BS-MS-KIT-0425

Enrollment Kit Booklet Effective: April 1, 2025

Blue Shield of California rates effective: July 1, 2025

A52767-MS-BS-0425

Keeping you well for all that's ahead

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

- Why choose Blue Shield of California?
- Benefits and services
- Opportunity for additional savings
- Dental plan information
- Summary of Benefits
- Rate Sheets
- Guaranteed Acceptance Guide

How to enroll


Pre-enrollment checklist


Understanding the timeline


Enrollment forms

What our plans offer

- Vision
- Hearing aid services
- Over-the-counter (OTC) items
- Personal Emergency Response System (PERS)
- SilverSneakers® fitness and wellness programs
- Acupuncture and chiropractic services
- NurseHelp 24/7℠
- Wellvolution

Questions?

Call us at **(855) 217-1539 (TTY: 711)**
We're available 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and 8 a.m. to 8 p.m., Monday through Friday from April 1 through September 30.

Learn more online at **blueshieldca.com/MedSupp2025**.

Why choose Blue Shield of California?

Blue Shield's mission is to create a healthcare system that is worthy of our family and friends – and that includes you.

Two things that are most important when choosing a Medicare Supplement plan:

How much does my plan cost?
Use the Summary of Benefits and Rate Sheets – located in this kit – to compare what you will pay with our plan versus other plans.

Can I still see my doctor?
You can go to any medical doctor who accepts Medicare anywhere in the United States.

More reasons to choose Blue Shield

Flexibility and savings[1]
You can choose from many different Medicare Supplement plans designed to fit your needs and budget. You can also complement your Medicare Supplement coverage with Medicare Part D prescription drug coverage and dental plans. We also have savings programs that give you the opportunity to save on your monthly plan dues.

Opportunity for additional savings

Welcome to Medicare Rate Savings[1]

New to Medicare? Then, we want to welcome you! You can save $25 each month for the first 12 months on your Medicare Supplement plan rates if you're new to Medicare Part B.[1] To qualify, you must be age 65 or older, and Blue Shield must receive your application within six months of the date you first enrolled for benefits under Medicare Part B. The savings will be in effect for the first 12 months of your plan dues.

Member dental plan savings[1]

You can save $3 each month for the first six months on your dental plan rates if you enroll in a dental plan at the same time you enroll in any Blue Shield Medicare Supplement plan.[1]

AutoPay

AutoPay is a simple, convenient way to pay your dues. Simply authorize Blue Shield to automatically withdraw the monthly dues from your personal checking or savings account each month. By choosing this method, you will save $3 per month on your plan dues.[1,2]

To enroll, after receiving and paying for your first bill, register for and log in to your Blue Shield account at **blueshieldca.com** and go to the *Billing and Payment* tab. You may also call Customer Service at **(800) 248-2341 (TTY: 711)**, 8 a.m. to 8 p.m., seven days a week, year-round. Requests to enroll in AutoPay may take up to two billing cycles for completion. You should pay all paper bills you receive until you receive a letter confirming registration in the AutoPay program.[1,2]

Household Savings Program[1]

If you and another member of your household are age 65 or older and are accepted in the same benefit plan type, you may be eligible for a 7% monthly savings on your combined medical dues when coverage is issued under one agreement.[1] Both members must share the same home, mailing, and billing address. For more information, please ask your Blue Shield representative for eligibility and details about our Household Savings Program.

Please note: If you are currently enrolled in a Medicare Supplement plan, you may transfer to a plan of equal or lesser value during your annual open enrollment period, which begins every year on the first day of your birthday month and ends 60 days after your birthday. However, if you have the Household Savings Program and change to a benefit plan that is different from the one the other member of your household has, you will no longer be eligible for the 7% savings.

[1] Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed along to the subscriber. Household Savings Program does not apply to tobacco users. Welcome to Medicare Rate Savings does not apply to Plan N.

[2] $3 savings per month up to six months.

Benefits and services

Plan F Extra additional benefits

Personal Emergency Response System (PERS)

LifeStation's services are designed to allow you to remain self-sufficient in your own home while keeping you connected to all that life has to offer.

- Emergency alert monitoring system that provides access to help 24/7 at the push of a button
- Stay safe and independent

Hearing aid services benefit

- **$0** routine hearing exam
- Choice between Private-labeled Silver (mid-level) or Gold (advanced-level) technology hearing aid models
- Charging case for rechargeable battery models or a two-year supply of batteries per hearing aid

Vision

- **$0** eye exam (every 12 months)
- Eyeglass frames allowance (every 24 months)
- Prescription eye lenses or contact lenses (every 12 months)

Vision benefits include coverage for costs that are not traditionally covered by Original Medicare, such as eye exam, frames, eyeglass lenses, or contact lenses.

Note: Plan F Extra is only available to applicants who attained age 65 before January 1, 2020, or who first became eligible for Medicare benefits due to disability before January 1, 2020.

Plan G Extra additional benefits

Teladoc

- Physician consultations 24/7 by phone or video
- Teladoc physicians can diagnose and treat many non-emergency medical conditions
- Teladoc physicians can also prescribe certain medications

Over-the-counter (OTC) items

- **$100** OTC items quarterly allowance
- You can buy items such as toothpaste, shampoo, heat pads, vitamins, and sunblock
- **Easy to order:** Order online or by phone

You can place two orders per quarter. Unused allowance cannot be rolled over into the next quarter. Some limitations may apply. Refer to OTC Items Catalog for more information.

Hearing aid services benefit

- **$0** routine hearing exam
- Choice between Private-labeled Silver (mid-level) or Gold (advanced-level) technology hearing aid models
- Charging case for rechargeable battery models or a two-year supply of batteries per hearing aid

Vision

- **$0** eye exam (every 12 months)
- Eyeglass frames allowance (every 24 months)
- Prescription eye lenses or contact lenses (every 12 months)

Vision benefits include coverage for costs that are not traditionally covered by Original Medicare, such as eye exam, frames, eyeglass lenses, or contact lenses.

Acupuncture & chiropractic services

- **20** visits per year
- Initial and after examinations
- X-rays and chiropractic adjustments (chiropractic only)
- Office visits

Non-Medicare covered.

Well-being support and resources

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

NurseHelp 24/7℠

- Connect with a registered nurse who will listen and offer you immediate information about treating minor illnesses and injuries
- Help you choose the most appropriate treatment
- Help you decide whether to see a doctor

Wellvolution

- Access to our award-winning Wellvolution® digital health program at no extra cost
- App-based programs designed to help you with your health goals such as losing weight, managing stress, treating type 2 diabetes, and quitting tobacco
- Available in mobile devices and computers whenever it fits your schedule

SilverSneakers fitness and wellness programs

- More active life through fitness and social connection
- Thousands of participating locations[1]
- You can take SilverSneakers instructor-led group classes at participating locations[2] plus use exercise equipment and other amenities.

[1] Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.

[2] Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.

Pre-enrollment checklist

Compare plan types
Use the Summary of Benefits and Rate Sheets to compare plan types for the best choice to fit your needs and budget.

See if you qualify for guaranteed acceptance
Certain situations qualify you for guaranteed acceptance in a Blue Shield Medicare Supplement plan. If you qualify for guaranteed acceptance into a Blue Shield Medicare Supplement plan, you will not be required to complete a health statement. Please read our Guaranteed Acceptance Guide included in this booklet or visit **blueshieldca.com/MedSupp2025** to determine if you qualify.

Locate your Medicare ID card
When you apply, make sure to have your Medicare ID card available, or some form of proof that you are entitled to Medicare.

Ways to apply

In person
Meet with your local authorized agent or call the number below to speak with a Blue Shield representative to set up an appointment.

By phone
Call us at **(855) 217-1539 (TTY: 711)**

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

Online
Visit **blueshieldca.com/MedSupp2025** to conveniently enroll on your own time.

By mail
Fill out the enclosed application form and mail to the address located on the enrollment form.

By fax
Fax the enclosed application form to **(877) 251-3660**.

What to expect next

Confirmation

Within 10 days of enrollment, you will receive a confirmation enrollment letter in the mail. It is also confirmation that Medicare has approved your enrollment.

Welcome package including ID card

Within 10 days of your confirmed enrollment, you will receive your welcome package that includes your ID card. This kit gives you a full explanation of how to use your new plan. Be sure to read the plan's *Evidence of Coverage* (EOC). Present your ID card every time you receive healthcare services

Questions?

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Key terms to know

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

Copayment (copay)
An amount you may be required to pay as your share of the cost for services. An amount you may be required to pay as your share of the cost for services after you pay any deductibles. A copayment is usually a set amount rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit.

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

Deductible
The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Medicare Part A
Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B
Part B covers certain doctor's services, outpatient care, medical supplies, and preventive services.

Out-of-pocket costs
Health care or prescription[1] drug costs you must pay on your own.

Premium, rate, or dues
The monthly amount you pay for your Medicare Supplement coverage or dental plan if you choose to enroll.

[1] Medicare Supplement plans do not cover the cost of prescription drugs.

Acupuncture and chiropractic benefits are limited to a combined visit maximum per calendar year. Acupuncture and chiropractic Services: For all acupuncture and chiropractic Services, Blue Shield has contracted with [American Specialty Health Plans of California, Inc. (ASH Plans)] to act as the plan's acupuncture and chiropractic services administrator.

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

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

Blue Shield offers Teladoc to all Medicare Advantage, and Medicare Supplement Plan G Extra members.

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

NurseHelp 24/7 is a service mark of Blue Shield of California. NurseHelp 24/7 is a healthcare advice line. Nurses do not provide medical services for treatment or diagnosis.

You may receive services from providers on an in-person basis or via telehealth, if available. Contact your provider, treating specialist, facility, or other health professional to learn more. Telehealth and in-person services are subject to the same timeliness and geographic access standards. You are subject to your Medicare Supplement plan's cost-sharing obligations and balance-billing protections.

Wellvolution is a registered trademark of Blue Shield of California. Wellvolution and all associated digital and in-person health programs, services, and offerings are managed by Solera, Inc. These program services are not a covered benefit of Blue Shield health plans and none of the terms or conditions of Blue Shield health plans apply. Blue Shield reserves the right to terminate this program at any time without notice. Any disputes regarding Wellvolution may be subject to Blue Shield's grievance process.

The company complies with applicable state laws and federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, ethnic group identification, medical condition, genetic information, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, mental disability, or physical disability. La compañía cumple con las leyes de derechos civiles federales y estatales aplicables, y no discrimina, ni excluye ni trata de manera diferente a las personas por su raza, color, país de origen, identificación con determinado grupo étnico, condición médica, información genética, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad, ni discapacidad física ni mental. 本公司遵守適用的州法律和聯邦民權法律，並且不會 以種族、膚色、原國籍、族群認同、醫療狀況、遺傳資訊、血統、宗教、性別、婚姻狀況、性別認同、性 取向、年齡、精神殘疾或身體殘疾而進行歧視、排斥或區別對待他人。

Dental plan and package options for Medicare Supplement plan members

blue california

Dental plan options for Medicare Supplement plan members

Blue Shield of California rates effective: July 1, 2025

Last updated: April 2025

Something to smile about

Make the choice, make it Blue Shield

Blue Shield offers two dental plans.

Good reasons to enroll

Dental plan advantages:

- An extensive network of nearly 46,000 general and specialty care dentists in California and nearly 350,000 nationwide.[1]
- Three annual teeth cleanings, X-rays, and an oral cancer screening are covered at 100% when using network providers.
- No waiting period for dental checkups, cleanings, fillings, X-rays, or basic services.[2]
- A wide range of major restorative dental services and procedures, including crowns, endodontics, periodontics, oral surgery, and prosthetics.

Adults age 60 and older have a greater risk of cavities.

The average age of people diagnosed with mouth cancer is 62, according to the American Cancer Society. Because mouth cancer develops without causing pain, early detection is essential. **Our dental PPO plans cover 100% of the cost of an oral cancer screening.**[3]

Get covered

With Blue Shield's dental plans, you have a choice of coverage that may fit your needs.

Monthly rates effective July 1, 2025:		
	Dental PPO 1000	**Dental PPO 1500**
Individual	$39.20	$58.80

Did you know?

You may be surprised to learn that more than 90% of all common diseases have oral symptoms.[4]

Whether you need treatment or just want preventive care, it's never too late to get on track and choose Blue Shield dental coverage to help maintain your overall health.

As we get older and take more medications, we can sometimes forget what those medications are. Something as simple as aspirin – a blood thinner – can end up causing bleeding during and after a dental procedure. **Make sure your dentist has your full medical history and list of medications.**

Choose from two dental plans

With a Blue Shield dental plan, you'll have the freedom to choose any provider you want, but you will save more when you choose a provider in your plan's network. For more details, please refer to the following dental plan charts.

Dental PPO highlights matrix

The following information is intended to help you compare coverage benefits and is a summary only. You should consult the *Dental PPO 1000 and Dental PPO 1500 Evidence of Coverage* and *Health Service Agreement* for a detailed description of coverage benefits and limitations.

