.

Services are listed with the American Dental Association (ADA) procedure code based on the current dental terminology. Federal law requires the use of the American Dental Association (ADA) codes to report dental procedures. Procedure codes may be revised from time to time by the ADA. The plan may revise this code list as required by law. You can obtain an updated ADA code list by contacting the Dental Plan Administrator (DPA) customer service department toll free at **(888) 679-8928 [TTY: 711]**, Monday through Friday between 5 a.m. and 8 p.m. (excluding holidays).

Summary of Benefits Chart

	Dental HMO	**Dental PPO**	
Network Access	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**
Calendar year deductible (not applicable to diagnostic and preventive services provided by in-network and out-of-network dentists)	None	$50	
Calendar year maximum	None	$1,500 for covered preventive and comprehensive dental services combined, no matter if the services are performed by an in-network 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 out-of-network dentists in a calendar year. You pay any amount above the $1,500 calendar year benefit maximum.	

There are no waiting periods for any covered services in the optional supplemental dental HMO plan or the optional supplemental dental PPO plan.

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
Oral Exams					
D0120	Periodic oral evaluation - established patient	$0	0%	20%	HMO: 2 every 12 months PPO: 2 per plan year
D0140	Limited oral evaluation - problem focused	$0	0%	20%	No frequency limit
D0150	Comprehensive oral evaluation - new or established patient	$5	0%	20%	HMO: No frequency limit PPO: 1 every 6 months
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0	0%	20%	No frequency limit
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0	0%	20%	No frequency limit
D0180	Comprehensive periodontal evaluation – new or established patient	$5	0%	20%	1 every 36 months
Dental X-rays					
D0210	Intraoral - comprehensive series of radiographic images	$0	0%	20%	1 every 24 months
D0220	Intraoral – periapical first radiographic image	$0	0%	20%	No frequency limit
D0230	Intraoral – periapical each additional radiographic image	$0	0%	20%	No frequency limit
D0240	Intraoral - occlusal radiographic image	$0	0%	20%	No frequency limit
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	$0	0%	20%	No frequency limit
D0270	Bitewing - single radiographic image	$0	0%	20%	HMO: No frequency limit PPO: 4 per plan year

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D0272	Bitewings - two radiographic images	$0	0%	20%	HMO: 1 every 6 months PPO: 1 per plan year
D0273	Bitewings - three radiographic images	$0	0%	20%	HMO: 1 every 6 months PPO: 1 per plan year
D0274	Bitewings - four radiographic images	$0	0%	20%	HMO: 1 every 6 months PPO: 1 per plan year
D0277	Vertical bitewings - 7 to 8 radiographic images	$0	0%	20%	HMO: 1 every 6 months PPO: 1 every 24 months
D0330	Panoramic radiographic image	$0	0%	20%	1 every 24 months
D0372	Intraoral tomosynthesis – comprehensive series of radiographic images	$0	0%	20%	1 every 24 months
D0373	Intraoral tomosynthesis – bitewing radiographic image	$0	0%	20%	HMO: 1 every 6 months PPO: 1 per plan year
D0374	Intraoral tomosynthesis – periapical radiographic image	$0	0%	20%	No frequency limit
D0387	Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	$0	0%	20%	1 every 24 months
D0388	Intraoral tomosynthesis – bitewing radiographic image – image capture only	$0	0%	20%	HMO: 1 every 6 months PPO: 1 per plan year
D0389	Intraoral tomosynthesis – periapical radiographic image – image capture only	$0	0%	20%	No frequency limit
D0701	Panoramic radiographic image – image capture only	$0	0%	20%	1 every 24 months

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D0702	2-D cephalometric radiographic image – image capture only	$0	0%	20%	1 every 24 months
D0706	Intraoral - occlusal radiographic image - image capture only	$0	0%	20%	No frequency limit
D0707	Intraoral - periapical radiographic image - image capture only	$0	0%	20%	No frequency limit
D0708	Intraoral - bitewing radiographic image - image capture only	$0	0%	20%	HMO: No frequency limit PPO: 4 per plan year
D0709	Intraoral – comprehensive series of radiographic images – image capture only	$0	0%	20%	1 every 24 months
Other Diagnostic Dental Services					
D0460	Pulp vitality tests	$0	0%	20%	No frequency limit
D0470	Diagnostic casts	$10	0%	20%	HMO: No frequency limit PPO: 1 every 24 months
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$0	20%	30%	No frequency limit
D9995	Teledentistry – synchronous; real-time encounter	$0	0%	20%	No frequency limit
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	$0	0%	20%	No frequency limit
Prophylaxis (Cleaning)					
D1110	Prophylaxis - adult	$5	0%	20%	1 every 6 months
Fluoride Treatment					
D1206	Topical application of fluoride varnish	$0	0%	20%	HMO: No frequency limit PPO: 1 per plan year
Other Preventive Dental Services					

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D1310	Nutritional counseling for control of dental disease	$0	0%	20%	No frequency limit
D1330	Oral hygiene instruction	$0	0%	20%	No frequency limit
D1351	Sealant - per tooth	$5	0%	20%	HMO: 1 every 36 months (exact tooth) PPO: 1 every 24 months (exact tooth)
Restorative Services					
D2140	Amalgam - one surface, primary or permanent	$8	20%	30%	No frequency limit
D2150	Amalgam - two surfaces, primary or permanent	$10	20%	30%	No frequency limit
D2160	Amalgam - three surfaces, primary or permanent	$15	20%	30%	No frequency limit
D2161	Amalgam - four or more surfaces, primary or permanent	$18	20%	30%	No frequency limit
D2330	Resin-based composite - one surface, anterior	$11	20%	30%	No frequency limit
D2331	Resin-based composite - two surfaces, anterior	$17	20%	30%	No frequency limit
D2332	Resin-based composite - three surfaces, anterior	$19	20%	30%	No frequency limit
D2335	Resin-based composite - four or more surfaces (anterior)	$19	20%	30%	No frequency limit
D2391	Resin-based composite – one surface, posterior	$50	Not Covered		HMO: 1 every 12 months (exact tooth/ surface)
D2392	Resin-based composite – two surfaces, posterior	$60	Not Covered		HMO: 1 every 12 months (exact tooth/ surface)
D2393	Resin-based composite – three surfaces, posterior	$70	Not Covered		HMO: 1 every 12 months (exact tooth/ surface)

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists	General Limitations
D2394	Resin-based composite – four or more surfaces, posterior	$80	Not Covered		HMO: 1 every 12 months (exact tooth/ surface)
D2510	Inlay - metallic - one surface	$50	50%	50%	HMO: 1 every 12 months (exact tooth/ surface) PPO: 1 every 5 years (exact tooth/surface)
D2520	Inlay - metallic - two surfaces	$70	50%	50%	HMO: 1 per plan year (exact tooth/ surface) every 5 years PPO: 1 every 5 years (exact tooth/surface)
D2530	Inlay - metallic - three or more surfaces	$90	50%	50%	HMO: 1 per plan year (exact tooth/ surface) every 5 years PPO: 1 every 5 years (exact tooth/surface)
D2543	Onlay - metallic - three surfaces	$110	50%	50%	HMO: 1 per plan year (exact tooth/ surface) every 5 years PPO: 1 every 5 years (exact tooth/surface)

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists	General Limitations
D2544	Onlay - metallic - four or more surfaces	$115	50%	50%	HMO: 1 per plan year (exact tooth/ surface) every 5 years PPO: 1 every 5 years (exact tooth/surface)
D2710	Crown - resin-based composite (indirect)	$95	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D2712	Crown - 3/4 resin-based composite (indirect)	$95	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 5 years (exact tooth)
D2720	Crown - resin with high noble metal	$122	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D2721	Crown - resin with predominantly base metal	$122	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D2722	Crown - resin with noble metal	$122	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D2740	Crown - porcelain/ceramic	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D2750	Crown - porcelain fused to high noble metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D2751	Crown - porcelain fused to predominantly base metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D2752	Crown - porcelain fused to noble metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D2753	Crown – porcelain fused to titanium and titanium alloys	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D2780	Crown - 3/4 cast high noble metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D2781	Crown - 3/4 cast predominantly base metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists	General Limitations
D2782	Crown - 3/4 cast noble metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D2790	Crown - full cast high noble metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D2791	Crown - full cast predominantly base metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D2792	Crown - full cast noble metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10	50%	50%	No frequency limit
D2915	Re-cement cast or re-bond indirectly fabricated or prefabricated post and core	$10	50%	50%	No frequency limit
D2920	Re-cement or re-bond crown	$10	50%	50%	No frequency limit
D2940	Placement of interim direct restoration	$0	50%	50%	No frequency limit
D2950	Core buildup, including any pins when required	$30	50%	50%	No frequency limit
D2951	Pin retention - per tooth, in addition to restoration	$5	50%	50%	No frequency limit

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D2952	Post and core in addition to crown, indirectly fabricated	$60	50%	50%	HMO: 1 per plan year every 5 years PPO: No frequency limit
D2953	Each additional indirectly fabricated post - same tooth	$60	50%	50%	HMO: 1 per plan year every 5 years PPO: No frequency limit
D2954	Prefabricated post and core in addition to crown	$35	50%	50%	No frequency limit
D2960	Labial veneer (resin laminate) - direct	$73	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D2961	Labial veneer (resin laminate) - indirect	$122	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D2962	Labial veneer (porcelain laminate) - indirect	$295	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D2989	Excavation of a tooth resulting in the determination of non-restorability	$8	20%	30%	No frequency limit
Endodontics					
D3110	Pulp cap - direct (excluding final restoration)	$5	50%	50%	No frequency limit
D3120	Pulp cap - indirect (excluding final restoration)	$5	50%	50%	No frequency limit

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D3310	Endodontic therapy - anterior tooth (excluding final restoration)	$195/ $268	50%	50%	HMO: 1 per lifetime (exact tooth) PPO: No frequency limit
D3320	Endodontic therapy - premolar tooth (excluding final restoration)	$250/ $332	50%	50%	HMO: 1 per lifetime (exact tooth) PPO: No frequency limit
D3330	Endodontic therapy - molar tooth (excluding final restoration)	$335/ $425	50%	50%	HMO: 1 per lifetime (exact tooth) PPO: No frequency limit
D3346	Retreatment of previous root canal therapy - anterior	$195/ $268	50%	50%	No frequency limit
D3347	Retreatment of previous root canal therapy - premolar	$250/ $332	50%	50%	No frequency limit
D3348	Retreatment of previous root canal therapy - molar	$335/ $425	50%	50%	No frequency limit
D3410	Apicoectomy - anterior	$100	50%	50%	No frequency limit
D3421	Apicoectomy - premolar (first root)	$195	50%	50%	No frequency limit
D3425	Apicoectomy - molar (first root)	$295	50%	50%	No frequency limit
D3426	Apicoectomy (each additional root)	$120	50%	50%	No frequency limit
D3430	Retrograde filling - per root	$120	50%	50%	No frequency limit
D3471	Surgical repair of root resorption – anterior	$100	50%	50%	No frequency limit
D3472	Surgical repair of root resorption – premolar	$100	50%	50%	No frequency limit
D3473	Surgical repair of root resorption – molar	$100	50%	50%	No frequency limit
D3911	Intraorifice barrier	$50	Not Covered		HMO: 1 every 12 months (exact tooth/ surface)
Periodontics					