Dental PPO highlights				
	DPPO 1000		**DPPO 1500**	
Calendar-year deductible (per member)	$75/person		$50/person	
Calendar-year maximum	$1,000 ($750 may be used for non-network dentist)[5]		$1,500 ($1,000 may be used for non-network dentist)[5]	
Service	**With network dentist**	**With non-network dentist,[6] Blue Shield pays:**	**With network dentist**	**With non-network dentist,[6] Blue Shield pays:**
Diagnostic and preventive care (not subject to plan deductibles with network dentists; includes an oral cancer screening, routine oral exams, X-rays, and three annual cleanings)	100%	50%	100%	80%
Basic services (includes anesthesia, palliative treatment, and restorative dentistry)	50%	50%	80%	70%
Major services[2] 12-month waiting period for DPPO 1500 and 6-month waiting period for DPPO 1000 (All plans include crown buildups, endodontics, periodontics, oral surgery, crowns, prosthetics, inlays, onlays, jacket, posts and cores, and veneers. DPPO 1500 also includes implants.)	50%	50%	50%	50%

Household Savings Program

If you are enrolled in a Medicare Supplement plan with household savings, you may enjoy the convenience of a single bill for you and your other household member. Keep the same convenience when you choose your dental plan by matching your dental plan enrollment with your Medicare Supplement plan enrollment. You and your other household member need to select and enroll in the same dental plan.*

Become a member today

If you are applying to become a Medicare Supplement plan member, you can sign up for a Blue Shield dental plan at the same time by selecting a plan on the Medicare Supplement plan application. If you're already a Blue Shield Medicare Supplement plan subscriber, or if you are only interested in our dental plans, please fill out a separate application.

If you have questions, contact your Blue Shield agent today or call toll-free **(855) 217-1539 (TTY: 711)**, 8 a.m. to 8 p.m., seven days a week from October 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday, from April 1 to September 30.

To find a dentist, or to see if your dentist is in our network, visit **blueshieldca.com** and click *Find a doctor*. Or, for a list of dentists, call **(888) 679-8928**.

Implants, crowns, and dentures can make dental care for seniors costly. Start planning for dental care before retirement and take care of your teeth.

* Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed along to the subscriber. Households Savings Program does not apply to Plan N.

Endnotes

1 Dental providers in and out of California are available through a contracted dental plan administrator.

2 Dental PPO 1500 plan members have a 12-month waiting period, and Dental PPO 1000 dental plan members have a 6-month waiting period for major restorative services and procedures (such as crowns, endodontics, periodontics, oral surgery, and removable or fixed prosthetics). The waiting period may be waived with proof of prior comprehensive coverage.

3 "Oral Cancer Screening," https://www.mayoclinic.org/tests-procedures/oral-cancer-screening/about/pac-20394802, Mayo Clinic, 2020.

4 "Oral Health Conditions," https://www.cdc.gov/oralhealth/conditions/index.html, CDC, 2020.

5 Each calendar year, the member is responsible for all charges incurred after the plan has paid these amounts for covered dental services.

6 The coinsurance percentage indicated is a percentage of allowed amounts that we pay to providers. Non-network providers can charge more than our allowable amount. When members use non-network providers, they must pay the applicable copayment/coinsurance plus any amount that exceeds our allowable amount. Charges in excess of the allowable amount do not count toward the calendar-year deductible or copayment maximum.

To find a dentist, or to see if your dentist is in our network, visit **blueshieldca.com** and click on *Find a doctor*.
For a list of dentists, call **(888) 679-8928**.

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Blue Shield Medicare Supplement plans

Summary of benefits and provisions

Benefit plans A, F Extra, G, G Extra and N

Effective January 1, 2025

blueshieldca.com/medicaresupplement

blue california

Blue Shield of California Medicare Supplement plans

Please take a few minutes to review the information in this booklet.

Benefit chart of Medicare Supplement plans sold on or after Effective January 1, 2025

This chart shows the benefits included in each of the standard Medicare Supplement plans. Every insurance company must offer Plan A. Some plans may not be available. Blue Shield offers plans A, F Extra, G, G Extra, and N, which are shaded in gray in the chart below.

	Plans Available to All Applicants				
Benefits	**A**	**B**	**D**	**G[1]**	**G Extra**
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	✓
Blood (first three pints)	✓	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	✓
Medicare Part A deductible		✓	✓	✓	✓
Medicare Part B deductible					
Medicare Part B excess charges				✓	✓
Foreign travel emergency (up to plan limits)			✓	✓	✓
Fitness program	✓		✓	✓	✓
Hearing aid services					✓
Vision services					✓
Acupuncture and chiropractic services					✓
Personal Emergency Response System (PERS)					
Teladoc					✓
Over-the-counter items					✓
Out-of-pocket limit in 2025[2]					

1 Plans F and G also have a high deductible option which require first paying a plan deductible of $2,870 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

2 Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

3 Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

Basic benefits

Hospitalization

- Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Blood

- First three pints of blood each year.

Medical expenses

- Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require the insured to pay a portion of Part B coinsurance or copayments.

Hospice

- Part A coinsurance.

Plans Available to All Applicants				Medicare first eligible before 2020 only[4]		
K	L	M	N	C	F[1]	F Extra
✓	✓	✓	✓	✓	✓	✓
50%	75%	✓	✓ copays apply[3]	✓	✓	✓
50%	75%	✓	✓	✓	✓	✓
50%	75%	✓	✓	✓	✓	✓
50%	75%	✓	✓	✓	✓	✓
50%	75%	50%	✓	✓	✓	✓
				✓	✓	✓
					✓	✓
		✓	✓	✓	✓	✓
			✓	✓	✓	✓
						✓
						✓
						✓
$7,220[2]	$3,610[2]					

4 Plan F Extra is only available to applicants who attained age 65 before January 1, 2020, or first became eligible for Medicare benefits due to disability before January 1, 2020.

DISCLOSURES

Use this outline to compare benefits and charges among policies.

INFORMATION ABOUT PREPAID OR PERIODIC CHARGES

Blue Shield can only raise your charges if it raises the charges for all contracts like yours in the state. Your dues will automatically increase annually on July 1st and the amount due will be based on your attained age on that date.

If you're applying more than 60 days before your effective date, the rates listed are subject to change.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing the most important features of your Medicare Supplement plan contract. This is not the plan contract, and only the actual contract provisions will prevail. You must read the contract itself to understand all of the rights and duties of both you and Blue Shield of California.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your contract, you may return it to **Blue Shield of California, 601 12th St, Oakland, CA 94607**. If you send the contract back to us within 30 days after you receive it, we will treat the contract as if it had never been issued, and will return all of your payments.

POLICY REPLACEMENT

If you are replacing other health coverage, **do NOT** cancel it until you have actually received your new contract and are sure you want to keep it.

NOTICE

This contract may not fully cover all of your medical costs. Neither Blue Shield of California nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "The Medicare Handbook" for further details and limitations applicable to Medicare.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new contract, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your contract and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A

MEDICARE (PART A)
HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* - Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$0	$1,676 (Part A deductible)
61st through 90th day	All but $419 a day	$419 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* - You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $209.50 a day	$0	Up to $209.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 Pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare Copayment/ Coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B)
MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-approved amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 Pints (Part B)	$0	All costs	$0
Next $257 of Medicare-approved amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES			
	100%	$0	$0

PLAN A

PARTS A & B

* Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $257 of Medicare-approved amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BASIC GYM ACCESS THROUGH SILVERSNEAKERS® FITNESS PROGRAM			
	$0	100%	$0

PLAN F EXTRA

MEDICARE (PART A)
HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* - Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st through 90th day	All but $419 a day	$419 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* - You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 Pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare Copayment/ Coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F EXTRA

MEDICARE (PART B)
MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-approved amounts*	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 Pints (Part B)	$0	All costs	$0
Next $257 of Medicare-approved amounts*	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES			
	100%	$0	$0

PLAN F EXTRA

PARTS A & B

* Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $257 of Medicare-approved amounts*	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC GYM ACCESS THROUGH SILVERSNEAKERS® FITNESS PROGRAM			
	$0	100%	$0
PERSONAL EMERGENCY RESPONSE SYSTEM (PERS) - Your PERS benefits are provided by Lifestation.			
• One personal emergency response system • Choice of an in-home system or mobile device with GPS/WiFi and fall detection • Monthly monitoring • Necessary chargers and cords	$0	100%	$0

PLAN F EXTRA

Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
VISION SERVICES - Your vision benefits are provided by Vision Service Plan (VSP). This benefit offers one of the largest national networks of independent doctors located in retail, neighborhood, medical, and professional settings. You can lower any out-of-pocket costs by choosing network providers for covered services. Participating providers may be located through an online directory at **blueshieldca.com**. Click on *Find a doctor*.			
Comprehensive eye exam once every 12 months	$0	**In-Network:** 100% after the $20 copayment **Out-of-Network:** Up to $50 allowance	**In-Network:** $20 copay **Out-of-Network:** All costs above the $50 allowance
Eyeglass frame once every 24 months	$0	**In-Network:** Up to $100 allowance **Out-of-Network:** Up to $40 allowance	**In-Network:** All costs above the $100 allowance **Out-of-Network:** All costs above the $40 allowance
Eyeglass lenses once every 12 months • Single vision • Bifocal • Trifocal • Aphakic, lenticular monofocal, or multifocal	$0	**In-Network:** 100% after the $25 copayment **Out-of-Network** Single Vision: Up to $43 allowance Bifocal: Up to $60 allowance Trifocal: Up to $75 allowance Aphakic or lenticular monofocal or multifocal: Up to $104 allowance	**In-Network:** $25 copay **Out-of-Network:** All costs above the allowance

PLAN F EXTRA

Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
VISION SERVICES - Your vision benefits are provided by Vision Service Plan (VSP). This benefit offers one of the largest national networks of independent doctors located in retail, neighborhood, medical, and professional settings. You can lower any out-of-pocket costs by choosing network providers for covered services. Participating providers may be located through an online directory at **blueshieldca.com**. Click on *Find a doctor*.			
Contact lenses (instead of eyeglass lenses) once every 12 months • Non-elective (medically necessary) – Hard or Soft – one pair • Elective (cosmetic/convenience) – Hard – one pair • Elective (cosmetic/convenience) – Soft – Up to a three- to six-month supply for each eye based on lenses selected	$0	**Non-elective In-Network:** Up to $500 allowance after the $25 copayment **Non-elective Out-Of-Network:** Non-elective (Hard or Soft): Up to $200 allowance **Elective In-Network:** Up to $120 allowance after the $25 copayment **Elective Out-Of-Network:** Up to $100 allowance	**Non-elective and Elective In-Network:** $25 copay **Non-elective and Elective Out-Of-Network:** All costs above the allowance

PLAN F EXTRA

Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HEARING AID SERVICES - Your hearing aid services benefits are provided by EPIC Hearing Healthcare (EPIC). This benefit is designed for you to use EPIC network providers. EPIC Participating Providers are listed at **blueshieldca.com/medicare/providerdirectory**. If you choose to use out-of-network providers, those services will not be covered. This benefit is separate from diagnostic hearing examinations and related charges as covered by Medicare.			
Hearing aid Benefits every year include: • One in-person routine hearing exam • Hearing aid instrument o Up to two hearing aids delivered in-person through a network hearing aid provider o Choice of private-labeled Silver (mid-level) or Gold (advanced level) technology hearing aid models o Silver technology hearing aids: – available in behind-the-ear and receiver-in-the-ear hearing aid styles only o Gold technology hearing aids: – available in multiple styles: in-the-ear, in-the-canal, completely-in-canal, behind-the-ear, and receiver-in-the-ear hearing aid styles – standard ear molds and impressions are available as needed o All technology levels include: – one consultation – up to three follow-up visits for hearing aid fitting, consultation, device check, and adjustment for no additional fee within 12 months of purchase	 $0 $0	 100% $0	 $0 **Silver Technology Level** $449 per hearing aid **Gold Technology Level** $699 per hearing aid

PLAN F EXTRA

Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HEARING AID SERVICES - Your hearing aid services benefits are provided by EPIC Hearing Healthcare (EPIC). This benefit is designed for you to use EPIC network providers. EPIC Participating Providers are listed at **blueshieldca.com/medicare/providerdirectory**. If you choose to use out-of-network providers, those services will not be covered. This benefit is separate from diagnostic hearing examinations and related charges as covered by Medicare.			
– charging case for rechargeable battery models or a two-year supply of batteries per hearing aid; and – three-year extended warranty.			

PLAN G

MEDICARE (PART A)
HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* - Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st through 90th day	All but $419 a day	$419 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* - You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 Pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare Copayment/ Coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B)
MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-approved amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 Pints (Part B)	$0	All costs	$0
Next $257 of Medicare-approved amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES			
	100%	$0	$0

PLAN G

PARTS A & B

* Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $257 of Medicare-approved amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC GYM ACCESS THROUGH SILVERSNEAKERS® FITNESS PROGRAM			
	$0	100%	$0

PLAN G EXTRA

MEDICARE (PART A)
HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* - Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st through 90th day	All but $419 a day	$419 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* - You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 Pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare Copayment/ Coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G EXTRA

MEDICARE (PART B)
MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-approved amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 Pints (Part B)	$0	All costs	$0
Next $257 of Medicare-approved amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES			
	100%	$0	$0

PLAN G EXTRA

PARTS A & B

* Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $257 of Medicare-approved amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC GYM ACCESS THROUGH SILVERSNEAKERS® FITNESS PROGRAM			
	$0	100%	$0

PLAN G EXTRA

Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
PHYSICIAN CONSULTATION BY PHONE OR VIDEO THROUGH TELADOC			
	$0	$0	$0 per consult
OVER-THE-COUNTER ITEMS THROUGH CVS Eligible over-the-counter (OTC) items are available through the OTC Items Catalog, at **blueshieldca.com/medicareOTC. Limitations may apply. Refer to the OTC Items Catalog for more information.**			
Up to two orders per quarter	$0	Up to $100 allowance per quarter	All costs above the $100 allowance per quarter
ACUPUNCTURE AND CHIROPRACTIC SERVICES - Your acupuncture and chiropractic services benefits are administered by American Specialty Health Plans of California, Inc. (ASH Plans). The benefits covered under this plan must be received from ASH Participating Providers. ASH Participating Providers may be located through an online directory at **blueshieldca.com**. Click on *Find a doctor*.			
Up to 20 visits per calendar year for acupuncture and chiropractic Services combined	Not Covered	100%	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
VISION SERVICES - Your vision benefits are provided by Vision Service Plan (VSP). This benefit offers one of the largest national networks of independent doctors located in retail, neighborhood, medical, and professional settings. You can lower any out-of-pocket costs by choosing network providers for covered services. Participating providers may be located through an online directory at **blueshieldca.com**. Click on *Find a doctor*.			
Comprehensive eye exam once every 12 months	$0	**In-Network:** 100% after the $20 copayment **Out-of-Network:** Up to $50 allowance	**In-Network:** $20 copay **Out-of-Network:** All costs above the $50 allowance
Eyeglass frame once every 24 months	$0	**In-Network:** Up to $100 allowance **Out-of-Network:** Up to $40 allowance	**In-Network:** All costs above the $100 allowance **Out-of-Network:** All costs above the $40 allowance

PLAN G EXTRA

Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
VISION SERVICES - Your vision benefits are provided by Vision Service Plan (VSP). This benefit offers one of the largest national networks of independent doctors located in retail, neighborhood, medical, and professional settings. You can lower any out-of-pocket costs by choosing network providers for covered services. Participating providers may be located through an online directory at **blueshieldca.com**. Click on *Find a doctor*.			
Eyeglass lenses once every 12 months • Single vision • Bifocal • Trifocal • Aphakic, lenticular monofocal, or multifocal	$0	**In-Network:** 100% after the $25 copayment **Out-of-Network** Single Vision: Up to $43 allowance Bifocal: Up to $60 allowance Trifocal: Up to $75 allowance Aphakic or lenticular monofocal or multifocal: Up to $104 allowance	**In-Network:** $25 copay **Out-of-Network:** All costs above the allowance
Contact lenses (instead of eyeglass lenses) once every 12 months • Non-elective (medically necessary) – Hard or Soft – one pair • Elective (cosmetic/convenience) – Hard – one pair • Elective (cosmetic/convenience) – Soft – Up to a three- to six-month supply for each eye based on lenses selected	$0	**Non-elective In-Network:** Up to $500 allowance after the $25 copayment **Non-elective Out-Of-Network:** Non-elective (Hard or Soft): Up to $200 allowance **Elective In-Network:** Up to $120 allowance after the $25 copayment **Elective Out-Of-Network:** Up to $100 allowance	**Non-elective and Elective In-Network:** $25 copay **Non-elective and Elective Out-Of-Network:** All costs above the allowance

PLAN G EXTRA

Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HEARING AID SERVICES - Your hearing aid services benefits are provided by EPIC Hearing Healthcare (EPIC). This benefit is designed for you to use EPIC network providers. EPIC Participating Providers are listed at **blueshieldca.com/medicare/providerdirectory**. If you choose to use out-of-network providers, those services will not be covered. This benefit is separate from diagnostic hearing examinations and related charges as covered by Medicare.			
Hearing aid Benefits every year include: • One in-person routine hearing exam • Hearing aid instrument o Up to two hearing aids delivered in-person through a network hearing aid provider o Choice of private-labeled Silver (mid-level) or Gold (advanced level) technology hearing aid models o Silver technology hearing aids: – available in behind-the-ear and receiver-in-the-ear hearing aid styles only o Gold technology hearing aids: – available in multiple styles: in-the-ear, in-the-canal, completely-in-canal, behind-the-ear, and receiver-in-the-ear hearing aid styles – standard ear molds and impressions are available as needed o All technology levels include: – one consultation – up to three follow-up visits for hearing aid fitting, consultation, device check, and adjustment for no additional fee within 12 months of purchase	 $0 $0	 100% $0	 $0 **Silver Technology Level** $449 per hearing aid **Gold Technology Level** $699 per hearing aid

PLAN G EXTRA

Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HEARING AID SERVICES - Your hearing aid services benefits are provided by EPIC Hearing Healthcare (EPIC). This benefit is designed for you to use EPIC network providers. EPIC Participating Providers are listed at **blueshieldca.com/medicare/providerdirectory**. If you choose to use out-of-network providers, those services will not be covered. This benefit is separate from diagnostic hearing examinations and related charges as covered by Medicare.			
– charging case for rechargeable battery models or a two-year supply of batteries per hearing aid; and – three-year extended warranty.			

PLAN N

MEDICARE (PART A)
HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* - Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st through 90th day	All but $419 a day	$419 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* - You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 Pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare Copayment/ Coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B)
MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-approved amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 Pints (Part B)	$0	All costs	$0
Next $257 of Medicare-approved amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES			
	100%	$0	$0

PLAN N

PARTS A & B

* Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $257 of Medicare-approved amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC GYM ACCESS THROUGH SILVERSNEAKERS® FITNESS PROGRAM			
	$0	100%	$0

NOTE: The preceding pages are only an outline describing the most important features of our Medicare Supplement plans. Complete information about the plans' benefits, limitations, and exclusions can be found in our Medicare Supplement plan *Evidence of Coverage and Health Service Agreement* (Service Agreement). The Service Agreement will be your plan contract if you become a Blue Shield member.

Please read the Service Agreement completely. You have the right to receive a copy of the Service Agreement before you enroll, and we will be happy to provide you with a copy upon request. To request a copy, or if you have questions or need additional information, please call Blue Shield Customer Service at **(800) 248-2341** [TTY: **711** for hearing impaired]. If you have special healthcare needs, be sure to carefully read the sections of both this summary and the Service Agreement that are relevant to you before you apply for coverage.

Enrolling in our plans

Please reference the enrollment form section of this book.

Be sure to check the information on the application carefully, keep a copy of each page of the application for your files, then mail the original application with your first payment in the enclosed envelope.

Our cashing your check or charging your credit card does not mean your application is approved. Blue Shield will refund your payment if your application is not approved. We will notify you of your effective date of coverage and send you a bill indicating the date your next payment is due if your application is approved.

Who may apply?

If you are 65 or older

You may apply to enroll in any of Blue Shield's Medicare Supplement plans (A, F Extra,* G, G Extra, or N) if:

- You are a resident of the state of California.
- You are enrolled in Medicare Parts A and B, Title 18, Public Law 89-97, at the time you apply.

If you are 64 or younger

You may be able to enroll in a Blue Shield Medicare Supplement plan (A, F Extra, G, G Extra, or N) under the following conditions:

- You are a resident of the state of California.
- You are enrolled in Medicare Parts A and B, Title 18, Public Law 89-97, at the time you apply.

* Plan F Extra is only available to applicants who attained age 65 before January 1, 2020, or first became eligible for Medicare benefits due to disability before January 1, 2020.

- You qualify for guaranteed acceptance in a Blue Shield of California Medicare Supplement plan according to Blue Shield's guidelines.
- You do not have end-stage renal disease.
- You are enrolled in Medicare Parts A and B, Title 18, Public Law 89-97, at the time you apply.
- You qualify for guaranteed acceptance in a Blue Shield of California Medicare Supplement plan according to Blue Shield's guidelines.
- You do not have end-stage renal disease.

Qualifying for guaranteed acceptance

If you qualify for guaranteed acceptance into a Blue Shield Medicare Supplement plan, you will not be required to complete a health statement. If you do *not* qualify for guaranteed acceptance, you will need to complete a health statement and be subject to underwriting.

To qualify for guaranteed acceptance, you must meet certain, specific criteria as outlined in Blue Shield's *Guaranteed Acceptance Guide*, included in the Blue Shield Medicare Supplement plan enrollment kit.

For additional information about qualifying for guaranteed acceptance in a Blue Shield Medicare Supplement plan, please call your agent, or call Blue Shield at **(855) 217-1539**. You may also contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP provides insurance counseling for California senior citizens. Call HICAP toll-free at **(800) 434-0222** for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

Effective date of coverage

You can expect to receive notice of approval or declination within approximately two weeks after

Blue Shield receives your application. Your coverage will be effective at 12:01 a.m. Pacific time on your effective date.

Switching from another plan to a Blue Shield Medicare Supplement plan

If you have a Medicare Advantage or Medicare Advantage Prescription Drug Plan

Most Medicare Supplement plans duplicate the coverage provided by Medicare Advantage Plans. Federal law prohibits Medicare Supplement plans from enrolling anyone who is still enrolled in a Medicare Advantage Plan if the Medicare Supplement coverage would duplicate the coverage provided by the Medicare Advantage Plan.

It works like this: Members of Medicare Advantage Plans agree to access services under the terms of that plan and from the providers who contract with that plan, rather than accessing services under the Original Medicare program. Medicare Advantage Plans contract with the government and receive funds under that contract to provide this coverage to their members. Consequently, enrollees of Medicare Advantage Plans do not have access to coverage under Original Medicare.

Medicare Supplement plans generally provide coverage only for the portion of a claim that is left over after Original Medicare has paid its share. Since Original Medicare generally does not pay for services provided to a Medicare Advantage enrollee, Medicare Supplement plans won't pay toward the claim either. And, since Original Medicare generally won't pay if a Medicare Advantage Plan member receives services outside their Medicare Advantage Plan's network, the member is usually financially responsible for the full cost of those services.

If you are currently a member of a Medicare Advantage Plan, and would like to enroll in a Medicare Prescription Drug Plan and Blue Shield Medicare Supplement plan, or if you decide to enroll only in a Blue Shield Medicare Supplement plan, it is in your best interest to choose one of the options listed below to disenroll from the Medicare Advantage Plan.

Important note: If you are also planning to enroll in a Medicare Prescription Drug Plan, make sure you enroll in a Medicare Prescription Drug Plan *before* you disenroll from your Medicare Advantage Plan. During the Annual Election Period, disenrolling from your Medicare Advantage Plan will count as your election, and you may have to wait until the next Annual Election Period to be able to enroll in a Medicare Prescription Drug Plan. Enrolling in a

Medicare Prescription Drug Plan will automatically disenroll you from your Medicare Advantage Plan.

If you are only interested in applying for a Medicare Supplement plan without a Medicare Prescription Drug Plan, you may choose one of the options below to disenroll from your Medicare Advantage Plan.

Option 1

Go directly to your Social Security office and disenroll there. If you choose this option, ask for a copy of the disenrollment form, and please fax or mail it to Blue Shield (see below).

Option 2

Call the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare, and ask to be disenrolled from your current Medicare Advantage Plan. You can reach the agency at **1-800-MEDICARE**. CMS will either mail or fax you confirmation of termination from your Medicare Advantage Plan. Please forward that termination confirmation to Blue Shield via mail or fax (see below).

Option 3

Submit a written request to your current Medicare Advantage Plan and ask to be disenrolled. You can do this one of two ways:

- Call your Medicare Advantage Plan and ask for a disenrollment form to be sent to you, then complete and return the form to your Medicare Advantage Plan. Keep a copy for your records.
- Send your Medicare Advantage Plan a letter, which includes your name and member ID number, requesting disenrollment. Keep a copy of your letter for your records.

Your disenrollment request will be processed the same month it's received, with an effective date the first of the following month. We will be happy to accept a verbal confirmation from your health plan that you have disenrolled from their plan – just have them call us.

Phone: **(800) 248-2341**

TTY: **711**

Fax: **(844) 266-1850**

Mailing address:

Blue Shield of California
P.O. Box 3008
Lodi, CA 95241-1912

This will help ensure that your current Medicare Advantage coverage is terminated and that your Original Medicare coverage, which works in conjunction with Medicare Supplement coverage, is in place. For that reason, we will work with you to coordinate the effective date of any Medicare Supplement coverage we approve with

the date you disenroll from your current Medicare Advantage Plan.

If you are a member of a Medicare Advantage Plan, your disenrollment date from the Medicare Advantage Plan must be confirmed prior to final acceptance. Once your application has been accepted, Blue Shield will establish a coverage effective date for your Medicare Supplement plan.

If you have other health coverage

State laws prevent Blue Shield from enrolling you in a Medicare Supplement plan if you already have coverage, such as an existing Medicare Supplement or employer group plan that the new plan would duplicate.

To help ensure that this doesn't happen, we will coordinate your effective date of coverage under your new Blue Shield Medicare Supplement plan to coincide with disenrollment from your previous health plan.

First, we will notify you that you have been accepted in a Blue Shield Medicare Supplement plan pending verification that your other health coverage has been terminated. Once you have terminated your previous coverage, please submit proof of termination so that we can finalize your acceptance. Please refer to the questions regarding replacement of coverage, which is included in the application.

Billing options

Once you have enrolled in a Blue Shield Medicare Supplement plan, you have several options for plan dues payment.

1. **AutoPay** – Pay your plan dues with Blue Shield's quick and convenient AutoPay program, an automatic electronic transfer on your billing due date from your checking or savings account. There's no check to write and no postage to pay. A record of your payment is included on your bank statement. ***Remember, if you choose this option, you can save $3 off your dues each month.***

   AutoPay authorization instructions are included in the application within this enrollment kit.
2. **Monthly billing** – Blue Shield will send you a bill each month.

With Option 2, the bill will tell you the date your payment is due.

The dues you pay or the benefits you receive may change during the year. In either case, Blue Shield will always let you know at least 60 days in advance.

Conditions of coverage

Termination of benefits

Your Service Agreement will not be terminated by Blue Shield for any cause except those outlined in your Service Agreement. These include:

1. You are no longer enrolled in Parts A and B of Medicare
2. Non-payment of dues

Blue Shield may cancel your Service Agreement for failure to pay the required dues.