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$100	50%	50%	1 every 36 months (exact tooth)
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$20	50%	50%	1 every 36 months (exact tooth)
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bonded spaces per quadrant	$168	50%	50%	1 every 36 months (exact tooth)
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bonded spaces per quadrant	$112	50%	50%	1 every 36 months (exact tooth)
D4260	Osseous surgery (including elevation of full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$293	50%	50%	1 every 36 months (exact tooth)
D4261	Osseous surgery (including elevation of full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$195	50%	50%	1 every 36 months (exact tooth)
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$168	50%	50%	1 every 36 months (exact tooth)
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$45	50%	50%	HMO: 1 every 12 months (exact tooth) PPO: 1 every 24 months (exact tooth)

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists	General Limitations
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$45	50%	50%	HMO: 1 every 12 months (exact tooth) PPO: 1 every 24 months (exact tooth)
D4346	Scaling in presence of generalized moderate or severe gingival inflammation	$20	Not Covered		HMO: 1 every 6 months
D4355	Full mouth debridement to enable a comprehensive evaluation and diagnosis on a subsequent visit	$40	Not Covered		HMO: 1 every 24 months
D4910	Periodontal maintenance	$20	50%	50%	1 every 6 months
Prosthodontics, removable					
D5110	Complete denture - maxillary	$285	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 5 years (exact tooth)
D5120	Complete denture - mandibular	$285	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 5 years (exact tooth)
D5130	Immediate denture - maxillary	$285	50%	50%	HMO: 1 per lifetime PPO: 1 every 5 years (exact tooth)
D5140	Immediate denture - mandibular	$285	50%	50%	HMO: 1 per lifetime PPO: 1 every 5 years (exact tooth)
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$149	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 5 years
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$149	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 5 years

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$310	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$185	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$300	Not Covered		HMO: 1 per plan year (exact tooth) every 5 years
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$300	Not Covered		HMO: 1 per plan year (exact tooth) every 5 years
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/ clasping materials, rests, and teeth), maxillary	$185	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 5 years (exact tooth)
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/ clasping materials, rests, and teeth), mandibular	$185	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 5 years (exact tooth)
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/ clasping materials, rests and teeth) - per quadrant	$185	Not Covered		HMO: 1 per plan year every 5 years
D5286	Removable unilateral partial denture – onepiece resin (including retentive/clasping materials, rests and teeth) - per quadrant	$185	Not Covered		HMO: 1 per plan year every 5 years

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D5410	Adjust complete denture - maxillary	$10	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months
D5411	Adjust complete denture - mandibular	$10	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months
D5421	Adjust partial denture - maxillary	$10	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months
D5422	Adjust partial denture - mandibular	$10	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months
D5511	Repair broken complete denture base, mandibular	$21	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months
D5512	Repair broken complete denture base, maxillary	$21	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months
D5520	Replace missing or broken teeth - complete denture - per tooth	$21	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months (exact tooth)
D5621	Repair cast partial framework, mandibular	$22	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D5622	Repair cast partial framework, maxillary	$21	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months
D5630	Repair or replace broken retentive/clasping materials - per tooth	$25	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months
D5640	Replace missing or broken teeth – partial denture - per tooth	$27	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months
D5650	Add tooth to existing partial denture – per tooth	$25	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months (exact tooth)
D5660	Add clasp to existing partial denture - per tooth	$33	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$134	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$134	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months
D5710	Rebase complete maxillary denture	$75	50%	50%	HMO: 1 every 12 months PPO: 1 every 6 months

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists	General Limitations
D5711	Rebase complete mandibular denture	$75	50%	50%	HMO: 1 every 12 months PPO: 1 every 6 months
D5720	Rebase maxillary partial denture	$67	50%	50%	HMO: 1 every 12 months PPO: 1 every 6 months
D5721	Rebase mandibular partial denture	$67	50%	50%	HMO: 1 every 12 months PPO: 1 every 6 months
D5725	Rebase hybrid prosthesis	$75	50%	50%	HMO: 1 every 12 months PPO: 1 every 6 months
D5730	Reline complete maxillary denture (direct)	$35	50%	50%	HMO: 1 every 12 months PPO: 1 every 6 months
D5731	Reline complete mandibular denture (direct)	$35	50%	50%	HMO: 1 every 12 months PPO: 1 every 6 months
D5740	Reline maxillary partial denture (direct)	$35	50%	50%	HMO: 1 every 12 months PPO: 1 every 6 months
D5741	Reline mandibular partial denture (direct)	$35	50%	50%	HMO: 1 every 12 months PPO: 1 every 6 months

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D5750	Reline complete maxillary denture (indirect)	$59	50%	50%	HMO: 1 every 12 months PPO: 1 every 6 months
D5751	Reline complete mandibular denture (indirect)	$59	50%	50%	HMO: 1 every 12 months PPO: 1 every 6 months
D5760	Reline maxillary partial denture (indirect)	$59	50%	50%	HMO: 1 every 12 months PPO: 1 every 6 months
D5761	Reline mandibular partial denture (indirect)	$59	50%	50%	HMO: 1 every 12 months PPO: 1 every 6 months
D5765	Soft liner for complete or partial removable denture - indirect	$28	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months
D5810	Interim complete denture (maxillary)	$145	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 5 years
D5811	Interim complete denture (mandibular)	$145	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 5 years
D5850	Tissue conditioning, maxillary	$28	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months
D5851	Tissue conditioning, mandibular	$28	50%	50%	HMO: 1 per plan year every 5 years PPO: 1 every 6 months
Implant Services					

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D6010	Surgical placement of implant services body: endosteal implant	Not Covered	50%	50%	PPO: 1 per lifetime
D6056	Prefabricated abutment - includes modification and placement	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6057	Custom fabricated abutment - includes placement	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6058	Abutment supported porcelain/ceramic crown	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6060	Abutment supported porcelain fused to metal crown (predominately base metal)	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6061	Abutment supported porcelain fused to metal crown (noble metal)	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6062	Abutment supported cast metal crown (high noble metal)	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6063	Abutment supported cast metal crown (predominately base metal)	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6064	Abutment supported cast metal crown (noble metal)	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6065	Implant supported porcelain/ceramic crown	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6066	Implant supported crown - porcelain fused to high noble alloys	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6067	Implant supported crown -high noble alloys	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prothesis and abutments	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6082	Implant supported crown - porcelain fused to predominantly base alloys	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists	General Limitations
D6083	Implant supported crown - porcelain fused to noble alloys	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6086	Implant supported crown - predominantly base alloys	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6087	Implant supported crown - noble alloys	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6088	Implant supported crown - titanium and titanium alloys	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6089	Accessing and retorquing loose implant screw - per screw	Not Covered	50%	50%	PPO: No frequency limit
D6090	Repair of implant/abutment supported prosthesis	Not Covered	50%	50%	PPO: 1 every 6 months (exact tooth)
D6092	Re-cement or re-bond implant/abutment supported crown	Not Covered	50%	50%	PPO: No frequency limit
D6094	Abutment supported crown - titanium and titanium alloys	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6096	Remove broken implant retaining screw	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6098	Implant supported retainer - porcelain fused to predominately base alloys	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6100	Surgical removal of implant body	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)
D6105	Removal of implant body not requiring bone removal nor flap elevation	Not Covered	50%	50%	PPO: 1 every 5 years (exact tooth)

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D6106	Guided tissue regeneration - resorbable barrier, per implant	Not Covered	50%	50%	PPO: 1 every 36 months (exact tooth)
D6107	Guided tissue regeneration - non-resorbable barrier, per implant	Not Covered	50%	50%	PPO: 1 every 36 months (exact tooth)
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	Not Covered	50%	50%	No frequency limit
D6193	Replacement of an implant screw	Not Covered	50%	50%	No frequency limit
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	Not Covered	50%	50%	PPO: 1 every 6 months (exact tooth)
Prosthodontics, fixed					
D6205	Pontic - indirect resin-based composite	$150	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6210	Pontic - cast high noble metal	$210	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6211	Pontic - cast predominantly base metal	$210	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D6212	Pontic - cast noble metal	$210	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6240	Pontic - porcelain fused to high noble metal	$210	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6241	Pontic - porcelain fused to predominantly base metal	$210	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6242	Pontic - porcelain fused to noble metal	$210	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6243	Pontic – porcelain fused to titanium and titanium alloys	$210	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6250	Pontic - resin with high noble metal	$210	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6251	Pontic - resin with predominantly base metal	$210	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists	General Limitations
D6252	Pontic - resin with noble metal	$210	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6602	Retainer inlay - cast high noble metal, two surfaces	$70	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth/ surface)
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$90	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth/ surface)
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$70	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth/ surface)
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$90	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth/ surface)
D6606	Retainer inlay - cast noble metal, two surfaces	$70	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth/ surface)

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D6607	Retainer inlay - cast noble metal, three or more surfaces	$90	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth/ surface)
D6610	Retainer onlay - cast high noble metal, two surfaces	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth/ surface)
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth/ surface)
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth/ surface)
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth/ surface)

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists	General Limitations
D6614	Retainer onlay - cast noble metal, two surfaces	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth/ surface)
D6615	Retainer onlay - cast noble metal, three or more surfaces	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth/surface)
D6710	Retainer crown - indirect resin-based composite	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6720	Retainer crown - resin with high noble metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6721	Retainer crown - resin with predominantly base metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6722	Retainer crown - resin with noble metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists	General Limitations
D6750	Retainer crown - porcelain fused to high noble metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6751	Retainer crown - porcelain fused to predominantly base metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6752	Retainer crown - porcelain fused to noble metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6780	Retainer crown - 3/4 cast high noble metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6781	Retainer crown - 3/4 cast predominantly base metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6782	Retainer crown - 3/4 cast noble metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D6784	Retainer crown - 3/4 titanium and titanium alloys	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6790	Retainer crown - full cast high noble metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6791	Retainer crown - full cast predominantly base metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6792	Retainer crown - full cast noble metal	$275	50%	50%	HMO: 1 per plan year (exact tooth) every 5 years PPO: 1 every 5 years (exact tooth)
D6930	Re-cement or re-bond fixed partial denture	$12	50%	50%	HMO: No frequency limit PPO: 1 every 6 months
Oral and Maxillofacial Surgery					
D7111	Extraction, coronal remnants - primary tooth	$10	50%	50%	HMO: 1 per lifetime (exact tooth) PPO: 2 per lifetime (exact tooth)
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$15	50%	50%	HMO: 1 per lifetime (exact tooth) PPO: 2 per lifetime (exact tooth)

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$30	50%	50%	HMO: 1 per lifetime (exact tooth) PPO: 2 per lifetime (exact tooth)
D7220	Removal of impacted tooth - soft tissue	$40	50%	50%	HMO: 1 per lifetime (exact tooth) PPO: 2 per lifetime (exact tooth)
D7230	Removal of impacted tooth - partially bony	$50	50%	50%	HMO: 1 per lifetime (exact tooth) PPO: 2 per lifetime (exact tooth)
D7240	Removal of impacted tooth - completely bony	$80	50%	50%	HMO: 1 per lifetime (exact tooth) PPO: 2 per lifetime (exact tooth)
D7250	Removal of residual tooth roots (cutting procedure)	$60	50%	50%	HMO: 1 per lifetime (exact tooth) PPO: 2 per lifetime (exact tooth)
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)	$30	50%	50%	No frequency limit
D7286	Incisional biopsy of oral tissue - soft	$70	50%	50%	No frequency limit
D7287	Exfoliative cytological sample collection	$15	50%	50%	No frequency limit
D7288	Brush biopsy - transepithelial sample collection	$30	50%	50%	No frequency limit
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$75	50%	50%	No frequency limit
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$75	50%	50%	No frequency limit

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70	50%	50%	No frequency limit
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70	50%	50%	No frequency limit
D7471	Removal of lateral exostosis (maxilla or mandible)	$94	50%	50%	No frequency limit
D7510	Incision and drainage of abscess - intraoral soft tissue	$19	50%	50%	No frequency limit
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$19	50%	50%	No frequency limit
D7520	Incision and drainage of abscess - extraoral soft tissue	$19	50%	50%	No frequency limit
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$19	50%	50%	No frequency limit
D7963	Frenuloplasty	Not Covered	50%	50%	PPO: No frequency limit
D7970	Excision of hyperplastic tissue - per arch	$71	50%	50%	No frequency limit
Adjunctive General Services					
D9110	Palliative treatment of dental pain - per visit	$8	20%	30%	No frequency limit
D9120	Fixed partial denture sectioning	$24	20%	30%	HMO: No frequency limit PPO: 1 every 6 months
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0	20%	30%	No frequency limit
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$0	Not Covered		HMO: No frequency limit

		What you must pay			
		Dental HMO	Dental PPO		
ADA Code	**ADA description of services covered for you**	**In-Network Dentists only**	**In-Network Dentists**	**Out-of-Network Dentists**	**General Limitations**
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$3	20%	30%	No frequency limit
D9440	Office visit - after regularly scheduled hours	$25	20%	30%	No frequency limit
D9450	Case presentation subsequent to detailed and extensive treatment planning	$0	20%	30%	No frequency limit
D9951	Occlusal adjustment - limited	Not Covered	20%	30%	PPO: 1 every 24 months

General notes for the optional supplemental HMO dental plan:

- For endodontic services with two copayments listed in the chart above, the higher Member copayment applies only if the procedure is performed by a specialist.
- If noble or high noble metals are used for fillings, crowns, bridges, or prosthetic devices, there will be an additional charge based on the amount of metal used.
- Unless you require non-Medicare covered emergency dental services, the listed Member Cost-Sharing amounts only apply when you receive dental services from a network dentist (see “Non-Medicare covered emergency dental care”).

General note for the Optional Supplemental HMO and PPO dental plans:

- Removable or fixed prosthodontics such as complete dentures, removable partial dentures, and bridgework are performed by a contracted general dentist. Prosthodontic specialists are not included in the contracted network.
- Since Blue Shield of California contracts with Medicare each year, these dental Benefits may not be available next year.

Getting dental care

Before Obtaining Dental Services

If you purchased the optional supplemental dental HMO plan, you are responsible for verifying that the dentist you choose is a network dentist. For the optional supplemental PPO

plan, you are able to choose from in- and out-of-network dentists. However, if you choose to go to a network dentist to lower your costs, you are responsible for verifying that the dentist you choose is a network dentist.

NOTE: A network dentist's status may change. It is your obligation to verify whether the dentist you choose is currently a network dentist in case there have been any changes to the list of contracted dentists. A list of network dentists located in your area can be obtained by contacting the DPA customer service department toll free at **(888) 679-8928 [TTY: 711],** Monday through Friday between 5 a.m. and 8 p.m. (excluding holidays).

Visiting your dentist

Optional Supplemental Dental HMO Plan:

If you purchased the optional supplemental dental HMO plan, call the network dentist you selected at the time of enrollment as your primary care dentist (PCD) and make an appointment. You must contact your PCD for all dental care needs including preventive services, routine dental problems, consultation with plan specialists, and emergency services (when possible). The PCD is responsible for providing general dental services and coordinating or arranging for referral to other necessary plan specialists. The Plan must authorize such referrals.

This in-network only dental plan does not pay benefits to out-of-network dentists. When you receive Covered Services from an out-of-network dentist, services will not be covered, except if there is a dental emergency. If you receive Covered Services from an out-of-network dentist, you will be responsible for paying the dentist directly for the entire amount billed by the dentist.

Optional Supplemental Dental PPO Plan:

If you purchased the optional supplemental dental PPO plan, call any in- or out-of-network general dentist or specialist and make an appointment. The dental office should be open during regular business hours. If you have questions about when the office is open, call the dental office directly.

The dental benefits are specifically designed for you to use network dentists. Network dentists agree to accept the DPA's payment, plus your payment of any applicable Deductible and Copayment or Coinsurance, as payment in full for Covered Services. This is not true of out-of-network dentists. Refer to the Member Cost-Sharing section below for additional costs you will incur.

NOTE: Members who have not kept up with their routine dental appointments (once every 6

months) may find that they require services involving periodontal scaling and root planing before routine care such as regular cleanings can or will be provided.

Member Cost-Sharing

Prior to beginning your treatment, your dentist will design a treatment plan to meet your individual needs. It is best to discuss your treatment plan and financial responsibilities with your dentist prior to beginning treatment.

Optional Supplemental Dental HMO Plan:

Your Copayments are due and payable at time of service or inception of care. Unless you require non-Medicare emergency dental services, the listed Member Copayments in the ***Summary of Benefits Chart*** only apply when you receive dental services from a network dentist (see “Non-Medicare covered emergency dental care”).

Optional Supplemental Dental PPO Plan:

The Deductible is due and payable at time of service or inception of care. Once you meet your Deductible, you will be billed a Coinsurance (percentage share of the charge). Coinsurance amounts are listed in the ***Summary of Benefits Chart***.

If you go to an out-of-network dentist, you will pay additional charges above the Coinsurance. You will be reimbursed up to a pre-determined maximum amount for Covered Services which may be substantially less than the billed amount. You are responsible for all differences between the amount you are reimbursed, and the amount billed by out-of-network dentists plus the applicable Coinsurance. Therefore, it is to your advantage to obtain covered dental services from network dentists.

OPTIONAL SUPPLEMENTAL DENTAL PPO PLAN MEMBER COST-SHARING EXAMPLE:

You need to visit the dentist for a procedure on your tooth. You have received Covered Services throughout the year and have already met your $50 Deductible.

You have a choice to visit an in-network dentist or an out-of-network dentist, but you will pay more if you visit a dentist that is not in your plan's network.

Network dentists agree to accept certain rates for Covered Services, and they can't charge you more. These rates are called the allowed amount.

Out-of-network dentists do not have a contract with the DPA, and they can charge any amount they choose. Since your plan will only cover the allowed amount, the dentist will charge you the balance. So, going out-of-network can be very costly. Talk to your dentist before obtaining services to find out how much it will cost.

Deductible: **$50**

Amount paid to date toward Deductible: **$50**

In-Network Dentist Coinsurance: ***50%***

Out-of-Network Dentist Coinsurance: **50%**

Dental Plan Administrator allowed amount for the dentist's visit: **$80**

In-Network Dentist billed charge for the dentist's visit: **$80**

Out-of-Network Dentist billed charge for the dentist's visit: **$580**

	In-Network Dentist	**Out-of-Network Dentist**
You pay	**$40** (50% Coinsurance)	**$540** (50% Coinsurance + $500 for charges over allowed amount)
Blue Shield DPA pays	$40 (allowed amount – your Coinsurance)	$40 (allowed amount – your Coinsurance)
Total payment to the dentist	$80 (allowed amount)	$580 (billed charge)

In this example, because you have already met your Deductible, you are responsible for:

- In-network dentist: the Coinsurance amount; or
- Out-of-network dentist: the Coinsurance amount plus all charges over the allowed amount.

If you go to an out-of-network dentist, you will pay additional charges above the Coinsurance. You will be reimbursed up to a pre-determined maximum amount for Covered Services which may be substantially less than the billed amount. You are responsible for all differences between the amount you are reimbursed and the amount billed by out-of-network dentists plus the applicable Coinsurance. Therefore, it is to your advantage to obtain covered dental services from network dentists.

If you need additional assistance in getting information about your treatment plan or if you have any questions about the Cost-Sharing amounts you are charged for covered dental procedures, you may contact the DPA customer service department toll free at **(888) 679-8928 (TTY: 711)**, Monday through Friday between 5 a.m. and 8 p.m. (excluding holidays).

Optional dental treatment

Optional dental treatment is any procedure that is:

- a dental laboratory upgrade of a standard Covered Service (Members may be charged a surcharge based on the additional laboratory costs), or
- a more extensive Covered Service that is an alternative to the adequate, but more conservative, covered dental service.

There are often several clinically acceptable, professionally recognized, treatment options, which could be considered for Members. To ensure that Members receive acceptable dental benefits in a consistent manner, the DPA publishes its Governing Administrative Policies (GAPs) and other clinical criteria and guidelines and distributes these to Network Providers. This document is revised periodically to incorporate guidelines on the circumstances under which some treatment should be considered covered or optional. Your dentist may refer to these guidelines in the determination of the treatment plan to be covered under this plan.

If you select a more extensive form of treatment that is recommended by your dentist or that is an alternative to an adequate, but more conservative, covered dental service, you must pay the difference between your selected dental office's usual fee for the more extensive form of treatment and the usual fee for the covered benefit plus your Cost-Sharing amount for the covered benefit, as listed in the ***Summary of Benefits Chart***.

NOTE: If you select optional dental treatment, you will be asked to sign an Agreement specifying the services you will receive under your treatment plan. Once you have signed an Agreement to accept and pay for optional treatment, and the treatment is initiated by the

dentist, you are responsible for payment for those services.

For more information, you may consult your dentist or contact the DPA customer service department.

Non-Medicare covered emergency dental care

Non-Medicare covered emergency dental care means care provided by a dentist (inside or outside the Blue Shield 65 Plus Plan Service Area) to treat a dental condition that manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected by the Member to result in either: (i) placing the Member's dental health in serious jeopardy (ii) serious impairment to dental functions, or (iii) subjecting the Member to undue suffering.

In-area non-Medicare covered emergency dental care

If you feel you need non-Medicare covered emergency dental care and you are in the Blue Shield 65 Plus Plan Service Area, immediately call your dentist. The dental office personnel will advise you what to do.

Out-of-area non-Medicare covered emergency dental care

If you are outside your Blue Shield 65 Plus Plan Service Area and require non-Medicare covered emergency dental care, you may obtain treatment from any licensed dentist.

Optional Supplemental Dental HMO reimbursement:

The services you receive from the out-of-area dentist are covered up to $100 minus any applicable Member Copayments as long as transfer to a network provider is a risk to your health.

To obtain reimbursement, submit your request for reimbursement, payment receipt, and description of services rendered in writing to:

Blue Shield of California
P.O. Box 30567
Salt Lake City, UT 84130-0567

There are time limits for filing claims. Claims must be submitted to Blue Shield of California within one year of the date of service, unless there is a reason for filing later.

Optional Supplemental Dental PPO reimbursement:

You will be reimbursed at the payment percentage listed under the out-of-network dentist's portion of the ***Summary of Benefits Chart***. You will be responsible for the remainder of your dentist's billed charges. Whenever possible, you should ask your dentist to send the bill directly to Blue Shield at the address listed above. Our DPA will review the non-Medicare covered emergency dental service you received and will process your claim within 30 calendar days of receipt if it is not missing any required information. If your claim is missing any required information, you or your provider will be notified and asked to submit the missing information. The DPA cannot process your claim until we receive the missing information. Once the missing information is received, the DPA will have 30 calendar days to process your claim. Except for non-Medicare covered emergency dental services, you will be responsible for full payment of dental services you receive outside of California.