If the Service Agreement is being cancelled because you failed to pay the required dues when owed, the Plan will send a Notice of Start of Grace Period and will terminate the day following the 30-day grace period. If you fail to pay premiums, the Plan will provide written notice of nonpayment and will terminate coverage no sooner than 30 days after the date of the written notice.

You will be liable for all dues accrued while the Service Agreement continues in force including those accrued during this 30-day grace period.

If you wish to terminate the Service Agreement, you are required to give Blue Shield 30 days' notice. Should Blue Shield have plan dues for any period after the date of termination, such dues will be returned to you within 30 days. Coverage terminates at 11:59 p.m. Pacific time on the 30th day following your request for termination.

The plan is not responsible for any services received after termination unless the subscriber is totally disabled at the time of termination. See your Service Agreement for a description of extension of benefits for disability.

Cancellation

Your coverage cannot be canceled for any reason other than those conditions specified above under "Termination of Benefits."

Reinstatement of benefits

If you receive a "Notice of End of Coverage," Blue Shield will allow you two coverage reinstatements per rolling 12-month period, if the amounts owed are paid within 30 days of the date the "Notice of End of Coverage" is mailed to you.

If your request for reinstatement and payment of all outstanding amounts is not received within the required 30 days, you must fill out an application and re-apply for coverage. Members who re-apply for coverage following termination may be

subject to medical underwriting. Call your broker or Blue Shield Customer Service representative at **(800) 248-2341** to request an application. Your coverage will begin on the day the application is approved by Blue Shield.

Renewal provision

Your Blue Shield health coverage is "guaranteed renewable" (it may not be canceled by Blue Shield) and will remain in effect as long as your dues are paid in advance, except under the conditions listed above under "Termination of Benefits" and as outlined in your Service Agreement. Blue Shield may modify or amend the Service Agreement by giving you at least 60 days' prior written notice.

Appeal of an underwriting decision

If you would like to appeal an underwriting decision, contact Customer Service at **(800) 248-2341**.

If you have questions about a service, a provider, your benefits, how to use your plan, or any other matter, you may also contact Customer Service at the number above.

Plan interpretation

Blue Shield shall have the power and discretionary authority to construe and interpret the provisions of the Service Agreement, to determine the benefits of the Service Agreement, and to determine eligibility to receive benefits under the Service Agreement. Blue Shield shall exercise this authority for the benefit of all subscribers entitled to receive benefits under the Service Agreement.

Confidentiality of personal and health information

Blue Shield of California protects the confidentiality/privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, or Social Security number. Blue Shield will not disclose this information without your authorization, except as permitted by law.

The Notice of Privacy Practices, which describes how Blue Shield protects your protected health information and individually identifiable information, will be provided to you upon enrollment. Additionally, you can request a copy of our Notice of Privacy Practices by calling Customer Service at **(800) 248-2341**, or by accessing Blue Shield of California's Internet site at **blueshieldca.com** and printing a copy.

If you are concerned that Blue Shield may have violated your confidentiality privacy rights, or you disagree with a decision we made about access to your personal and health information, you may contact us at:

Correspondence address:

Blue Shield of California Privacy Official
P.O. Box 272540
Chico, CA 95927-2540

Toll-free telephone:
(888) 266-8080

Email address:
privacy@blueshieldca.com

Principal exclusions and limitations on benefits

Please note:

Blue Shield Medicare Supplement plans do not cover custodial care in any institution, including a skilled nursing facility. Custodial care includes such services as help with walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.

Unless exceptions to the following exclusions are specifically made in the *Evidence of Coverage and Health Service Agreement* (Service Agreement) for your plan, no benefits are provided for:

1. Services incident to hospitalization or confinement in a health facility primarily for Custodial, Maintenance, or Domiciliary Care; rest; or to control or change a patient's environment.
2. Dental care and treatment, dental surgery, and dental appliances.
3. Examinations for and the cost of eyeglasses and hearing aids, except when covered under Plan F Extra, Plan G Extra.
4. Services for cosmetic purposes.
5. Services for or incident to vocational, educational, recreational, art, dance or music therapy; and unless (and then only to the extent) medically necessary as an adjunct to medical treatment of an underlying medical condition, prescribed by the attending physician, and recognized by Medicare; weight control programs; or exercise programs (with the exception of SilverSneakers® Fitness Program).
6. Blood and plasma, except that this exclusion shall not apply to the first three (3) pints of blood the Subscriber receives in a Calendar Year.
7. Acupuncture, except when covered under Plan G Extra.
8. Physical examinations, except for a one-time "Welcome to Medicare" physical examination if received within the first 12 months of your initial coverage under Medicare Part B, and a yearly "Wellness" exam thereafter; or routine foot care.
9. Routine immunizations except those covered under Medicare Part B preventive services.
10. Services not specifically listed as benefits.
11. Services for which you are not legally obligated to pay, or services for which no charge is made to you.
12. Services for which you are not receiving benefits from Medicare unless otherwise noted in the Service Agreement as a covered service.
13. Vision benefits have limited nationwide access or access outside of California

See the plan *Evidence of Coverage* for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your right to independent medical review.

HICAP
(800) 434-0222
For additional information concerning covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens.

Blue Shield of California
Medicare Plans
Regional Sales Office
6300 Canoga Ave.
Woodland Hills, CA 91367-2555

Blue Shield of California is an independent member of the Blue Shield Association MSP14541-PR-DS (01/25)

Blue Shield Medicare Supplement plan rates

Blue Shield of California rates effective:
July 1, 2025

blue california

Blue Shield of California Medicare Supplement plans

Please take a few minutes to review the information in this booklet.

Locate your rate

Several factors determine your rate including where you live, the Medicare Supplemental plan you chose, and your age.

To see the rate you will pay, locate your region, age range, and plan selected in the following rate schedule.

Information about prepaid or periodic charges

Your dues will automatically increase annually and the amount due will be based on your attained age on that date.

If you're applying more than 60 days before your effective date, the rates listed are subject to change.

Enrolling in our plans

Plan F Extra is only available to applicants who attained age 65 before January 1, 2020, or first became eligible for Medicare benefits due to disability before January 1, 2020.

The Notice of New or Innovative Benefits Form contains information about benefits, costs, and premiums of the new or innovative benefits (our Extra benefits) included with your plan. Please visit **blueshieldca.com/innovativebenefits** to access the form. On the plan documents page, select your plan and click the drop-down menu to view the notice. Please keep this notice with your plan documents for your records. You can also request a copy of the form by contacting us at **(800) 248-2341 (TTY: 711)**. Representatives are available from 8 a.m. to 8 p.m., seven days a week, year round.

Region 1

Los Angeles County (except for ZIP codes 91711, 91759, 91765, 91766, 91767, 93535, 93544, 93563, and 93591)

Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.[1]

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$134	$251	$192	$211	$181
66	$138	$260	$200	$220	$191
67	$142	$270	$213	$230	$195
68	$149	$281	$226	$244	$203
69	$155	$292	$238	$257	$212
70	$165	$298	$251	$267	$223
71	$177	$312	$266	$284	$237
72	$183	$328	$280	$299	$251
73	$193	$351	$299	$317	$272
74	$206	$362	$310	$327	$277
75	$220	$376	$322	$340	$286
76	$227	$406	$346	$364	$303
77	$237	$438	$373	$392	$323
78	$246	$471	$397	$416	$332
79	$244	$493	$410	$428	$331
80	$256	$527	$438	$456	$346
81	$266	$560	$463	$481	$361
82	$272	$574	$481	$502	$370
83	$279	$590	$503	$521	$382
84	$284	$607	$520	$540	$395
85 and over	$292	$637	$545	$563	$414
Under 65[2]	$576	$1,250	$1,071	$1,107	$812

Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$160	$299	$229	$252	$216
66	$165	$310	$239	$262	$228
67	$169	$322	$254	$274	$233
68	$178	$335	$270	$291	$242
69	$185	$348	$284	$307	$253
70	$197	$356	$299	$319	$266
71	$211	$372	$317	$339	$283
72	$218	$391	$334	$357	$299
73	$230	$419	$357	$378	$324
74	$246	$432	$370	$390	$330
75	$262	$449	$384	$406	$341
76	$271	$484	$413	$434	$361
77	$283	$523	$445	$468	$385
78	$293	$562	$474	$496	$396
79	$291	$588	$489	$511	$395
80	$305	$629	$523	$544	$413
81	$317	$668	$552	$574	$431
82	$324	$685	$574	$599	$441
83	$333	$704	$600	$622	$456
84	$339	$724	$620	$644	$471
85 and over	$348	$760	$650	$672	$494
Under 65[2]	$687	$1,491	$1,278	$1,321	$969

Region 2

Orange County

Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.[1]

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$135	$262	$198	$218	$186
66	$139	$268	$208	$227	$193
67	$143	$280	$219	$239	$196
68	$150	$291	$232	$251	$205
69	$156	$301	$246	$265	$213
70	$166	$310	$259	$277	$225
71	$179	$322	$274	$293	$239
72	$185	$339	$291	$309	$253
73	$194	$361	$309	$328	$274
74	$210	$375	$319	$337	$286
75	$228	$391	$333	$350	$299
76	$235	$420	$359	$376	$315
77	$245	$451	$387	$405	$334
78	$254	$487	$410	$428	$343
79	$254	$511	$423	$442	$343
80	$264	$545	$450	$470	$361
81	$274	$576	$478	$497	$377
82	$281	$594	$498	$517	$386
83	$287	$608	$520	$539	$394
84	$293	$628	$537	$555	$409
85 and over	$302	$660	$563	$582	$427
Under 65[2]	$596	$1,296	$1,104	$1,144	$839

Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$161	$313	$236	$260	$222
66	$166	$320	$248	$271	$230
67	$171	$334	$261	$285	$234
68	$179	$347	$277	$299	$245
69	$186	$359	$293	$316	$254
70	$198	$370	$309	$330	$268
71	$214	$384	$327	$350	$285
72	$221	$404	$347	$369	$302
73	$231	$431	$369	$391	$327
74	$251	$447	$381	$402	$341
75	$272	$466	$397	$418	$357
76	$280	$501	$428	$449	$376
77	$292	$538	$462	$483	$398
78	$303	$581	$489	$511	$409
79	$303	$610	$505	$527	$409
80	$315	$650	$537	$561	$431
81	$327	$687	$570	$593	$450
82	$335	$709	$594	$617	$460
83	$342	$725	$620	$643	$470
84	$350	$749	$641	$662	$488
85 and over	$360	$787	$672	$694	$509
Under 65[2]	$711	$1,546	$1,317	$1,365	$1,001

Region 3

San Diego, Sonoma, San Bernardino and Kern counties, and Los Angeles ZIP codes 91711, 91759, 91765, 91766, 91767, 93535, 93544, 93563, and 93591

Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.[1]

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$131	$242	$183	$203	$171
66	$135	$250	$193	$212	$183
67	$139	$258	$204	$223	$194
68	$148	$268	$216	$235	$204
69	$156	$277	$229	$247	$211
70	$166	$287	$241	$260	$221
71	$178	$299	$256	$274	$236
72	$184	$315	$269	$288	$253
73	$194	$335	$285	$306	$272
74	$208	$345	$295	$313	$279
75	$223	$360	$308	$326	$290
76	$228	$387	$332	$349	$305
77	$238	$417	$358	$376	$321
78	$247	$452	$380	$398	$331
79	$247	$472	$391	$410	$331
80	$258	$504	$417	$437	$348
81	$268	$536	$442	$461	$362
82	$275	$549	$461	$480	$371
83	$282	$562	$480	$500	$382
84	$287	$582	$497	$517	$394
85 and over	$295	$609	$520	$541	$412
Under 65[2]	$581	$1,195	$1,022	$1,062	$810

Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$156	$289	$218	$242	$204
66	$161	$298	$230	$253	$218
67	$166	$308	$243	$266	$231
68	$177	$320	$258	$280	$243
69	$186	$330	$273	$295	$252
70	$198	$342	$288	$310	$264
71	$212	$357	$305	$327	$282
72	$220	$376	$321	$344	$302
73	$231	$400	$340	$365	$324
74	$248	$412	$352	$373	$333
75	$266	$429	$367	$389	$346
76	$272	$462	$396	$416	$364
77	$284	$497	$427	$449	$383
78	$295	$539	$453	$475	$395
79	$295	$563	$466	$489	$395
80	$308	$601	$497	$521	$415
81	$320	$639	$527	$550	$432
82	$328	$655	$550	$573	$443
83	$336	$670	$573	$597	$456
84	$342	$694	$593	$617	$470
85 and over	$352	$727	$620	$645	$492
Under 65[2]	$693	$1,426	$1,219	$1,267	$966

Region 4

Riverside and Ventura counties

Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.[1]

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$141	$268	$203	$223	$192
66	$145	$276	$214	$232	$203
67	$150	$287	$224	$245	$212
68	$162	$298	$240	$259	$220
69	$171	$311	$255	$273	$227
70	$182	$317	$265	$285	$242
71	$195	$329	$283	$301	$258
72	$201	$348	$298	$318	$276
73	$210	$372	$317	$336	$295
74	$226	$382	$327	$345	$303
75	$243	$398	$342	$359	$314
76	$249	$430	$367	$386	$330
77	$258	$465	$396	$415	$349
78	$270	$501	$421	$438	$359
79	$268	$524	$433	$453	$359
80	$281	$560	$464	$480	$376
81	$291	$594	$490	$510	$392
82	$297	$608	$512	$532	$402
83	$304	$625	$534	$552	$414
84	$310	$645	$551	$570	$428
85 and over	$320	$676	$578	$597	$450
Under 65[2]	$630	$1,327	$1,133	$1,173	$884

Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$168	$320	$242	$266	$229
66	$173	$329	$255	$277	$242
67	$179	$342	$267	$292	$253
68	$193	$356	$286	$309	$262
69	$204	$371	$304	$326	$271
70	$217	$378	$316	$340	$289
71	$233	$392	$338	$359	$308
72	$240	$415	$356	$379	$329
73	$251	$444	$378	$401	$352
74	$270	$456	$390	$412	$361
75	$290	$475	$408	$428	$375
76	$297	$513	$438	$460	$394
77	$308	$555	$472	$495	$416
78	$322	$598	$502	$523	$428
79	$320	$625	$517	$540	$428
80	$335	$668	$554	$573	$449
81	$347	$709	$585	$608	$468
82	$354	$725	$611	$635	$480
83	$363	$746	$637	$659	$494
84	$370	$769	$657	$680	$511
85 and over	$382	$806	$690	$712	$537
Under 65[2]	$752	$1,583	$1,352	$1,399	$1,055

Region 5

Santa Barbara, San Joaquin, and Stanislaus counties

Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.[1]

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$121	$221	$168	$186	$157
66	$124	$227	$174	$195	$163
67	$128	$236	$184	$203	$171
68	$133	$244	$195	$214	$182
69	$138	$254	$207	$227	$188
70	$147	$260	$220	$238	$197
71	$158	$271	$232	$251	$211
72	$165	$288	$244	$263	$224
73	$174	$305	$262	$279	$241
74	$185	$315	$269	$287	$248
75	$197	$328	$280	$299	$256
76	$202	$354	$302	$321	$271
77	$211	$380	$325	$344	$288
78	$220	$410	$345	$363	$295
79	$220	$430	$357	$376	$295
80	$230	$458	$380	$400	$309
81	$238	$485	$404	$422	$323
82	$244	$498	$420	$439	$332
83	$249	$511	$438	$456	$339
84	$253	$529	$451	$471	$352
85 and over	$261	$553	$473	$493	$366
Under 65[2]	$514	$1,087	$930	$967	$720

Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$144	$264	$200	$222	$187
66	$148	$271	$208	$233	$194
67	$153	$282	$220	$242	$204
68	$159	$291	$233	$255	$217
69	$165	$303	$247	$271	$224
70	$175	$310	$262	$284	$235
71	$188	$323	$277	$299	$252
72	$197	$344	$291	$314	$267
73	$208	$364	$313	$333	$288
74	$221	$376	$321	$342	$296
75	$235	$391	$334	$357	$305
76	$241	$422	$360	$383	$323
77	$252	$453	$388	$410	$344
78	$262	$489	$412	$433	$352
79	$262	$513	$426	$449	$352
80	$274	$546	$453	$477	$369
81	$284	$579	$482	$503	$385
82	$291	$594	$501	$524	$396
83	$297	$610	$523	$544	$404
84	$302	$631	$538	$562	$420
85 and over	$311	$660	$564	$588	$437
Under 65[2]	$613	$1,297	$1,109	$1,154	$859

Region 6

Lake, Lassen, Inyo, and Kings counties

Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.[1]

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$117	$223	$170	$190	$161
66	$119	$230	$178	$197	$166
67	$122	$240	$187	$205	$170
68	$129	$248	$199	$217	$176
69	$135	$258	$211	$230	$182
70	$143	$265	$222	$239	$192
71	$153	$276	$236	$255	$203
72	$158	$291	$247	$266	$217
73	$167	$309	$264	$282	$228
74	$179	$319	$272	$291	$239
75	$191	$332	$284	$301	$250
76	$197	$357	$305	$324	$264
77	$205	$386	$329	$349	$280
78	$213	$416	$350	$369	$286
79	$212	$436	$361	$380	$286
80	$222	$465	$386	$404	$300
81	$230	$494	$408	$427	$313
82	$237	$505	$426	$445	$322
83	$242	$518	$445	$464	$331
84	$247	$537	$459	$478	$342
85 and over	$255	$561	$480	$500	$359
Under 65[2]	$502	$1,104	$942	$981	$705

Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$140	$266	$203	$227	$192
66	$142	$274	$212	$235	$198
67	$146	$286	$223	$245	$203
68	$154	$296	$237	$259	$210
69	$161	$308	$252	$274	$217
70	$171	$316	$265	$285	$229
71	$183	$329	$282	$304	$242
72	$188	$347	$295	$317	$259
73	$199	$369	$315	$336	$272
74	$214	$381	$324	$347	$285
75	$228	$396	$339	$359	$298
76	$235	$426	$364	$387	$315
77	$245	$460	$392	$416	$334
78	$254	$496	$418	$440	$341
79	$253	$520	$431	$453	$341
80	$265	$555	$460	$482	$358
81	$274	$589	$487	$509	$373
82	$283	$602	$508	$531	$384
83	$289	$618	$531	$554	$395
84	$295	$641	$548	$570	$408
85 and over	$304	$669	$573	$597	$428
Under 65[2]	$599	$1,317	$1,124	$1,170	$841

Region 7

Napa, Alameda, Contra Costa, Siskiyou, and Yolo counties

Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.[1]

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$124	$234	$177	$195	$168
66	$128	$240	$186	$205	$173
67	$131	$251	$195	$215	$177
68	$146	$258	$209	$226	$192
69	$162	$269	$221	$238	$207
70	$171	$276	$231	$250	$219
71	$184	$287	$247	$263	$235
72	$190	$303	$259	$277	$246
73	$201	$323	$276	$294	$263
74	$215	$333	$285	$303	$269
75	$231	$346	$297	$314	$283
76	$237	$373	$320	$336	$302
77	$246	$403	$345	$361	$319
78	$256	$436	$367	$384	$328
79	$254	$457	$378	$396	$325
80	$266	$486	$403	$420	$343
81	$276	$516	$427	$447	$358
82	$283	$528	$446	$463	$369
83	$289	$544	$464	$483	$377
84	$295	$560	$479	$498	$388
85 and over	$304	$589	$502	$520	$408
Under 65[2]	$599	$1,156	$986	$1,022	$801

Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$148	$279	$211	$233	$200
66	$153	$286	$222	$245	$206
67	$156	$299	$233	$256	$211
68	$174	$308	$249	$270	$229
69	$193	$321	$264	$284	$247
70	$204	$329	$276	$298	$261
71	$220	$342	$295	$314	$280
72	$227	$361	$309	$330	$293
73	$240	$385	$329	$351	$314
74	$256	$397	$340	$361	$321
75	$276	$413	$354	$375	$338
76	$283	$445	$382	$401	$360
77	$293	$481	$412	$431	$381
78	$305	$520	$438	$458	$391
79	$303	$545	$451	$472	$388
80	$317	$580	$481	$501	$409
81	$329	$616	$509	$533	$427
82	$338	$630	$532	$552	$440
83	$345	$649	$554	$576	$450
84	$352	$668	$571	$594	$463
85 and over	$363	$703	$599	$620	$487
Under 65[2]	$715	$1,379	$1,176	$1,219	$956

Region 8

Alpine, Butte, Del Norte, Fresno, Glenn, Humboldt, Imperial, Madera, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, San Francisco, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Solano, Sutter, Trinity, Tulare, Tuolumne, and Yuba counties

Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.[1]

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$120	$221	$168	$186	$157
66	$124	$227	$174	$195	$166
67	$130	$236	$184	$203	$176
68	$133	$244	$195	$214	$181
69	$137	$254	$207	$227	$188
70	$149	$260	$220	$238	$199
71	$163	$271	$232	$251	$217
72	$169	$288	$244	$263	$231
73	$179	$305	$262	$279	$246
74	$190	$316	$269	$287	$254
75	$202	$329	$280	$299	$262
76	$209	$355	$302	$321	$277
77	$219	$383	$325	$344	$295
78	$227	$411	$345	$363	$302
79	$224	$433	$357	$376	$301
80	$235	$460	$380	$400	$317
81	$245	$489	$404	$422	$332
82	$251	$500	$420	$439	$340
83	$257	$513	$438	$456	$350
84	$262	$530	$451	$471	$361
85 and over	$269	$555	$473	$493	$378
Under 65[2]	$531	$1,089	$930	$967	$743

Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$143	$264	$200	$222	$187
66	$148	$271	$208	$233	$198
67	$155	$282	$220	$242	$210
68	$159	$291	$233	$255	$216
69	$163	$303	$247	$271	$224
70	$178	$310	$262	$284	$237
71	$194	$323	$277	$299	$259
72	$202	$344	$291	$314	$276
73	$214	$364	$313	$333	$293
74	$227	$377	$321	$342	$303
75	$241	$392	$334	$357	$313
76	$249	$424	$360	$383	$330
77	$261	$457	$388	$410	$352
78	$271	$490	$412	$433	$360
79	$267	$517	$426	$449	$359
80	$280	$549	$453	$477	$378
81	$292	$583	$482	$503	$396
82	$299	$597	$501	$524	$406
83	$307	$612	$523	$544	$418
84	$313	$632	$538	$562	$431
85 and over	$321	$662	$564	$588	$451
Under 65[2]	$633	$1,299	$1,109	$1,154	$886

Region 9

Sacramento, Amador, Calaveras, Colusa, El Dorado, Tehama, and Marin counties

Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.[1]

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$117	$219	$167	$186	$157
66	$118	$226	$173	$192	$165
67	$120	$236	$184	$201	$168
68	$127	$246	$196	$213	$172
69	$134	$253	$208	$226	$173
70	$142	$260	$219	$236	$184
71	$152	$272	$232	$250	$196
72	$157	$285	$245	$262	$209
73	$165	$303	$262	$280	$220
74	$178	$314	$269	$286	$231
75	$190	$327	$281	$297	$240
76	$196	$352	$301	$319	$250
77	$204	$380	$326	$343	$264
78	$211	$411	$344	$364	$272
79	$210	$431	$357	$374	$275
80	$220	$458	$380	$398	$286
81	$228	$487	$402	$421	$296
82	$233	$498	$420	$438	$307
83	$239	$513	$438	$459	$315
84	$244	$529	$453	$471	$327
85 and over	$252	$554	$473	$493	$343
Under 65[2]	$497	$1,089	$929	$967	$674

Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance

Single-party rates

Age range	A	F Extra[3]	G	G Extra	N
65	$140	$261	$199	$222	$187
66	$141	$270	$206	$229	$197
67	$143	$282	$220	$240	$200
68	$152	$293	$234	$254	$205
69	$160	$302	$248	$270	$206
70	$169	$310	$261	$282	$220
71	$181	$324	$277	$298	$234
72	$187	$340	$292	$313	$249
73	$197	$361	$313	$334	$262
74	$212	$375	$321	$341	$276
75	$227	$390	$335	$354	$286
76	$234	$420	$359	$381	$298
77	$243	$453	$389	$409	$315
78	$252	$490	$410	$434	$324
79	$251	$514	$426	$446	$328
80	$262	$546	$453	$475	$341
81	$272	$581	$480	$502	$353
82	$278	$594	$501	$523	$366
83	$285	$612	$523	$548	$376
84	$291	$631	$540	$562	$390
85 and over	$301	$661	$564	$588	$409
Under 65[2]	$593	$1,299	$1,108	$1,154	$804

Rates for Blue Shield Dental PPO plans

Blue Shield dental rates no dental savings

	Dental PPO 1000	Dental PPO 1500
Individual	$39.20	$58.80

Please note: Monthly premiums for the dental plans are in addition to the premium for medical benefits covered by the Blue Shield health plan. However, your client will receive one bill that combines their health and dental premiums.

Endnotes

1. Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed on to the subscriber. Household Savings Program does not apply to tobacco users. Welcome to Medicare Rate Savings does not apply to Plan N.
2. If you are age 64 or younger and do not have end-stage renal disease, you may apply for Blue Shield of California Medicare Supplement coverage as described in Blue Shield's *Guaranteed Acceptance Guide*. Blue Shield of California does not offer coverage if you are age 64 or younger unless you qualify for guaranteed acceptance. The Household Savings Program is not available to those 64 or younger.
3. Plan F Extra is only available to applicants who attained age 65 before January 1, 2020, or first became eligible for Medicare benefits due to disability before January 1, 2020.

HICAP
(800) 434-0222

For additional information concerning covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens.

Blue Shield of California
Medicare Plans
Regional Sales Office
6300 Canoga Ave.
Woodland Hills, CA 91367-2555

Medicare Supplement Plan F Extra
Notice of new or innovative benefits

The purpose of this form is to notify consumers of the availability of Medicare Supplement plans offered for sale by Blue Shield of California, which, in addition to the standardized coverage offered by the plan, include new or innovative benefits. For additional details, please contact **(800) 248-2341 (TTY: 711)**, 8 a.m. – 8 p.m., seven days a week, year-round.

New or innovative benefits added to Medicare Supplement Plan F Extra

Description	**Your out-of-pocket costs** (In-network provider)	**Your out-of-pocket costs** (Out-of-network provider)
Basic gym access through SilverSneakers® fitness program		
Exercise, education, and social activities with access to: • Thousands of fitness locations • Exercise equipment and SilverSneakers classes • Social events and activities • SilverSneakers FLEX™ classes such as yoga, Latin dance, and tai chi • Live and SilverSneakers On-Demand™ online workout videos • Hundreds of SilverSneakers LIVE classes each week plus On-Demand videos	$0	All costs
Personal Emergency Response System (PERS)		
PERS benefits are provided by LifeStation: • One personal emergency response system • Choice of an in-home system or mobile device with GPS/WiFi and fall detection • Monthly monitoring • Necessary chargers and cords	$0	All costs
Hearing aids services		
Hearing aid services benefits are provided by EPIC Hearing Healthcare (EPIC). This benefit is designed for you to use EPIC network providers. EPIC participating providers are listed at **blueshieldca.com/HearingAids**. If you choose to use out-of-network providers, those services will not be covered. This benefit is separate from diagnostic hearing examinations and related charges as covered by Medicare.		