Denial of a claim for reimbursement for out-of-area non-Medicare covered emergency dental care

If your claim for reimbursement of out-of-area non-Medicare covered emergency dental care is partially or fully denied, the DPA will notify you of the decision in writing within 30 calendar days from the receipt of the claim. The notification will include the specific reason for the denial and will inform you that you may request a reconsideration of the denial.

To request reconsideration of the denial or partial denial, submit a written notice to Blue Shield 65 Plus within 65 calendar days from the date on the written denial notice.

For additional information, refer to Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Obtaining a second opinion for dental care

You may request a second opinion about your dental care from another dentist who contracts with the DPA if:

- You are not satisfied with treatment you received from your selected dentist;
- You are uncertain about a proposed treatment plan;
- You do not agree with the recommendations of your selected dentist and/or the DPA's Director; or
- You are dissatisfied with the quality of dental work being performed.

Price comparison regarding a proposed procedure or treatment plan is not sufficient grounds for obtaining a second opinion.

To request a second opinion, call the DPA customer service department at **(888) 679-8928 (TTY: 711)**.

The DPA Director will review your request for a second opinion and, if the request is appropriate, will send you an authorization to visit another network dentist within your area. You will have 30 calendar days to contact and visit the second dentist for your second opinion. You will need to pay any plan Cost-Sharing required for the second dentist to render a second opinion (including office visit, radiographs taken, testing devices used, and costs for written statements to the DPA Director). The second dentist will only provide a second opinion, not treat you, at that time.

If you need further assistance, you may contact the Blue Shield 65 Plus Customer Service department at the number on your ID card.

Transferring to another dentist

Whether you are a Member of either the optional supplemental dental HMO plan or the optional supplemental dental PPO plan, if you are not satisfied with the network dentist you selected or are currently seeing, you may select another dentist from the directory. If you need help selecting another network dentist, simply contact the DPA's customer service department toll free at **(888) 679-8928 [TTY: 711].**

NOTE: If you owe your current dentist any money at the time you want to transfer to another dentist, you must settle your account with your current dentist first. If you transfer to a new dentist, you may be responsible for a nominal fee for the duplication and transfer of X-rays and other records to your new dentist.

NOTE: Members may not usually transfer to a new dentist while in the middle of a multi-visit procedure where a final impression for a fabrication of a dental appliance has occurred, unless exceptional cause can be shown. This includes transferring for crowns, inlays and onlays (advanced restorative procedures), removable partial dentures and complete dentures (removable prosthodontics) and components of bridges (fixed prosthodontics).

In cases where Blue Shield 65 Plus allows for transfer in mid-procedure, you may be charged for laboratory charges incurred by the dentist in fabricating the dental appliance. If you are enrolled in the optional supplemental dental HMO plan and you go to an in-network dentist, the charges may not exceed the listed Copayments for the covered procedures. If you are enrolled in the optional supplemental dental PPO plan and you go to an in-network dentist, the charges may not exceed your percentage of the covered procedure's allowed amount as listed under the in-network dentist portion of the Summary of Benefits Chart. If you are enrolled in the optional supplemental dental PPO plan and you go to an out-of-network dentist, you will be responsible for your cost share of the allowed amount plus the difference between the allowed amount and the billed charge. In addition, you may be charged for laboratory charges for any optional features ordered for you by your dentist.

Since the DPA cannot compel or require a contracted dentist to treat any Member for any

reason, the DPA will notify Blue Shield 65 Plus when a breakdown of a workable dentist-patient relationship occurs or cannot be established.

Blue Shield 65 Plus will work with you and the DPA to resolve issues or to select another dentist. If it is necessary for you to select another dentist due to the breakdown or non-establishment of a workable dentist-patient relationship, fees for the duplication and transfer of X-rays or other records are waived. However, routine Member-initiated transfers to a new dentist are subject to fees for duplication and transfer of X-rays or other records. You may contact the DPA customer service department toll free at **(888) 679-8928 (TTY: 711)** for more information.

If your dentist no longer contracts with the Blue Shield 65 Plus DPA

If your selected network dentist is unable to continue under contract with the DPA because he or she is unable to perform or has breached the contract, or if the DPA has terminated the contract, the DPA will notify you at least 30 calendar days prior to the dentist's effective termination date so you may select another dentist. If you are enrolled in the optional supplemental dental PPO plan, you may choose to select another network dentist or continue seeing your current dentist at the out-of-network Cost Sharing amount which will be higher.

If you are notified by the DPA of the need to select another network dentist for this reason, fees for the duplication and transfer of X-rays or other records to another network dentist are waived.

If you have another dental plan

If you purchase the Blue Shield 65 Plus optional supplemental dental HMO or PPO plan, we recommend you contact the other dental plan's customer service department to terminate that other plan to avoid being billed for both. If you opt to keep two network prepaid plans, you may use the Blue Shield 65 Plus optional supplemental dental HMO or PPO plan or your other network prepaid plan, but not both, for a specified procedure. Your dentist will charge you the Cost-Sharing amounts associated with whichever plan ID card you present at the time of service.

Resolving disagreements

If you have concerns about any aspect of your dental plan benefits, contact the DPA customer service department for assistance toll free at **(888) 679-8928 (TTY: 711)**. You may also contact Blue Shield 65 Plus Customer Service (phone numbers are printed on the back cover of this document).

If your concerns are not fully resolved, you have the right to file an appeal or a grievance with Blue Shield 65 Plus. Please go to Chapter 9: (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information on how to file an appeal or grievance.

General exclusions for the optional supplemental Dental HMO and PPO plans

1. Dispensing of drugs that are not associated with a course of dental care, such as medicinal irrigation, locally administered antibiotics and prescription drugs are excluded from coverage.

2. Services for which it is the professional opinion of Blue Shield's attending dentist or the Dental Director that a satisfactory result cannot be obtained, or the prognosis is poor or guarded, i.e., without a minimum service expectancy of 3 years, are excluded from coverage.

3. Removal of asymptomatic teeth, non-pathological teeth, extractions for orthodontic purposes, surgical orthognathic procedures, and crown exposure are excluded from coverage. Third molar (wisdom teeth) extraction is limited to only those instances where the teeth cannot be treated in a minimally invasive manner.

4. Dental conditions arising out of, and due to, the Member's employment or for which Workers' Compensations is payable, or any other third-party is liable are excluded from coverage. Services that are provided to the Member by state government or a state agency, or are provided without cost to the Member by any municipality, county, or subdivision except as provided in Section 1373(a) of the California Health and Safety Code, are not covered.

5. Dental services and any related fees performed in a treatment facility other than the contracted provider's office are not covered (i.e. hospital, ambulatory facility, outpatient clinic, surgical center, etc.).

6. Treatment/removal of malignancies, cysts, tumors, or neoplasms are not covered.

7. Dental services and treatments for restoring tooth structure loss from abnormal or excessive wear or attrition, abrasion, abfraction, bruxism, and/or erosion, except when due to normal masticatory function; changing or restoring vertical dimension, or occlusion, and full mouth reconstruction, diagnosis and/or treatment of the temporomandibular joint (TMJ) are not covered.

8. Treatment of fractures and dislocations of the jaws are not covered.

9. Dental procedures, appliances, or restorations to correct congenitally and/or developmentally missing teeth or other congenital and/or developmental conditions, developmental malformations (including, but not limited to cleft palate, enamel hypoplasia, fluorosis, jaw malformations, and anodontia) and supernumerary teeth are not covered.

10. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage, and dental expenses incurred for treatment in progress prior to Member's eligibility with Blue Shield 65 Plus optional supplemental dental HMO or PPO coverage (for example: teeth prepared for crowns, root canals in progress, fixed and removable prosthetics) are not covered. For the purpose of this exclusion, the date on which a procedure shall be considered to have started is defined as follows:

    a. For full dentures or partial dentures: on the date the final impression is taken;
    b. For fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared;
    c. For root canal therapy: on the later of the date the pulp chamber is opened or the date canals are explored to the apex;
    d. For periodontal surgery: on the date the surgery is actually performed;
    e. For all other services: on the date the service is performed.

11. Crowns, bridges or dentures started in one office (while under Blue Shield 65 Plus optional supplemental dental HMO or PPO coverage) are considered "in progress" until delivered. Additional benefits will not be provided for such treatment in progress.

12. Care provided by a prosthodontic specialist is not covered.

General exclusions for the optional supplemental Dental HMO plan only

1. General anesthesia and the services of a special anesthesiologist, intravenous and inhalation sedation, and prescription drugs for dental procedures are excluded from coverage.

2. Replacement of lost or stolen fixed and removable dental prosthetics (crowns, bridges, full or partial dentures) regardless of payer is excluded from coverage.

3. The "ADA description of services" chart above is the definitive statement of coverage and supersedes all other materials. Any dental service that is not specifically listed as a covered benefit is excluded from coverage, regardless of any other written material presented or implied.

4. Crown lengthening procedures are not covered.

5. Replacement of long-standing missing teeth in an otherwise stable dentition is excluded from coverage. (For example: teeth missing two years or longer, not currently replaced, and where adjacent and opposing teeth are in occlusion.)

6. Treatment for individuals with medical or other barriers to receiving dental care in a network dental provider's office or who have mental or behavioral limitations that affect the provider's ability to render appropriate dental care in a network dental provider's office is excluded from coverage.

7. Benefits do not include splinting, hemisection, implants, overdentures, grafting (unless otherwise stated), guided tissue regeneration, all ceramic-cast restorations, precision attachments, duplicate dentures, and appliances for the treatment of bruxism.

8. Pathology reports are excluded from coverage.

9. Dental treatment for crowns, bridges and/or dentures to restore tooth structure lost as a result of accidental injury are not covered. Accidental dental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from external forces to the mouth. Treatment for all accident-related services payable by another liability carrier other than a dental plan are not covered.

10. Dental services received from any dentist other than a network dentist, unless expressly authorized in writing by Blue Shield 65 Plus prior to treatment, are excluded from coverage.

General exclusions for the optional supplemental Dental PPO plan only

Unless exceptions to the following general exclusions are specifically made elsewhere under this Plan, this Plan does not provide Benefits with respect to:

1. Charges for vestibuloplasty (i.e., surgical modification of the jaw, gums and adjacent tissues), and for any procedure, service, or supply including office visits, examination, and diagnosis provided directly or indirectly to treat a muscular, neural, or skeletal disorder, diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint syndrome (TMJ) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint.

2. Charges for services performed by a close relative or by a person who ordinarily resides in the Member's home.

3. Services, procedures, or supplies which are not reasonably necessary for the care of the Member's dental condition according to broadly accepted standards of professional care

or which are experimental or investigational in nature or which do not have uniform professional endorsement.

4. Myofunctional therapy; biofeedback procedures; athletic mouthguards; precision or semi-precision attachments; denture duplication; treatment of jaw fractures.
5. Alloplastic bone grafting materials.
6. Bone grafting done for socket preservation after tooth extraction or in preparation for implants.
7. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable.
8. Extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues).
9. Services for which the Member is not legally obligated to pay, or for services for which no charge is made.
10. Treatment for which payment is made by any governmental agency, including any foreign government.
11. Charges for prosthetic appliances, fixed or removable, which are related to periodontal treatment.
12. Charges for onlays or crowns installed as multiple abutments.
13. Charges for any inlay restoration.
14. Charges for dental appointments which are not kept.
15. Charges for services incident to any intentionally self-inflicted injury.
16. Removal of third molar (wisdom teeth) other than for dental necessity. Dental necessity is defined as a pathological condition which includes horizontal, medial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericornitis alone is not dental necessity.
17. Periodontal splinting of teeth by any method including, but not limited to, crowns, fillings, appliances or any other method that splints or connects teeth together.
18. Services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein.
19. Procedures which are principally cosmetic in nature such as bleaching, use of porcelain on molar teeth, personalization and characterization of dentures.

SECTION 3 Services that aren't covered by our plan (exclusions)

This section tells you what services are excluded from Medicare coverage and therefore, aren't covered by this plan.

The chart below lists services and items that either aren't covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	Not covered under any condition
Experimental medical and surgical procedures, equipment, and medications	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan

Services not covered by Medicare	Covered only under specific conditions
Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	(Go to Chapter 3, Section 5 for more information on clinical research studies)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Home-delivered meals	Not covered under any condition
Homemaker services include basic household help, including light housekeeping or light meal preparation	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Private room in a hospital	Covered only when medically necessary
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered
Routine dental care, such as cleanings, fillings, or dentures	Coverage as described in the optional supplemental dental *Summary of Benefits Chart* earlier in this chapter.
Routine eye examinations, eyeglasses, radial keratotomy,	One pair of eyeglasses (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens.

Services not covered by Medicare	Covered only under specific conditions
LASIK surgery, and other low vision aids	Additional coverage as described in the Medical Benefits Chart earlier in this chapter.
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
Routine hearing exams, hearing aids, or exams to fit hearing aids	Not covered under any condition
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

CHAPTER 5:
Using plan coverage for Part D drugs

SECTION 1 Basic rules for our plan's Part D coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

Our plan will generally cover your drugs as long as you follow these rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription (Go to Section 2) or you can fill your prescription through our plan's home delivery service.
- Your drug must be on our plan's Drug List (go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 in this chapter for more information)

SECTION 2 Fill your prescription at a network pharmacy or through our plan's home delivery service

In most cases, your prescriptions are covered *only* if they're filled at our plan's network pharmacies. (Go to Section 2.5 for information about when we cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with our plan to provide your covered drugs. The term "covered drugs" means all the Part D drugs that are on our plan's Drug List.

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Pharmacy Directory*, visit our website **blueshieldca.com/medpharmacy2026**, and/or call Customer Service at (800) 776-4466 (TTY users call 711).

You may go to any of our network pharmacies. Some network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost sharing. The *Pharmacy Directory* will tell you which network pharmacies offer preferred cost sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. If the pharmacy you use stays in our network but no longer offers preferred cost sharing, you may want to switch to a different network or preferred pharmacy, if available. To find another pharmacy in your area, get help from Customer Service at (800) 776-4466 (TTY users call 711) or use the *Pharmacy Directory*. You can also find information on our website at **blueshieldca.com/medpharmacy2026**.

Specialized pharmacies

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call Customer Service at (800) 776-4466 (TTY users call 711).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, go to your *Pharmacy Directory* (**blueshieldca.com/medpharmacy2026**) or call Customer Service at (800) 776-4466 (TTY users call 711).

Section 2.2 Our plan's home delivery service

For certain kinds of drugs, you can use our plan's network home delivery service. Generally, the drugs provided through home delivery are drugs you take on a regular basis, for a chronic or long-term medical condition. The drugs that aren't available through our plan's home delivery service are marked with the symbol **NDS** in our Drug List.

Our plan's home delivery service allows you to order **up to a 100-day supply for Tier 1: Preferred Generic Drugs, Tier 2: Generic Drugs, Tier 3: Preferred Brand Drugs, Tier 3: Covered Insulins, Tier 4: Non-Preferred Drugs, and Tier 4: Covered Insulins, and up to a 30-day supply for Tier 5: Specialty Tier Drugs.**

To get information about filling your prescriptions by home delivery please call Customer Service at the number on the back cover of this document. If you use a home delivery service not in the plan's network, your prescription will not be covered.

Usually, a home delivery order will be delivered to you in no more than 5 business days. You will receive a notification if there is a delay with your home delivery prescription order. If you have questions about this, please contact Amazon Pharmacy at **(856) 208-4665**, 24 hours a day, 7 days a week. **TTY** users call **711**. If needed, Blue Shield 65 Plus Customer Service can assist you in obtaining a sufficient supply of medication from a local retail network pharmacy, so you are not without medication until your home delivery medication arrives. This may require contacting your physician to have him/her phone or fax a new prescription to the retail network pharmacy for the quantity of medication needed until you receive your home delivery medication.

If the delay is greater than 5 business days from the date the prescription was ordered from the home delivery provider and is due to a loss of medication in the home delivery system, Amazon Pharmacy Customer Service can coordinate a replacement order.

New prescriptions the pharmacy gets directly from your doctor's office.
After the pharmacy gets a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It's important to respond each time you're contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

Refills on home delivery prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.

If you choose not to use our auto-refill program but still want the home delivery pharmacy to send you your prescription, contact your pharmacy 14 business days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares home delivery refills, please contact us by calling Amazon Pharmacy at **(856) 208-4665**, 24 hours a day, 7 days a week. **TTY** users call **711**.

If you get a refill automatically by home delivery that you don't want, you may be eligible for a refund.

Section 2.3 How to get a long-term supply of drugs

When you get a long-term supply of drugs, your cost sharing may be lower. Our plan offers 2 ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs (which offer preferred cost sharing) at the home delivery cost-sharing amount. Other retail pharmacies may not agree to the home delivery cost-sharing amounts. In this case you'll be responsible for the difference in price. Your *Pharmacy Directory* (**blueshieldca.com/medpharmacy2026**) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service at (800) 776-4466 (TTY users call 711) for more information.
2. You can also get maintenance drugs through our home delivery program. Go to Section 2.2 for more information.

Section 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. **Check first with Customer Service at (800) 776-4466 (TTY users call 711)** to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.

- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or home delivery service (these drugs include orphan drugs, high cost and unique drugs or other specialty pharmaceuticals).
- Some vaccines administered in your physician's office that are not covered under Medicare Part B and cannot reasonably be obtained at a network pharmacy may be covered under our out-of-network access.
- Prescriptions filled at out-of-network pharmacies are limited to a 30-day supply of covered medications.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

SECTION 3 Your drugs need to be on our plan's Drug List

Section 3.1 The Drug List tells which Part D drugs are covered

Our plan has a *List of Covered Drugs* (formulary). In this *Evidence of Coverage*, **we call it the Drug List.**

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. The Drug List only shows drugs covered under Medicare Part D.

We generally cover a drug on our plan's Drug List as long as you follow the other coverage rules explained in this chapter and use of the drug for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- Approved by the FDA for the diagnosis or condition for which it's being prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of types of drugs that may be on the Drug List.

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that's not on the Drug List. (For more information, go to Chapter 9.)

Section 3.2 Five cost-sharing tiers for drugs on the Drug List

Every drug on our plan's Drug List is in one of five cost-sharing tiers. In general, the higher the tier, the higher your cost for the drug:

- Cost-Sharing Tier 1: Preferred Generic Drugs (lowest cost-sharing tier)
  Includes preferred generic drugs.

- Cost-Sharing Tier 2: Generic Drugs
  Includes generic drugs and biosimilars.

- Cost-Sharing Tier 3: Preferred Brand Drugs
  Includes preferred brand name, biosimilars, and some generic drugs.

- Cost-Sharing Tier 4: Non-Preferred Drugs
  Includes non-preferred brand name, biosimilars, and some generic drugs
- Cost-Sharing Tier 5: Specialty Tier Drugs (highest cost-sharing tier)
  Includes very high-cost brand name, biosimilars, and generic drugs which may require special handling and/or close monitoring.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

Section 3.3 How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

- Check the most recent Drug List we provided electronically.
- Visit our plan's website (**blueshieldca.com/medformulary2026**). The Drug List on the website is always the most current.
- Call Customer Service at (800) 776-4466 (TTY users call 711) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" (**blueshieldca.com/pricecheck**) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Customer Service at (800) 776-4466 (TTY users call 711).

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once on our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Customer Service at (800) 776-4466 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug**. If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 9.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Customer Service at (800) 776-4466 (TTY users call 711) or on our website (**blueshieldca.com/medformulary2026**).

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling Customer Service at (800) 776-4466 (TTY users call 711) or on our website (**blueshieldca.com/medformulary2026**).

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it's normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take that isn't on our Drug List has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

- You may be able to get a temporary supply of the drug.

- You can change to another drug.
- You can ask for an **exception** and ask our plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you take **must no longer be on our plan's Drug List OR is now restricted in some way**.

- **If you're a new member,** we'll cover a temporary supply of your drug during the first **90 days** of your membership in our plan**.**
- **If you were in our plan last year,** we'll cover a temporary supply of your drug during the first **90 days** of the calendar year.
- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

For questions about a temporary supply, call Customer Service at (800) 776-4466 (TTY users call 711).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Customer Service at (800) 776-4466 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

You and your provider can ask our plan to make an exception and cover the drug in the way you'd like it covered. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception. For example, you can ask our plan to cover a drug even though it is not on our plan's Drug List. Or you can ask our plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.4 to learn what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Customer Service at (800) 776-4466 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask our plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception to the rule.

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.4 for what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Tier 1: Preferred Generic Drugs and Tier 5: Specialty Tier Drugs are not eligible for this type of exception. We don't lower the cost-sharing amount for drugs in these tiers.

SECTION 6 Our Drug List can change during the year

Most changes in drug coverage happen at the beginning of each year (January 1). However, during the year, our plan can make some changes to the Drug List. For example, our plan might:

- **Add or remove drugs from the Drug List**
- **Move a drug to a higher or lower cost-sharing tier**
- **Add or remove a restriction on coverage for a drug**
- **Replace a brand name drug with a generic version of the drug**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product**

We must follow Medicare requirements before we change our plan's Drug List.

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes are made to a drug that you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and <u>immediately</u> removing or making changes to a like drug on the Drug List.**
    - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
    - We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
    - We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.]
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List with advance notice.**
    - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.

  - We'll make these changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We'll tell you at least 30 days before we make the change or tell you about the change and cover an additional 30-day fill of the version of the drug you're taking.

- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
  - Sometimes a drug can be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you take that drug, we'll tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 30-day fill of the drug you're taking.

If we make changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or asking for a coverage decision to satisfy any new restrictions on the drug you take. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you take. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

Changes to the Drug List that don't affect you during this plan year

We may make certain changes to the Drug List that aren't described above. In these cases, the change won't apply to you if you're taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that won't affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change

won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan year. You'll need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to drugs you take that will impact you during the next plan year.

SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are *excluded*. This means Medicare doesn't pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.
- Our plan can't cover *off-label* use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs aren't covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain

- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

If you get Extra Help to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 How to fill a prescription

To fill your prescription, provide our plan membership information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will automatically bill our plan for *our* share of your drug cost. You need to pay the pharmacy *your* share of the cost when you pick up your prescription.

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy can't get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. You can then **ask us to reimburse you** for our share. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

If you're admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we'll generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all our rules for coverage described in this chapter.

Section 9.2 As a resident in a long-term care (LTC) facility

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy or uses a pharmacy that supplies drugs for all its residents. If you're a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it's part of our network.