Description	Your out-of-pocket costs (In-network provider)	Your out-of-pocket costs (Out-of-network provider)
(continued from previous page)		
Hearing aid benefits every year include: • One in-person routine hearing exam • Hearing aid instrument: ◦ Up to two hearing aids delivered in-person through a network hearing aid provider ◦ Choice of private-labeled Silver (mid-level) or Gold (advanced-level) technology hearing aid models ◦ Silver technology hearings aids: - Available in the behind-the-ear and receiver-in-the-ear hearing aid style only - Choice of virtual or in-person delivery ◦ Gold technology hearing aids: - Available in multiple styles - In-the-ear, in-the-canal, completely-in-canal, behind-the-ear, and receiver-in-the-ear hearing aid styles - Standard ear molds and impressions are available as needed ◦ All technology levels include: - One consultation - Up to three follow-up visits for hearing aid fittings, consultations, device checks, and adjustments for no additional fee, within 12 months of purchase - Charging case for rechargeable battery models, or - A two-year supply of batteries per hearing aid; and - Three-year extended warranty	$0 **Silver technology level** $449 per hearing aid **Gold technology level** $699 per hearing aid	All costs
Vision services		

Vision benefits are provided by Vision Service Plan (VSP). This benefit offers one of the largest national networks of independent doctors located in retail, neighborhood, medical, and professional settings. You can lower any out-of-pocket costs by choosing network providers for covered services. Find participating providers by visiting our online directory at **blueshieldca.com** and clicking on *Find a doctor*.

Description	Your out-of-pocket costs (In-network provider)	Your out-of-pocket costs (Out-of-network provider)
(continued from previous page)		
Comprehensive eye exam once every 12 months	$20 copay	All costs above $50
Eyeglass frames once every 24 months	All costs above $100 allowance	All costs above $40 allowance
Eyeglass lenses once every 12 months • Single vision • Bifocal • Trifocal • Aphakic, lenticular monofocal, or multifocal	$25 copay	Single vision: All costs above $43 Bifocal: All costs above $60 Trifocal: All costs above $75 Aphakic or lenticular monofocal or multifocal: All costs above $104
Contact lenses (instead of eyeglass lenses) once every 12 months • Non-elective (medically necessary) – Hard or soft – one pair	**Non-elective (hard or soft):** $25 copay and all costs above $500	**Non-elective (hard or soft):** All costs above $200
• Elective (cosmetic/convenience) – Hard – one pair • Elective (cosmetic/convenience) – Soft – Up to a three- to six-month supply for each eye based on lenses selected	**Elective:** $25 copay and all costs above $120	**Elective (hard or soft):** All costs above $100
Total annual premium for new or innovative benefits only:	$144.00	$144.00

* Plan F Extra is only available to applicants who attained age 65 before January 1, 2020, or first became eligible for Medicare benefits due to disability before January 1, 2020.

Medicare Supplement Plan G Extra
Notice of new or innovative benefits

The purpose of this form is to notify consumers of the availability of Medicare Supplement plans offered for sale by Blue Shield of California, which, in addition to the standardized coverage offered by the plan, include new or innovative benefits. For additional details, please contact **(800) 248-2341 (TTY: 711)**, 8 a.m. – 8 p.m., seven days a week, year-round.

New or innovative benefits added to Medicare Supplement Plan G Extra

Description	**Your out-of-pocket costs** (In-network provider)	**Your out-of-pocket costs** (Out-of-network provider)
Basic gym access through SilverSneakers® fitness program		
Exercise, education, and social activities with access to: • Thousands of fitness locations • Exercise equipment and SilverSneakers classes • Social events and activities • SilverSneakers FLEX™ classes such as yoga, Latin dance, and tai chi • Live and SilverSneakers On-Demand™ online workout videos	$0	All costs
Acupuncture and chiropractic services		
Your acupuncture and chiropractic services benefits are administered by American Specialty Health Plans of California, Inc. (ASH Plans). The benefits covered under this plan must be received from ASH Participating Providers. ASH participating providers may be located through an online directory at **blueshieldca.com**. Click on *Find a doctor*. Up to 20 visits per calendar year for acupuncture and chiropractic services combined.	$0	All costs
Hearing aids services		
Hearing aid services benefits are provided by EPIC Hearing Healthcare (EPIC). This benefit is designed for you to use EPIC network providers. EPIC Participating Providers are listed at **blueshieldca.com/HearingAids.** If you choose to use out-of-network providers, those services will not be covered. This benefit is separate from diagnostic hearing examinations and related charges as covered by Medicare.		

Description	**Your out-of-pocket costs** (In-network provider)	**Your out-of-pocket costs** (Out-of-network provider)
(continued from previous page)		
Hearing aid benefits every year include: • One in-person routine hearing exam • Hearing aid instrument: ◦ Up to two hearing aids delivered in-person through a network hearing aid provider ◦ Choice of private-labeled Silver (mid-level) or Gold (advanced-level) technology hearing aid models ◦ Silver technology hearings aids: - Available in the behind-the-ear and receiver-in-the-ear hearing aid style only ◦ Gold technology hearing aids: - Available in multiple styles: - Choice of virtual or in-person delivery - In-the-ear, in-the-canal, completely-in-canal, behind-the-ear, and receiver-in-the-ear hearing aid styles - Standard ear molds and impressions are available as needed ◦ All technology levels include: - One consultation - Up to three follow-up visits for hearing aid fittings, consultations, device checks, and adjustments for no additional fee, within 12 months of purchase - Charging case for rechargeable battery models, or - A two-year supply of batteries per hearing aid; and - Three-year extended warranty	$0 **Silver technology level** $449 per hearing aid $699 per hearing aid	All costs
Vision services		
Vision benefits are provided by Vision Service Plan (VSP). This benefit offers one of the largest national networks of independent doctors located in retail, neighborhood, medical, and professional settings. You can lower any out-of-pocket costs by choosing network providers for covered services. Find participating providers by visiting our online directory at **blueshieldca.com** and clicking on *Find a doctor*.		
Comprehensive eye exam once every 12 months	$20 copay	All costs above $50
Eyeglass frames once every 24 months	All costs above $100 allowance	All costs above $40 allowance

Description	Your out-of-pocket costs (In-network provider)	Your out-of-pocket costs (Out-of-network provider)
(continued from previous page)		
Eyeglass lenses once every 12 months • Single vision • Bifocal • Trifocal • Aphakic, lenticular monofocal, or multifocal	$25 copay	Single vision: All costs above $43 Bifocal: All costs above $60 Trifocal: All costs above $75 Aphakic or lenticular monofocal or multifocal: All costs above $104
Contact lenses (instead of eyeglass lenses) once every 12 months • Non-elective (medically necessary) – Hard or soft – one pair	**Non-elective (hard or soft):** $25 copay and all costs above $500	**Non-elective (hard or soft):** All costs above $200
• Elective (cosmetic/convenience) – Hard – one pair • Elective (cosmetic/convenience) – Soft – Up to a three- to six-month supply for each eye based on lenses selected	**Elective:** $25 copay and all costs above $120	**Elective (hard or soft):** All costs above $100
Physician consultation by phone or video through Teladoc Health	$0 per consult	All costs
Over-the-Counter items through CVS		
Eligible over-the-counter (OTC) items are available through the OTC Items Catalog, at **blueshieldca.com/medicareOTC.** Limitations may apply. Refer to the OTC Items Catalog for more information. Up to two orders per quarter.	All costs above the $100 allowance per quarter	All costs
Total annual premium for new or innovative benefits only:	$300.00	$300.00

You may receive services from providers on an in-person basis or via telehealth, if available. Contact your provider, treating specialist, facility, or other health professional to learn more. Telehealth and in-person services are subject to the same timeliness and geographic access standards. You are subject to your Medicare Supplement plan's cost-sharing obligations and balance billing protections.

Application form

blue california

Application for Blue Shield of California Medicare Supplement plans

Here's how to apply

1. Provide ALL requested information and print clearly in all capital letters in black ink.
2. Sign and date in all places indicated.
3. Within 30 days of your signature date, please submit your completed application to:
   Fax (844) 266-1850 **Email** msinstall@blueshieldca.com
   Mail Medicare Supplement Installation
   P.O. Box 3008
   Lodi, CA 95241-1912
4. It is required that a signed copy of this contract is made for your records. Be sure to keep the second copy of this application with all other important Blue Shield of California documents and information.

If you are a current member interested in transferring to a Medicare Supplement plan of equal or lesser value outside your enrollment period or to a richer benefit plan at any time, you must complete this application.

Plan F Extra is only available to applicants who attained age 65 before January 1, 2020, or first became eligible for Medicare benefits due to disability before January 1, 2020.

Personal information

Last name:	First name:	Middle initial:
Date of birth (MM/DD/YYYY):	Gender: ☐ Male ☐ Female ☐ Nonbinary	
Phone number:	Phone Type: ☐ Landline ☐ Mobile	
Home address:		
City:	State:	ZIP code:

Language preference:
☐English ☐Spanish ☐Chinese ☐Korean ☐Vietnamese

Select one if you want us to send you information in an accessible format.
☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Email address:	**Mobile phone number:**

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

You will get many of your required plan communications delivered electronically. We will send you an email when new communications are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

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

Mailing address (if different from above):		
City:	State:	ZIP code:
Billing address (if different from above):		
City:	State:	ZIP code:

Medicare Beneficiary Identification (MBI) number:

I'm entitled to:
Hospital (Part A) effective date (MM/DD/YYYY) Medicare (Part B) effective date (MM/DD/YYYY)

Please check the plan type you are applying for:	Requested effective date:
☐ A ☐ F Extra * ☐ G ☐ G Extra ☐ N	The 1st day of (MM/YYYY)

Current Blue Shield of California members please provide member ID number:

Household Savings Program[1]

If you and the other member of your household are age 65 or older and both members have or are applying for the same plan (including any dental plans), you may be eligible for a 7% monthly savings on your combined medical plan dues when **both members are enrolled in the same eligible plan. Both members must share the same home and mailing addresses.** Tobacco users are not eligible for the Household Savings Program.

Is the other member of your household enrolled in, or applying for, the **same** Blue Shield Medicare Supplement plan that you are applying for and share both addresses? ☐ Yes ☐ No

If Yes, please provide the other household member

Name:

Medicare Beneficiary Identification (MBI) number:

Blue Shield Medicare Supplement plan member ID (if available):

Please provide other household member's authorization to cancel their separate Blue Shield contract and enroll under the primary subscriber's agreement for the Household Savings Program by having the other household member sign below:

Signature of individual listed above: Date (MM/DD/YYYY):

Each individual must complete their own application if not already a current member. If both members are either new enrollees or existing enrollees, the subscriber is determined based on which application is enrolled first. Otherwise, the existing member already enrolled in the requested plan type will be designated as the subscriber. The subscriber is responsible for payment of dues/premiums to Blue Shield, and only the subscriber can make changes to the contract/policy. When enrolled under the Household Savings Program, Blue Shield will also accept payment of dues/premiums from the other household member enrolled in the plan. Billing information and amounts due can/will be shared with both parties enrolled in the plan when calling Customer Service.

Dental PPO plans

Dental plans for Medicare Supplement plan members.
Please see the page on **blueshieldca.com/MedSuppDental2025** for more information.

To sign up for Blue Shield dental coverage, select a plan below:
Dental plan options (check one): ☐ Dental PPO 1000 ☐ Dental PPO 1500 ☐ No dental plan

You can save $3 each month for the first six months on your dental plan rates if you enroll in a dental plan **at the same time** you enroll in any Blue Shield Medicare Supplement plan.[1]

Conditions of coverage

- Dental benefits aren't subject to health plan deductible requirements.
- If your dental coverage is canceled for any reason (by you or by Blue Shield), you may apply for reenrollment, but you will have to wait six months to reapply.

* Plan F Extra is only available to applicants who attained age 65 before January 1, 2020, or first became eligible for Medicare benefits due to disability before January 1, 2020.

1 Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed along to the subscriber.

Current insurance coverage information (required for all submissions)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance contract, or that you had certain rights to buy such a contract, you may be eligible for guaranteed acceptance in one or more of our Medicare Supplement plans. The Blue Shield Guaranteed Acceptance Guide describes the different situations in which you may be eligible for guaranteed issue of a Medicare Supplement plan. It is important to note that the time period of eligibility for guaranteed issuance may vary by situation, and you must apply within this time period to be eligible for guaranteed acceptance.

If you think you qualify for guaranteed acceptance, please write the number of the qualifying situation, as described in the Blue Shield Guaranteed Acceptance Guide included in the enrollment kit or visit **blueshieldca.com/medicareoptions**, in the space below. Then attach proof of prior coverage as a separate sheet, and sign and date the sheet.

I believe I qualify for guaranteed acceptance based on situation number _____.

If applying for guaranteed acceptance under situation No. 2 on the Blue Shield Guaranteed Acceptance Guide, please complete the Notice of Replacement of Coverage form on the next page and submit with your completed enrollment application.

Please include a copy of the front and back of your current carrier ID card. Please also include a copy of the notice from your prior insurer with your application.