Check your *Pharmacy Directory* (**blueshieldca.com/medpharmacy2026**) to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Customer Service at (800) 776-4466 (TTY users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

Section 9.3 If you also have drug coverage from an employer or retiree group plan

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator.** They can help you understand how your current drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage pays first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells you if your drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that our plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard drug coverage.

Keep any notices about creditable coverage because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 If you're in a Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy

when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems like:

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we'll work with your provider to correct the problem.

Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request about the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) program to help members manage medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Customer Service at (800) 776-4466 (TTY users call 711).

CHAPTER 6:
What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

If you're in a program that helps pay for your drugs, **some information in this** *Evidence of Coverage* **about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Customer Service at (800) 776-4466 (TTY users call 711) and ask for the *LIS Rider*.

We use "drug" in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage (**blueshieldca.com/pricecheck**), the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling Customer Service at (800) 776-4466 (TTY users call 711).

Section 1.1 Types of out-of-pocket costs you may pay for covered drugs

There are 3 different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.2 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what doesn't count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments are included in your out-of-pocket costs

Your out-of-pocket costs **include** the payments listed below (as long as they are for covered Part D drugs, and you followed the rules for drug coverage explained in Chapter 5):

- The amount you pay for drugs when you're in the following drug payment stages:
  - The Deductible Stage
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs and most charities

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2,100 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments aren't included in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs and vaccines covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Payments you make toward drugs not normally covered in a Medicare Drug Plan
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Customer Service at (800) 776-4466 (TTY users call 711).

Tracking your out-of-pocket total costs

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches $2,100, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for Blue Shield 65 Plus members

There are **3 drug payment stages** for your drug coverage under Blue Shield 65 Plus. How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

- **Stage 1: Yearly Deductible Stage**
- **Stage 2: Initial Coverage Stage**
- **Stage 3: Catastrophic Coverage Stage**

SECTION 3 Your *Part D Explanation of Benefits (EOB)* explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs and charities.
- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month, we'll send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month**. This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable.

Section 3.1 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here's how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
    - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
    - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
    - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
    - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.

- **Check the written report we send you.** When you get the *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Customer Service at (800) 776-4466 (TTY users call 711). Be sure to keep these reports.

SECTION 4 The Deductible Stage

The Deductible Stage is the first payment stage for your drug coverage. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. You'll pay a yearly deductible of $340 on Tier 3 through Tier 5 drugs. **You must pay the full cost of your Tier 3 through Tier 5 drugs** until you reach our plan's deductible amount. For all other drugs, you won't have to pay any deductible. The **full cost** is usually lower than the normal full price of the drug since our plan has negotiated lower costs for most drugs at network pharmacies. The full cost cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.

Once you pay $340 for your Tier 3 through Tier 5 drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, our plan pays its share of the cost of your covered drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

Our plan has five cost-sharing tiers

Every drug on our plan's Drug List is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Cost-Sharing Tier 1: Preferred Generic Drugs (lowest cost-sharing tier)
  Includes preferred generic drugs.
- Cost-Sharing Tier 2: Generic Drugs
  Includes generic drugs and biosimilars.
- Cost-Sharing Tier 3: Preferred Brand Drugs
  Includes preferred brand name, biosimilars and some generic drugs. You pay the lesser of

$35 copayment or 20% coinsurance per month supply of each covered insulin product on this tier.

- Cost-Sharing Tier 4: Non-Preferred Drugs
  Includes non-preferred brand name, biosimilars and some generic drugs. You pay the lesser of $35 copayment or 25% coinsurance per month supply of each covered insulin product on this tier.
- Cost-Sharing Tier 5: Specialty Tier Drugs (highest cost-sharing tier)
  Includes very high cost brand name, biosimilars and generic drugs which may require special handling and/or close monitoring.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy that offers standard cost sharing. Costs may be less at pharmacies that offer preferred cost sharing
- A network retail pharmacy that offers preferred cost sharing
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.5 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's home delivery service

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Pharmacy Directory* **(blueshieldca.com/medpharmacy2026**).

Section 5.2 Your costs for a *one-month* supply of a covered drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

The amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a *one-month* supply of a covered Part D drug

Tier	Standard retail in-network cost sharing (up to a 30-day supply)	Preferred retail in-network cost sharing (up to a 30-day supply)	Home delivery cost sharing (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generic Drugs)	$5 copayment	$0 copayment	Home delivery is not available for drugs in Tier 1.	$5 copayment	$5 copayment
Cost-Sharing Tier 2 (Generic Drugs)	$18 copayment	$10 copayment	Home delivery is not available for drugs in Tier 2.	$18 copayment	$18 copayment
Cost-Sharing Tier 3 (Preferred Brand Drugs)	20% coinsurance	20% coinsurance	Home delivery is not available for drugs in Tier 3.	20% coinsurance	20% coinsurance
Cost-Sharing Tier 3 (Covered Insulins*)	The lesser of $35 copayment or 20% coinsurance	The lesser of $35 copayment or 20% coinsurance	Home delivery is not available for drugs in Tier 3.	The lesser of $35 copayment or 20% coinsurance	The lesser of $35 copayment or 20% coinsurance
Cost-Sharing Tier 4 (Non-Preferred Brand Drugs)	25% coinsurance	25% coinsurance	Home delivery is not available for drugs in Tier 4.	25% coinsurance	25% coinsurance

Tier	Standard retail in-network cost sharing (up to a 30-day supply)	Preferred retail in-network cost sharing (up to a 30-day supply)	Home delivery cost sharing (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 4 (Covered Insulins*)	The lesser of $35 copayment or 25% coinsurance	The lesser of $35 copayment or 25% coinsurance	Home delivery is not available for drugs in Tier 4.	The lesser of $105 copayment or 25% coinsurance	The lesser of $35 copayment or 25% coinsurance
Cost-Sharing Tier 5 (Specialty Tier Drugs)	29% coinsurance	29% coinsurance	29% coinsurance	29% coinsurance	29% coinsurance

*Covered Insulins are marked with the symbol **INS** on the Drug List. This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs (“Extra Help”.)

You won’t pay more than the lesser of $35 copayment or 25% coinsurance for a one-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven’t paid your deductible.

Go to Section 7 of this chapter for more information on cost sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month’s supply

Typically, the amount you pay for a drug covers a full month’s supply. There may be times when you or your doctor would like you to have less than a month’s supply of a drug (for example, when you’re trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month’s supply, if this will help you better plan refill dates.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you get.

Section 5.4 Your costs for a *long-term* (up to a 100-day) supply of a covered Part D drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 100-day supply.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a *long-term* (up to a 100-day) supply of a covered Part D drug

Tier	Standard retail cost sharing (in-network) (up to a 100-day supply)	Preferred retail cost sharing (in-network) (up to a 100-day supply)	Home delivery cost sharing (up to a 100-day supply)
Cost-Sharing Tier 1 (Preferred Generic Drugs)	$5 copayment	$0 copayment	$0 copayment
Cost-Sharing Tier 2 (Generic Drugs)	$54 copayment	$15 copayment	$15 copayment
Cost-Sharing Tier 3 (Preferred Brand Drugs)	20% coinsurance	20% coinsurance	20% coinsurance
Cost-Sharing Tier 3 (Covered Insulins*)	The lesser of $105 copayment or 20% coinsurance	The lesser of $105 copayment or 20% coinsurance	The lesser of $105 copayment or 20% coinsurance

Tier	Standard retail cost sharing (in-network) (up to a 100-day supply)	Preferred retail cost sharing (in-network) (up to a 100-day supply)	Home delivery cost sharing (up to a 100-day supply)
Cost-Sharing Tier 4 (Non-Preferred Brand Drugs)	25% coinsurance	25% coinsurance	25% coinsurance
Cost-Sharing Tier 4 (Covered Insulins*)	The lesser of $105 copayment or 25% coinsurance	The lesser of $105 copayment or 25% coinsurance	The lesser of $105 copayment or 25% coinsurance
Cost-Sharing Tier 5 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

*Covered Insulins are marked with the symbol **INS** on the Drug List. This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help".)

You won't pay more than the lesser of $70 copayment or 25% coinsurance for up to a 2-month supply or the lesser of $105 copayment or 25% coinsurance for up to a 100-day supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,100. You then move to the Catastrophic Coverage Stage.

The *Part D EOB* you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year. Not all members will reach the $2,100 out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.3 for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the $2,100 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 7 What you pay for Part D vaccines

Important message about what you pay for vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Go to our plan's Drug List or call Customer Service at (800) 776-4466 (TTY users call 711) for coverage and cost-sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

- The first part is the cost of **the vaccine itself**.
- The second part is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccine depend on 3 things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
   - Most adult Part D vaccines are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
   - A pharmacist or another provider may give the vaccine in the pharmacy. Or a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccine can vary depending on the circumstances and what **drug payment stage** you're in.

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you'll be reimbursed the entire cost you paid.
- Other times when you get a vaccine, you pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states don't allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you pay the pharmacy your coinsurance or copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccine at your doctor's office.

- When you get the vaccine, you may have to pay the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance or copayment for the vaccine (including administration).

Situation 3: You buy the Part D vaccine itself at the network pharmacy and take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.

- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance for the vaccine administration.

CHAPTER 7:
Asking us to pay our share of a bill for covered medical services or drugs

SECTION 1 Situations when you should ask us to pay our share for covered services or drugs

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you got emergency or urgently needed medical care from a provider who's not in our plan's network**

   Outside the service area, you can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

   - You're only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care.
   - If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
   - You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
     - If the provider is owed anything, we'll pay the provider directly.

- If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you shouldn't pay

Network providers should always bill our plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get covered services. We don't allow providers to add additional separate charges, called **balance billing**. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out of pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork, such as receipts and bills, for us to handle the reimbursement.

4. When you use an out-of-network pharmacy to fill a prescription

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.5 to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount we'd pay at an in-network pharmacy.

5. When you pay the full cost for a prescription because you don't have our plan membership card with you

If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

- For example, the drug may not be on our plan's Drug List, or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or pay a bill you got

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your medical claim to us within one year** of the date you got the service, item, or drug. **You must submit your Part D prescription drug claim to us within three years** of the date you got the service, item, or drug.

To make sure you're giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it'll help us process the information faster.

- Download a copy of the form from our website (**blueshieldca.com**) or call Customer Service at (800) 776-4466 (TTY users call 711) and ask for the form.

Mail your request for payment together with any bills or paid receipts to us at this address:

Medical claims:
Blue Shield 65 Plus
Medicare Customer Service
P.O. Box 272640
Chico, CA 95927-2640

Part D Prescription drug claims:
Claims Processing
1606 Ave. Ponce de Leon
San Juan, PR 00909-4830

SECTION 3 We'll consider your request for payment and say yes or no

When we get your request for payment, we'll let you know if we need any additional information from you. Otherwise, we'll consider your request and make a coverage decision.

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide the medical care or drug is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision.

Section 3.1 If we tell you that we won't pay for all or part of the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9.

CHAPTER 8:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, braille, large print, or other alternate formats, etc.)

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan can meet these accessibility requirements include but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in languages other than English including Spanish and braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Service at (800) 776-4466 (TTY users call 711).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to 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 also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697. You can update how you'd like us to contact you, as well as your race, ethnicity, language, and sexual orientation, gender identity, and pronouns information by visiting the member portal, go to blueshieldca.com/login and click "My Profile" and update your "Personal Details". This information helps us understand and support your specific needs and preferences. We understand the importance of keeping your personal information private and confidential, and we take our obligations to do so seriously. We have policies and procedures in place to manage access to determine when and how we use this data. This information will not be used to determine the coverage of your benefits and/or services. We may share your individual language needs with your specific providers(s) to help support your healthcare needs.

Section 1.1 Debemos brindar información de una manera que a usted le sea útil y se ajuste a sus sensibilidades culturales (en otros idiomas que no sean el inglés, en braille, en letra grande, en formatos alternativos, etc.)

Nuestro plan debe asegurarse de que todos los servicios, tanto clínicos como no clínicos, se brinden de una manera culturalmente competente y de que todas las personas inscritas puedan obtener acceso a estos servicios, incluidas aquellas que tienen un dominio limitado del inglés, habilidades de lectura limitadas o problemas de audición, o aquellas de distinto origen cultural y étnico. Ejemplos de cómo nuestro plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, los servicios de traducción e interpretación y la conexión por teletipo, o teléfono de teletipo o de texto (TTY, por sus siglas en inglés).

Nuestro plan ofrece servicios gratis de interpretación para responder las preguntas de los miembros que no hablan inglés. Además, podemos brindarle la información en otros idiomas además del inglés (incluso en español), en braille, en letra grande o en algún otro formato alternativo sin costo, si es necesario. Tenemos la obligación de brindarle información acerca de los beneficios de nuestro plan en un formato que sea adecuado y accesible para usted. Para obtener información de nosotros de una manera que le sea útil, llame a Servicio al Cliente al (800) 776-4466 (los usuarios del sistema TTY pueden llamar al 711).

Nuestro plan debe ofrecerles a las mujeres inscritas la opción de obtener acceso directo a un especialista en salud femenina dentro de la red para que reciban servicios de atención de la salud de rutina y preventivos.

Si en la red de nuestro plan no hay proveedores disponibles para una determinada especialidad, será nuestra responsabilidad encontrar proveedores especializados fuera de la red para que le brinden la atención necesaria. En este caso, usted solo pagará el costo compartido dentro de la red. Si no hay especialistas en la red de nuestro plan que brinden un servicio que usted necesita, llame al plan y pida información sobre dónde puede obtener este servicio por el mismo costo compartido que tendría dentro de la red.

Si tiene alguna dificultad para obtener información sobre nuestro plan en un formato que sea adecuado y accesible para usted, para atenderse con un especialista en salud femenina o para encontrar un especialista de la red, comuníquese para presentar un reclamo:

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

También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles (Office for Civil Rights) al 1-800-368-1019 (TTY 1-800-537-7697). Puede actualizar la forma en que quiere que nos comuniquemos con usted, como también su raza, origen étnico, idioma, orientación sexual, identidad de género y pronombres visitando el portal de miembros. Vaya a blueshieldca.com/login, haga clic “My Profile” (Mi perfil) y actualice su información en “Personal Details” (Información personal). Esta información nos ayuda a entender y satisfacer sus necesidades y preferencias específicas. Entendemos la importancia de mantener la privacidad y la confidencialidad de su información personal, y nos tomamos muy en serio nuestra obligación. Tenemos políticas y procedimientos para administrar el acceso y determinar cuándo y cómo usamos estos datos. Esta información no se usará para determinar la cobertura de sus beneficios y/o servicios. Podemos compartir sus necesidades personales de idiomas con sus proveedores específicos para ayudarles a satisfacer sus necesidades de atención de la salud.

Section 1.2 We must ensure you get timely access to covered services and drugs

You have the right to choose a primary care physician (PCP) in our plan’s network to provide and arrange for your covered services. You also have the right to go to a women’s health specialist (such as a gynecologist) without a referral.

You have the right to get appointments and covered services from our plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think you aren't getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

Section 1.3 We must protect the privacy of your protected health information

Federal and state laws protect the privacy of your medical records and protected health information. We protect your protected health information as required by these laws.

- Your protected health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practices*, that tells you about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We're required to release health information to government agencies that are checking on quality of care.
    - Because you're a member of our plan through Medicare, we're required to give Medicare your health information including information about your Part D drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it's been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us

to make additions or corrections to your medical records. If you ask us to do this, we'll work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your protected health information, call Customer Service at (800) 776-4466 (TTY users call 711).

Section 1.4 We must give you information about our plan, our network of providers, and your covered services

As a member of Blue Shield 65 Plus, you have the right to get several kinds of information from us. You also have a right to make recommendations regarding the Plan's Member Rights and Responsibilities.

If you want any of the following kinds of information, call Customer Service at (800) 776-4466 (TTY users call 711):

- **Information about our plan**. This includes, for example, information about our plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know your treatment options and participate in decisions about your care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*. You have a right to be treated with respect in all aspects of your health care, and recognition to your dignity and a right to your privacy.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you're in this situation. This means, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Legal documents you can use to give directions in advance of these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Customer Service at (800) 776-4466 (TTY users call 711) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.

- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you're going to be hospitalized, and you signed an advance directive, **take a copy with you to the hospital**.

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with Commence Health (formerly Livanta). See Chapter 2 for contact information.

Section 1.6 You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we're required to treat you fairly**.

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY users call 1-800-537-7697), or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Customer Service at (800) 776-4466 (TTY users call 711)**
- **Call your local SHIP** at (800) 434-0222

- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call our plan's Customer Service at (800) 776-4466 (TTY users call 711)**
- **Call your local SHIP** at (800) 434-0222
- **Contact Medicare**
    - Visit www.Medicare.gov to read the publication *Medicare Rights & Protections* (available at: www.Medicare.gov/publications/11534-medicare-rights-and-protections.pdf)
    - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Customer Service at (800) 776-4466 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
    - Chapters 3 and 4 give details about medical services.
    - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care or Part D drugs.
- **Help your doctors, other providers, and your plan help you by giving them information, asking questions, and following through on your care.**
    - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
    - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have questions, be sure to ask and get an answer you can understand.

- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
    - You must continue to pay a premium for your Medicare Part B to stay a member of our plan.
    - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
    - If you're required to pay a late enrollment penalty, you must pay the penalty to keep your drug coverage.
    - If you're required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to stay a member of our plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 9:
If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints** (also called grievances).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Customer Service at (800) 776-4466 (TTY users call 711) for help. In some situations, you may also want help or

guidance from someone who isn't connected with us. Two organizations that can help you are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare for help.

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Visit www.Medicare.gov.

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they are covered, and problems related to payment for medical care.

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 10, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems about your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 6.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Customer Service at (800) 776-4466 (TTY users call 711)**
- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Customer Service at (800) 776-4466 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at **blueshieldca.com/apptofrep**.)
    - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.

- For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.

- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Customer Service at (800) 776-4466 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at **blueshieldca.com/apptofrep**.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
  - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

- **Section 5**: Medical care: How to ask for a coverage decision or make an appeal
- **Section 6**: Part D drugs: How to ask for a coverage decision or make an appeal
- **Section 7**: How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 8**: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Customer Service at (800) 776-4466 (TTY users call 711). You can also get help or information from your SHIP.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**

2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**

3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an appeal. Section 5.3.**

4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**

5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 7 and 8. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination.**

A fast coverage decision is called an **expedited determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services you already got).
- You can get a fast coverage decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to your prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or

service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.

- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 10 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 10 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration**.

A fast appeal is also called an **expedited reconsideration.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.

- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We're allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all the information. We check to see if we followed all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
    - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.

- **If our answer is no to part or all of what you asked for,** we'll automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we receive your appeal. We'll give you our decision sooner if your health condition requires us to.
    - If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
    - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 10 of this chapter for information on complaints.)
    - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 The Level 2 appeal process

Legal Term:

The formal name for the independent review organization is the **Independent Review Entity.** It's sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We're allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information about your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within **72 hours** or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.

- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests.** For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal**, it means it agrees with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
    - Explains the decision.
    - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
    - Tells you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay for our share of a bill you got for medical care

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request**: If the medical care is covered and you followed the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.

- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

SECTION 6 Part D drugs: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term:

An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not on our plan's Drug List. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to ask for an appeal.

Section 6.2 Asking for an exception

Legal Terms:

Asking for coverage of a drug that's not on the Drug List is a **formulary exception**.

Asking for removal of a restriction on coverage for a drug is a **formulary exception**.

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception.**

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in Tier 4: Non-Preferred Drugs. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug.
    - If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
    - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
    - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
    - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
    - You can't ask us to change the cost-sharing tier for any drug in Tier 1: Preferred Generic Drugs and Tier 5: Specialty Tier Drugs.
    - If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you're asking for and wouldn't cause more side effects or other health

problems, we generally won't approve your request for an exception. If you ask us for a tiering exception, we generally *won't* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of our plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 6.4 How to ask for a coverage decision, including an exception

Legal term:

A fast coverage decision is called an **expedited coverage determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet 2 requirements:**

- You must be asking for a drug you didn't get yet. (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
    - Explains that we'll use the standard deadlines.
    - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.

- Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form* or on our plan's form, which is available on our website (**blueshieldca.com/medappeals**). Chapter 2 has contact information. You may also submit an appeal through our website; visit **blueshieldca.com/medappeals.** To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor (or other prescriber), or your representative can do this. You can also have a lawyer act on your behalf. Section 4 tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we get your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request.

  - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you asked for,** we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll will send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you're going to Level 1 of the appeals process.

Section 6.5 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a Part D drug coverage decision is called a plan **redetermination**.

A fast appeal is called an **expedited redetermination.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you're appealing a decision, we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at** (800) 776-4466 (TTY users call 711). Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website (**blueshieldca.com/medappeals**). Include your name, contact information, and information about your claim to help us process your request.
- You may also submit an appeal through our website; visit **blueshieldca.com/medappeals.**
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We're allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
    - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.
    - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within **30 calendar** days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 6.6 How to make a Level 2 appeal

Legal Term:

The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

The independent review organization is an independent organization hired by Medicare. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE.
- We'll send the information about your appeal to the independent review organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We're allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all the information about your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

Step 3: The independent review organization gives you its answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you asked for,** we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent review organization says no to your appeal?

If this organization says no to **part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It's also called **turning down your appeal**.). In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

Section 7.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Service at (800) 776-4466 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.

- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.

2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Customer Service at (800) 776-4466 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 7.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it**. If you have questions or need help, call Customer Service at (800) 776-4466 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with

Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
    - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service at (800) 776-4466 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.) Or you can get a sample notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in

detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the independent review organization says *no*, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you are going on to *Level 2* of the appeals process.

Section 7.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information about your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you its decision.

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary**.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called upholding the decision.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.1 We'll tell you in advance when your coverage will be ending

Legal Term:

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal.** Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:

   - The date when we'll stop covering the care for you.
   - How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.

2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got.** Signing the notice shows *only* that you have got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 8.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call Customer Service at (800) 776-4466 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you its decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, **you'll have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 8.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information about your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you its decision.

What happens if the independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you'll need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Levels 3, 4, and 5

Section 9.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
    - If you decide to accept the decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
    - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 9.2 Appeal Levels 3, 4, and 5 for Part D Drug Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An Administrative Law Judge or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney

adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.

- **If the answer is no, the appeals process *may* or *may not* be over**.
    - If you decide to accept the decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
    - If you decide to accept the decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making complaints

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems about quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Service? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at our plan? ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint.

Complaint	Example
	• You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 How to make a complaint

Legal Terms:

A **complaint** is also called a **grievance**.

Making a complaint is called **filing a grievance**.