Please answer all questions to the best of your knowledge.
(Please check Yes or No below)

1	☐ Yes ☐ No	a. Did you turn 65 years of age in the last six months?
	☐ Yes ☐ No	b. Did you enroll in Medicare Part B in the last six months?
		c. If Yes, what is the effective date? (MM/DD/YYYY) _____
2	☐ Yes ☐No	Are you covered for medical assistance through California's Medi-Cal program? NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program and have not met your share of cost, please answer NO to this question.
	If Yes, ☐ Yes ☐ No	a. Will Medi-Cal pay your premiums for this Medicare Supplement plan contract?
	☐ Yes ☐ No	b. Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?
3	☐ Yes ☐ No	a. Have you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO)? If yes, fill in your start and end dates below. If you are still covered under this plan, leave the "END" blank. Start (MM/DD/YYYY) _____ Carrier name: _____ End (MM/DD/YYYY) _____ Plan type: _____ Reason for coverage ending:
	If Yes, ☐ Yes ☐ No	b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan contract?
	☐ Yes ☐ No	c. Was this your first time in this type of Medicare plan?
	☐ Yes ☐ No	d. Did you drop a Medicare Supplement plan contract to enroll in the Medicare plan?

4	☐ Yes ☐ No	a. Do you have another Medicare Supplement plan policy, certificate, contract in force? b. If so, with what company? _____ What plan do you have? _____
	☐ Yes ☐ No	c. If so, do you intend to replace your current Medicare Supplement plan policy or certificate with this contract? If you answered yes, please complete the Notice to applicant regarding replacement of Medicare Supplement or Medicare Advantage coverage on the next page.
5	☐ Yes ☐ No	Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? a. If so, what companies and what kind of policy? Carrier name: _____ Carrier phone no.: _____ Plan type: _____ Current ID no.: _____ b. What are your dates of coverage under the other policy? (If you are still covered under this plan, leave the "END" blank.) Start (MM/DD/YYYY) End (MM/DD/YYYY)
6	☐ Yes ☐ No	Are you under age 65?
	If Yes, ☐ Yes ☐ No	a. Do you have end-stage renal disease?

You may contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll-free at (800) 434-0222 for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Managed Health Care's consumer toll-free telephone number (888) 466-2219, by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (800) 434-0222, or by accessing the Department of Managed Health Care's website (www.dmhc.ca.gov).

Notice to applicant regarding replacement of Medicare Supplement or Medicare Advantage coverage

According to question four on the previous page, you intend to lapse or otherwise terminate an existing Medicare Supplement policy or contract or Medicare Advantage plan and replace it with a contract to be issued by Blue Shield. Your contract to be issued by Blue Shield will provide 30 days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or plan contract only if, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

Statement to applicant by plan, solicitor, solicitor firm, or other representative

1	I have reviewed your current medical or health coverage. To the best of my knowledge, the replacement of coverage involved in this transaction does not duplicate coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement contract is being purchased for the following reason (check one): ☐ Additional benefits ☐ No change in benefits, but lower premiums or charges ☐ Fewer benefits and lower premiums or charges ☐ Plan has outpatient prescription drug coverage, and applicant is enrolled in Medicare Part D ☐ Disenrollment from a Medicare Advantage plan. Reasons for disenrollment: _____ ☐ Other (please specify): _____

2	If the issuer of the Medicare supplement contract being applied for does not impose or is otherwise prohibited from imposing, preexisting condition limitations, please skip to statement 3 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.
3	State law provides that your replacement Medicare Supplement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.
4	If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.
5	**Do not cancel your present Medicare Supplement coverage until you have received your new contract and are sure you want to keep it.**

Terms, conditions, and authorizations

Information regarding Medicare Supplement plan coverage: Before you apply, it's important that you read the following information, then sign and date at the end of this application.	
1	You do not need more than one Medicare Supplement plan policy or contract.
2	If you purchase this contract, you may want to evaluate your existing health coverage to decide if you need multiple coverage.
3	You may be eligible for benefits under Medi-Cal or Medicaid, and may not need a Medicare Supplement plan contract.
4	If after purchasing this contract you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement plan contract can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstituted if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5	If you are eligible for, and have enrolled in, a Medicare Supplement plan contract by reason of disability, and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement plan contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement plan contract under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

6	Counseling services are available in California to provide advice concerning your purchase of Medicare Supplement plan coverage and concerning medical assistance through the Medi-Cal program, including your benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). You may obtain information regarding counseling services from the State Department of Aging.
7	Receiving materials and communications electronically versus print: You may receive required benefit plan and coverage-related materials and communications via email and/or the Blue Shield website blueshieldca.com, as applicable. Obtaining a document electronically will confirm your consent to electronic delivery. You also have the right to obtain printed, mailed materials at any time and at no expense to you. To receive printed materials in the mail and to opt out of email communications, please call **(800) 248-2341 (TTY: 711)**, 8 a.m. – 8 p.m., seven days a week.
Conditions of membership	
1	I understand this application and the Statement of Health, if applicable, together with the *Evidence of Coverage and Health Service Agreement* and any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.
2	I will not receive coverage from Blue Shield unless Blue Shield's Underwriting Department approves this application. Blue Shield is not liable for bills incurred before the effective date of coverage.
3	Only Blue Shield can approve this application. I understand that any insurance agent, broker, or sales representative cannot grant approval, change terms, or waive requirements.
4	I acknowledge receipt of the • Summary of Benefits • Rate table • The Guide to Health Insurance for People with Medicare • a copy of this application. With my signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage, the Household Savings Program, and the authorizations I have provided. I have read the Summary of Benefits and the terms, conditions, and authorizations set forth above. I certify that I meet the eligibility requirements set forth in the Summary of Benefits. I alone am responsible for the accuracy and completeness of this application and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

Applicant's signature:	**Date (MM/DD/YYYY):**

Producer/writing agent information

* Indicates required field

A producer who assists an applicant or applicants in submitting an application to a health plan or insurer has a duty to assist the applicant(s) in providing answers to health questions accurately and completely.

This attestation must be completed by the producer and submitted with each Blue Shield Medicare Supplement plan application. This form is available for use with Medicare Supplement plan applications not containing a producer attestation with these questions and shall become part of the original application.

Review and select one of the following:

☐ I did not assist the applicant/applicants in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me.

☐ I assisted the applicant/applicants in submitting this application. All information in the health questionnaire was provided by them. I advised the applicant(s) that they should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that, if information is withheld, that could result in their coverage being cancelled later. The applicant(s) indicated to me that they understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to $10,000.

Notice: Please ensure each part of the application is complete. In the event of missing or incomplete information, Blue Shield may contact your applicant directly to obtain complete information.

Appointed agency name: (please print appointed agency name)	Appointed agency's Tax ID*: (please print appointed agency's tax ID)
Producer/writing agent's name*: (please print producer/writing agent's name)	Producer/Writing agent's NPN: (please print producer/writing agent's individual NPN)

Producer/writing agent's email address:	Producer/writing agent's fax number:	Producer/writing agent's phone number:
Producer/writing agent's signature (required):	**Print name:**	**Today's date (required) (MM/DD/YYYY):**

Applicant's statement of health

Blue Shield does not collect or use genetic information in Underwriting. No genetic information, including family medical history, and no information related to HIV testing should be provided. If you qualify for guaranteed acceptance, do not complete this section. (See the Guaranteed Acceptance Guide for qualifying information.) Otherwise, please answer Yes or No to each of the following questions:

1	Have you, within the past five years, received treatment or been hospitalized for any of the conditions listed below? If Yes, please explain the condition and indicate the date of treatment at the end of this section.	
	☐ Yes ☐ No	a. Brain or nervous system disorders such as multiple sclerosis, Parkinson's disease, Huntington's chorea, dementia, Alzheimer's, paralysis, stroke, etc.
	☐ Yes ☐ No	b. Respiratory system disorders such as chronic obstructive lung disease, emphysema, cystic fibrosis, etc.
	☐ Yes ☐ No	c. Cardiovascular disorders such as heart disease, high blood pressure, angina, coronary artery disease, clotting disorders, etc.
	☐ Yes ☐ No	d. Gastrointestinal disorders such as liver cirrhosis, hepatitis, ulcerative colitis, etc.
	☐ Yes ☐ No	e. Musculoskeletal system disorders such as rheumatoid arthritis, herniated or bulging discs, etc.
	☐ Yes ☐ No	f. Metabolic disorders such as diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, etc., or immune system disorders such as lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT, HIVID, or pentamidine therapy.*
	☐ Yes ☐ No	g. Cancer or malignant tumors.
	☐ Yes ☐ No	h. Have you received treatment or been hospitalized for any other condition than those listed above?

2	☐ Yes ☐ No	Do you have a pacemaker or artificial heart valve, or have you had transplant surgery or heart surgery such as angioplasty or bypass? If Yes, please explain the condition and indicate the date of treatment at the end of this section.
3	☐ Yes ☐ No	Have you been bedridden or confined to a hospital, nursing home, convalescent hospital, or other institution within the past three years? If Yes, please explain the confinement and indicate the date of confinement at the end of this section.
4	☐ Yes ☐ No	Are you currently taking medication? If Yes, please list at the end of this section all medications you are currently taking and the condition for which the medication is prescribed.
5	☐ Yes ☐ No	Have you used any tobacco-related products in the last 24 months?

If you answered Yes to any of the above questions, please provide additional information and dates associated with the condition, as well as current status of the condition. If additional space is required, please use additional sheets as necessary, and sign and date each sheet.

Condition	**Date (MM/DD/YYYY)**	**Explanation/current status**
		Medication(s) for this condition? ☐ Yes ☐ No Name(s) and dosage:
		Medication(s) for this condition? ☐ Yes ☐ No Name(s) and dosage:

* California law prohibits an HIV test from being required or used by healthcare service plans as a condition of obtaining coverage.

I alone am responsible for the accuracy and completeness of the information provided in this application. I have personally reviewed all information provided on this application. To the best of my knowledge and belief, all information on this application, including all information provided in the Statement of Health section, is accurate, true, and complete. I understand that coverage may be canceled or rescinded if Blue Shield determines that information on this application is materially inaccurate, not true, or incomplete. I further understand that I must provide Blue Shield with any new information that arises after the submission of this application but before my enrollment with Blue Shield begins.

Signature†:	**Date (MM/DD/YYYY):**

†Your signature is required in this section only if completing the Statement of Health.

Authorization for release of medical information

By signing below, you are authorizing the release of your healthcare information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent, to Blue Shield of California for the purpose of reviewing your application for Blue Shield coverage.

Further, by signing below you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization, health plan, or your insurance agent for the purpose of investigating or valuating any claim for benefits.

You have the right to refuse to sign this authorization. However, Blue Shield has the right to condition your eligibility for coverage and enrollment determinations if you choose not to sign the authorization below unless you qualify for enrollment on the basis of guaranteed acceptance.

You are entitled to a copy of this authorization after you sign it.

Expiration: This authorization will remain valid until 1) for 30 months from the date of this authorization for the purposes of processing your application, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health services agreement/policy.

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation.

If you qualify for guaranteed acceptance, do not sign this release. (See the Guaranteed Acceptance Guide for qualifying information.)

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

Payment information

To determine the monthly dues amount, refer to Blue Shield's rate tables included in the enrollment kit or visit **blueshieldca.com/MedSupp2025**. If you are not approved, Blue Shield will refund your payment amount. If your application is approved, you will receive a monthly bill indicating the amount and the date your next payment is due. Blue Shield will also send you an approval letter, an *Evidence of Coverage and Health Service Agreement*, and a member identification card as proof of approval.

Save $3 a month by paying dues through automatic monthly debit from your checking or savings account using our AutoPay program[1]. **To enroll, after receiving and paying for your first bill, register for and log into your Blue Shield account at blueshieldca.com and access the Billing and Payment tab.** You may also call Customer Service at **(800) 248-2341 (TTY: 711)**, 8 a.m. – 8 p.m., seven days a week, year-round. Requests to enroll in the AutoPay program may take up to two billing cycles for completion. Members should pay all paper bills received until an email confirming registration in the AutoPay program is received.

[1] Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed along to the subscriber.

blue california

Application for Blue Shield of California Medicare Supplement plans

Here's how to apply

1. Provide ALL requested information and print clearly in all capital letters in black ink.
2. Sign and date in all places indicated.
3. Within 30 days of your signature date, please submit your completed application to:
   Fax (844) 266-1850 **Email** msinstall@blueshieldca.com
   Mail Medicare Supplement Installation
   P.O. Box 3008
   Lodi, CA 95241-1912
4. It is required that a signed copy of this contract is made for your records. Be sure to keep the second copy of this application with all other important Blue Shield of California documents and information.

If you are a current member interested in transferring to a Medicare Supplement plan of equal or lesser value outside your enrollment period or to a richer benefit plan at any time, you must complete this application.

Plan F Extra is only available to applicants who attained age 65 before January 1, 2020, or first became eligible for Medicare benefits due to disability before January 1, 2020.

Personal information

Last name:	First name:	Middle initial:
Date of birth (MM/DD/YYYY):	Gender: ☐ Male ☐ Female ☐ Nonbinary	
Phone number:	Phone Type: ☐ Landline ☐ Mobile	
Home address:		
City:	State:	ZIP code:

Language preference:
☐English ☐Spanish ☐Chinese ☐Korean ☐Vietnamese

Select one if you want us to send you information in an accessible format.
☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Email address:	**Mobile phone number:**

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

You will get many of your required plan communications delivered electronically. We will send you an email when new communications are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

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

Mailing address (if different from above):		
City:	State:	ZIP code:
Billing address (if different from above):		
City:	State:	ZIP code:

Medicare Beneficiary Identification (MBI) number:

I'm entitled to:
Hospital (Part A) effective date (MM/DD/YYYY) Medicare (Part B) effective date (MM/DD/YYYY)

Please check the plan type you are applying for:	Requested effective date:
☐ A ☐ F Extra * ☐ G ☐ G Extra ☐ N	The 1st day of (MM/YYYY)

Current Blue Shield of California members please provide member ID number:

Household Savings Program[1]

If you and the other member of your household are age 65 or older and both members have or are applying for the same plan (including any dental plans), you may be eligible for a 7% monthly savings on your combined medical plan dues when **both members are enrolled in the same eligible plan. Both members must share the same home and mailing addresses.** Tobacco users are not eligible for the Household Savings Program.