Using the process for complaints is called **using the process for filing a grievance**.

A **fast complaint** is called an **expedited grievance**.

Step 1: Contact us promptly – either by phone or in writing.

- **Calling Customer Service at (800) 776-4466 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Customer Service will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.

- Step 1: File a Grievance

  To begin the process, call a Customer Service representative within 60 calendar days of the event and ask to file a grievance. You may also file a grievance by fax or in writing within 60 calendar days of the event by sending it to:

  Blue Shield 65 Plus
  Appeals & Grievances Department
  P.O. Box 927, Woodland Hills CA 91365-9856
  FAX: (916) 350-6510

  You may also call us to request a **Blue Shield 65 Plus Appeals & Grievance Form** (use of this form is optional).

  We will send you a letter within 5 calendar days letting you know that we received the notice of your concern. We must address your grievance as quickly as your case

requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

If you ask for an expedited grievance because we decided not to give you a fast decision or fast appeal or because we asked for an extension on our initial decision or fast appeal, we will forward your request to a medical director who was not involved in our original decision. We may ask if you have additional information that was not available at the time you requested a fast initial decision or fast appeal. The medical director will review your request and decide if our original decision was appropriate. We will send you a letter with our decision within 24 hours of your request for an expedited grievance.

- Step 2: Grievance Hearing

  If you are not satisfied with the resolution of your grievance related to a quality of care issue, you may make a written request to the Blue Shield Medicare Appeals & Grievances Department for a grievance hearing. Within 31 calendar days of your written request being received, we will assemble a panel to hear your case. You will be invited to attend the hearing, which includes an uninvolved medical director and a representative from the Appeals and Grievance Resolution Department. You may attend in person or by teleconference. After the hearing, we will send you a final resolution letter.

  If you are not satisfied with the resolution of your grievance that does not include a quality of care issue, such as waiting time, disrespect, customer service or cleanliness, you may contact the Blue Shield 65 Plus Customer Service department to request an additional review.

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.

- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 10.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization**. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

Section 10.4 You can also tell Medicare about your complaint

You can submit a complaint about Blue Shield 65 Plus directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 10:
Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in Blue Shield 65 Plus may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and prescription drugs, and you'll continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
    - Another Medicare health plan, with or without drug coverage,
    - Original Medicare *with* a separate Medicare drug plan, or
    - Original Medicare *without* a separate Medicare drug plan.
        - If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
    - Switch to another Medicare Advantage Plan with or without drug coverage.
    - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Blue Shield 65 Plus may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply. These are just examples. For the full list you can contact our plan, call Medicare, or visit www.Medicare.gov.

- Usually, when you move
- If you have Medi-Cal (Medicaid)
- If you're eligible for Extra Help paying for Medicare drug coverage
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)

Note: If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage,
- Original Medicare *with* a separate Medicare drug plan, or
- Original Medicare *without* a separate Medicare drug plan.

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will usually end** on the first day of the month after we get your request to change our plan.
- **If you get Extra Help from Medicare to pay your drugs coverage costs:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Customer Service at (800) 776-4466 (TTY users call 711)**
- Find the information in the ***Medicare & You 2026*** handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from Blue Shield 65 Plus when your new plan's coverage starts.

Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from Blue Shield 65 Plus when your new drug plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan	• **Send us a written request to disenroll.** Call Customer Service at (800) 776-4466 (TTY users call 711) if you need more information on how to do this. • You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from Blue Shield 65 Plus when your coverage in Original Medicare starts.

SECTION 4 Until your membership ends, you must keep getting your medical items, services, and drugs through our plan

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical services, items, and prescription drugs through our plan.

- **Continue to use our network providers to get medical care.**
- **Continue to use our network pharmacies or home delivery service to get your prescriptions filled**.
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 Blue Shield 65 Plus must end your plan membership in certain situations

Blue Shield 65 Plus must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you're away from our service area for more than 6 months

  - If you move or take a long trip, call Customer Service at (800) 776-4466 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or lawfully present in the United States
- If you lie or withhold information about other insurance, you have that provides prescription drug coverage
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you don't pay our plan premiums for 3 calendar months.
  - We must notify you in writing that you have 3 calendar months to pay our plan premium before we end your membership.
- If you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose drug coverage.

If you have questions or want more information on when we can end your membership, call Customer Service at (800) 776-4466 (TTY users call 711).

Section 5.1 We <u>can't</u> ask you to leave our plan for any health-related reason

Blue Shield 65 Plus isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11: Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, pregnancy or related conditions, sex characteristics, sex stereotypes, gender, gender identity, sexual orientation, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage Plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at www.HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call us at Customer Service (800) 776-4466 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108

and 423.462, Blue Shield 65 Plus, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Administration of the *Evidence of Coverage*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this *Evidence of Coverage*.

SECTION 5 Member cooperation

You must complete any applications, forms, statements, releases, authorizations, lien forms and any other documents that we request in the normal course of business or as specified in this *Evidence of Coverage*.

SECTION 6 Assignment

You may not assign this *Evidence of Coverage* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

SECTION 7 Employer responsibility

For any services that the law requires an employer to provide, we will not pay the employer, and when we cover any such services we may recover the value of the services from the employer.

SECTION 8 Government agency responsibility

For any services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such services we may recover the value of the services from the government agency.

SECTION 9 U.S. Department of Veterans Affairs

For any services for conditions that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such services we may recover the value of the services from the Department of Veterans Affairs.

SECTION 10 Workers' compensation or employer's liability benefits

You may be eligible for payments or other benefits under workers' compensation or employer's liability law. We will provide covered Part D drugs even if it is unclear whether you are entitled to benefits, but we may recover the value of any Covered Services from the following sources:

1. From any source providing benefits or from whom a benefit is due.
2. From you, to the extent that a benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the benefits under any workers' compensation or employer's liability law.

SECTION 11 Overpayment recovery

We may recover any overpayment that we make for services from anyone who receives such an overpayment or from any person or organization obligated to pay for the services.

SECTION 12 When a third party causes your injuries

If you are injured or becomes ill due to the act or omission of another person (a third party), Blue Shield shall, with respect to Services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement or other available remedy to recover the amounts Blue Shield paid for Services provided to you from any recovery (defined below) obtained by or on behalf of you, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

This right to restitution, reimbursement or other available remedy is against any recovery you receive as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the Recovery), without regard to whether you have been made whole by the Recovery. The right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due for the Benefits paid in connection with such injury or illness, calculated in accordance with California Civil Code Section 3040.

You are required to:

1. Notify Blue Shield in writing of any actual or potential claim or legal action which you expect to bring or has brought against the third party arising from the alleged acts or

omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,

2. Agree to fully cooperate and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and,

3. Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,

4. Provide a lien calculated in accordance with the California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,

5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield, in writing, within ten (10) days after any Recovery has been obtained.

Your failure to comply with 1. through 5., above shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield.

SECTION 13 Notice about health information exchange participation

Blue Shield participates in the **Manifest MedEx** Health Information Exchange ("HIE") making its Members' health information available to Manifest MedEx for access by their authorized health care providers. Manifest MedEx is an independent, not-for-profit organization that maintains a statewide database of electronic patient records that includes health information contributed by doctors, health care facilities, health care service plans, and health insurance companies. Authorized health care providers (including doctors, nurses, and hospitals) may securely access their patients' health information through the Manifest MedEx HIE to support the provision of safe, high-quality care.

Manifest MedEx respects Members' right to privacy and follows applicable state and federal privacy laws. Manifest MedEx uses advanced security systems and modern data encryption techniques to protect Members' privacy and the security of their personal information.

Every Blue Shield Member has the right to direct Manifest MedEx not to share their health information with their health care providers. Although opting out of Manifest MedEx may limit your health care provider's ability to quickly access important health care information about you, a Member's health insurance or health plan benefit coverage will not be affected by an election to opt-out of Manifest MedEx. No doctor or hospital participating in Manifest MedEx will deny medical care to a patient who chooses not to participate in the Manifest MedEx HIE.

Members who do not wish to have their healthcare information displayed in Manifest MedEx should fill out the online form at https://www.manifestmedex.org/opt-out or call Manifest MedEx at (888) 510-7142, 7 a.m. to 7 p.m. PST, Monday through Friday. TTY 711 for the hearing impaired.

SECTION 14 Reporting Fraud, Waste, and Abuse

What is fraud, waste, and abuse (FWA)?

- **Fraud** is an intentional misrepresentation that may result in unauthorized costs to a healthcare program.
- **Waste** is the inappropriate use of healthcare funds or resources without a justifiable need to do so.
- **Abuse** is a practice that is inconsistent with sound medical or business practices that may directly or indirectly result in unnecessary costs to a healthcare program.

Protect yourself and your benefits

- Never give out your Social Security, Medicare or health plan numbers or banking information to someone you don't know.
- Do not consent to any lab tests without your doctor's order.
- It is illegal to accept anything of value in exchange for medical services.

Be aware of genetic testing fraud

Scammers approach unsuspecting enrollees at local health fairs, senior housing facilities, community centers, home health agencies, and other trustworthy locations to carry out genetic testing fraud. They falsely promise that Medicare will pay for the test, and you simply need to provide a cheek swab, your ID, and Medicare information in order to receive your test results.

Unfortunately, now these scammers have your health plan or Medicare number, and they can bill Medicare thousands of dollars for tests or even services that you never receive. They also have your personal genetic information.

To report suspected fraud, waste, and abuse, please contact:

- **Blue Shield of California's Medicare fraud hotline: (855) 331-4894 (TTY: 711)** or via email: **MedicareStopFraud@blueshieldca.com**.

- **Medicare at 1-800 MEDICARE (1-800-633-4227),** 24 hours a day, seven days a week (TTY users call 1-877-486-2048).

CHAPTER 12: Definitions

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of Blue Shield 65 Plus, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (go to "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (go to "**Interchangeable Biosimilar**").

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,100 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.]

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

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

Complaint - The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – 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 a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are gotten. Cost sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services or drugs are covered; 2) any fixed copayment amount that a plan requires when a specific service or drug is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is gotten.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the prescription drugs covered by our plan.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is $1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

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

Generic Drug – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice - A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll

pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people won't not pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Maximum Out-of-Pocket Amount – The most that you pay out of pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for Medicare Part A and Part B premiums, and prescription drugs don't count toward the maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – **Provider** is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and aren't included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits to get them.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (**Traditional Medicare or Fee-for-Service Medicare**) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by

Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs gotten is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan.

Preferred Cost Sharing – Preferred cost sharing means lower cost sharing for certain covered Part D drugs at certain network pharmacies.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services gotten from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary Care Physician (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care physician before you see any other health care provider.

Prior Authorization – Approval in advance to get services and/or certain drugs based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of a drug for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

"Real-Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you're getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Standard Cost Sharing– Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

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

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this

service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Blue Shield 65 Plus Customer Service

Method	Customer Service – Contact Information
Call	(800) 776-4466 Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week. Customer Service [(800) 776-4466 (TTY users call 711)] also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m. PT, seven days a week.
Fax	(877) 251-6671
Write	Blue Shield 65 Plus P.O. Box 927, Woodland Hills, CA 91365-9856
Website	**blueshieldca.com/medicare**

Health Insurance Counseling and Advocacy Program (HICAP) (California's SHIP)

HICAP is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
Call	(800) 434-0222
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	California Department of Aging 2880 Gateway Oaks Dr, Suite 200, Sacramento, CA 958333
Website	**https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/**

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