Is the other member of your household enrolled in, or applying for, the **same** Blue Shield Medicare Supplement plan that you are applying for and share both addresses? ☐ Yes ☐ No

If Yes, please provide the other household member

Name:

Medicare Beneficiary Identification (MBI) number:

Blue Shield Medicare Supplement plan member ID (if available):

Please provide other household member's authorization to cancel their separate Blue Shield contract and enroll under the primary subscriber's agreement for the Household Savings Program by having the other household member sign below:

Signature of individual listed above: Date (MM/DD/YYYY):

Each individual must complete their own application if not already a current member. If both members are either new enrollees or existing enrollees, the subscriber is determined based on which application is enrolled first. Otherwise, the existing member already enrolled in the requested plan type will be designated as the subscriber. The subscriber is responsible for payment of dues/premiums to Blue Shield, and only the subscriber can make changes to the contract/policy. When enrolled under the Household Savings Program, Blue Shield will also accept payment of dues/premiums from the other household member enrolled in the plan. Billing information and amounts due can/will be shared with both parties enrolled in the plan when calling Customer Service.

Dental PPO plans

Dental plans for Medicare Supplement plan members.
Please see the page on **blueshieldca.com/MedSuppDental2025** for more information.

To sign up for Blue Shield dental coverage, select a plan below:
Dental plan options (check one): ☐ Dental PPO 1000 ☐ Dental PPO 1500 ☐ No dental plan

You can save $3 each month for the first six months on your dental plan rates if you enroll in a dental plan **at the same time** you enroll in any Blue Shield Medicare Supplement plan.[1]

Conditions of coverage

- Dental benefits aren't subject to health plan deductible requirements.
- If your dental coverage is canceled for any reason (by you or by Blue Shield), you may apply for reenrollment, but you will have to wait six months to reapply.

* Plan F Extra is only available to applicants who attained age 65 before January 1, 2020, or first became eligible for Medicare benefits due to disability before January 1, 2020.

1 Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed along to the subscriber.

Current insurance coverage information (required for all submissions)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance contract, or that you had certain rights to buy such a contract, you may be eligible for guaranteed acceptance in one or more of our Medicare Supplement plans. The Blue Shield Guaranteed Acceptance Guide describes the different situations in which you may be eligible for guaranteed issue of a Medicare Supplement plan. It is important to note that the time period of eligibility for guaranteed issuance may vary by situation, and you must apply within this time period to be eligible for guaranteed acceptance.

If you think you qualify for guaranteed acceptance, please write the number of the qualifying situation, as described in the Blue Shield Guaranteed Acceptance Guide included in the enrollment kit or visit **blueshieldca.com/medicareoptions**, in the space below. Then attach proof of prior coverage as a separate sheet, and sign and date the sheet.

I believe I qualify for guaranteed acceptance based on situation number _____.

If applying for guaranteed acceptance under situation No. 2 on the Blue Shield Guaranteed Acceptance Guide, please complete the Notice of Replacement of Coverage form on the next page and submit with your completed enrollment application.

Please include a copy of the front and back of your current carrier ID card. Please also include a copy of the notice from your prior insurer with your application.

Please answer all questions to the best of your knowledge.
(Please check Yes or No below)

1	☐ Yes ☐ No	a. Did you turn 65 years of age in the last six months?
	☐ Yes ☐ No	b. Did you enroll in Medicare Part B in the last six months?
		c. If Yes, what is the effective date? (MM/DD/YYYY) _____
2	☐ Yes ☐No	Are you covered for medical assistance through California's Medi-Cal program? NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program and have not met your share of cost, please answer NO to this question.
	If Yes, ☐ Yes ☐ No	a. Will Medi-Cal pay your premiums for this Medicare Supplement plan contract?
	☐ Yes ☐ No	b. Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?
3	☐ Yes ☐ No	a. Have you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO)? If yes, fill in your start and end dates below. If you are still covered under this plan, leave the "END" blank. Start (MM/DD/YYYY) _____ Carrier name: _____ End (MM/DD/YYYY) _____ Plan type: _____ Reason for coverage ending:
	If Yes, ☐ Yes ☐ No	b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan contract?
	☐ Yes ☐ No	c. Was this your first time in this type of Medicare plan?
	☐ Yes ☐ No	d. Did you drop a Medicare Supplement plan contract to enroll in the Medicare plan?

4	☐ Yes ☐ No	a. Do you have another Medicare Supplement plan policy, certificate, contract in force? b. If so, with what company? _____ What plan do you have? _____
	☐ Yes ☐ No	c. If so, do you intend to replace your current Medicare Supplement plan policy or certificate with this contract? If you answered yes, please complete the Notice to applicant regarding replacement of Medicare Supplement or Medicare Advantage coverage on the next page.
5	☐ Yes ☐ No	Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? a. If so, what companies and what kind of policy? Carrier name: _____ Carrier phone no.: _____ Plan type: _____ Current ID no.: _____ b. What are your dates of coverage under the other policy? (If you are still covered under this plan, leave the "END" blank.) Start (MM/DD/YYYY) End (MM/DD/YYYY)
6	☐ Yes ☐ No	Are you under age 65?
	If Yes, ☐ Yes ☐ No	a. Do you have end-stage renal disease?

You may contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll-free at (800) 434-0222 for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Managed Health Care's consumer toll-free telephone number (888) 466-2219, by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (800) 434-0222, or by accessing the Department of Managed Health Care's website (www.dmhc.ca.gov).

Notice to applicant regarding replacement of Medicare Supplement or Medicare Advantage coverage

According to question four on the previous page, you intend to lapse or otherwise terminate an existing Medicare Supplement policy or contract or Medicare Advantage plan and replace it with a contract to be issued by Blue Shield. Your contract to be issued by Blue Shield will provide 30 days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or plan contract only if, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

Statement to applicant by plan, solicitor, solicitor firm, or other representative

1	I have reviewed your current medical or health coverage. To the best of my knowledge, the replacement of coverage involved in this transaction does not duplicate coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement contract is being purchased for the following reason (check one): ☐ Additional benefits ☐ No change in benefits, but lower premiums or charges ☐ Fewer benefits and lower premiums or charges ☐ Plan has outpatient prescription drug coverage, and applicant is enrolled in Medicare Part D ☐ Disenrollment from a Medicare Advantage plan. Reasons for disenrollment: _____ ☐ Other (please specify): _____

2	If the issuer of the Medicare supplement contract being applied for does not impose or is otherwise prohibited from imposing, preexisting condition limitations, please skip to statement 3 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.
3	State law provides that your replacement Medicare Supplement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.
4	If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.
5	**Do not cancel your present Medicare Supplement coverage until you have received your new contract and are sure you want to keep it.**

Terms, conditions, and authorizations

Information regarding Medicare Supplement plan coverage: Before you apply, it's important that you read the following information, then sign and date at the end of this application.	
1	You do not need more than one Medicare Supplement plan policy or contract.
2	If you purchase this contract, you may want to evaluate your existing health coverage to decide if you need multiple coverage.
3	You may be eligible for benefits under Medi-Cal or Medicaid, and may not need a Medicare Supplement plan contract.
4	If after purchasing this contract you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement plan contract can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstituted if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5	If you are eligible for, and have enrolled in, a Medicare Supplement plan contract by reason of disability, and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement plan contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement plan contract under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

6	Counseling services are available in California to provide advice concerning your purchase of Medicare Supplement plan coverage and concerning medical assistance through the Medi-Cal program, including your benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). You may obtain information regarding counseling services from the State Department of Aging.
7	Receiving materials and communications electronically versus print: You may receive required benefit plan and coverage-related materials and communications via email and/or the Blue Shield website blueshieldca.com, as applicable. Obtaining a document electronically will confirm your consent to electronic delivery. You also have the right to obtain printed, mailed materials at any time and at no expense to you. To receive printed materials in the mail and to opt out of email communications, please call **(800) 248-2341 (TTY: 711)**, 8 a.m. – 8 p.m., seven days a week.
Conditions of membership	
1	I understand this application and the Statement of Health, if applicable, together with the *Evidence of Coverage and Health Service Agreement* and any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.
2	I will not receive coverage from Blue Shield unless Blue Shield's Underwriting Department approves this application. Blue Shield is not liable for bills incurred before the effective date of coverage.
3	Only Blue Shield can approve this application. I understand that any insurance agent, broker, or sales representative cannot grant approval, change terms, or waive requirements.
4	I acknowledge receipt of the • Summary of Benefits • Rate table • The Guide to Health Insurance for People with Medicare • a copy of this application. With my signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage, the Household Savings Program, and the authorizations I have provided. I have read the Summary of Benefits and the terms, conditions, and authorizations set forth above. I certify that I meet the eligibility requirements set forth in the Summary of Benefits. I alone am responsible for the accuracy and completeness of this application and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

Applicant's signature:	**Date (MM/DD/YYYY):**

Producer/writing agent information

* Indicates required field

A producer who assists an applicant or applicants in submitting an application to a health plan or insurer has a duty to assist the applicant(s) in providing answers to health questions accurately and completely.

This attestation must be completed by the producer and submitted with each Blue Shield Medicare Supplement plan application. This form is available for use with Medicare Supplement plan applications not containing a producer attestation with these questions and shall become part of the original application.

Review and select one of the following:

☐ I did not assist the applicant/applicants in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me.

☐ I assisted the applicant/applicants in submitting this application. All information in the health questionnaire was provided by them. I advised the applicant(s) that they should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that, if information is withheld, that could result in their coverage being cancelled later. The applicant(s) indicated to me that they understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to $10,000.

Notice: Please ensure each part of the application is complete. In the event of missing or incomplete information, Blue Shield may contact your applicant directly to obtain complete information.

Appointed agency name: (please print appointed agency name)	Appointed agency's Tax ID*: (please print appointed agency's tax ID)
Producer/writing agent's name*: (please print producer/writing agent's name)	Producer/Writing agent's NPN: (please print producer/writing agent's individual NPN)

Producer/writing agent's email address:	Producer/writing agent's fax number:	Producer/writing agent's phone number:
Producer/writing agent's signature (required):	**Print name:**	**Today's date (required) (MM/DD/YYYY):**

Applicant's statement of health

Blue Shield does not collect or use genetic information in Underwriting. No genetic information, including family medical history, and no information related to HIV testing should be provided. If you qualify for guaranteed acceptance, do not complete this section. (See the Guaranteed Acceptance Guide for qualifying information.) Otherwise, please answer Yes or No to each of the following questions:

1	Have you, within the past five years, received treatment or been hospitalized for any of the conditions listed below? If Yes, please explain the condition and indicate the date of treatment at the end of this section.	
	☐ Yes ☐ No	a. Brain or nervous system disorders such as multiple sclerosis, Parkinson's disease, Huntington's chorea, dementia, Alzheimer's, paralysis, stroke, etc.
	☐ Yes ☐ No	b. Respiratory system disorders such as chronic obstructive lung disease, emphysema, cystic fibrosis, etc.
	☐ Yes ☐ No	c. Cardiovascular disorders such as heart disease, high blood pressure, angina, coronary artery disease, clotting disorders, etc.
	☐ Yes ☐ No	d. Gastrointestinal disorders such as liver cirrhosis, hepatitis, ulcerative colitis, etc.
	☐ Yes ☐ No	e. Musculoskeletal system disorders such as rheumatoid arthritis, herniated or bulging discs, etc.
	☐ Yes ☐ No	f. Metabolic disorders such as diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, etc., or immune system disorders such as lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT, HIVID, or pentamidine therapy.*
	☐ Yes ☐ No	g. Cancer or malignant tumors.
	☐ Yes ☐ No	h. Have you received treatment or been hospitalized for any other condition than those listed above?

2	☐ Yes ☐ No	Do you have a pacemaker or artificial heart valve, or have you had transplant surgery or heart surgery such as angioplasty or bypass? If Yes, please explain the condition and indicate the date of treatment at the end of this section.
3	☐ Yes ☐ No	Have you been bedridden or confined to a hospital, nursing home, convalescent hospital, or other institution within the past three years? If Yes, please explain the confinement and indicate the date of confinement at the end of this section.
4	☐ Yes ☐ No	Are you currently taking medication? If Yes, please list at the end of this section all medications you are currently taking and the condition for which the medication is prescribed.
5	☐ Yes ☐ No	Have you used any tobacco-related products in the last 24 months?

If you answered Yes to any of the above questions, please provide additional information and dates associated with the condition, as well as current status of the condition. If additional space is required, please use additional sheets as necessary, and sign and date each sheet.

Condition	**Date (MM/DD/YYYY)**	**Explanation/current status**
		Medication(s) for this condition? ☐ Yes ☐ No Name(s) and dosage:
		Medication(s) for this condition? ☐ Yes ☐ No Name(s) and dosage:

* California law prohibits an HIV test from being required or used by healthcare service plans as a condition of obtaining coverage.

I alone am responsible for the accuracy and completeness of the information provided in this application. I have personally reviewed all information provided on this application. To the best of my knowledge and belief, all information on this application, including all information provided in the Statement of Health section, is accurate, true, and complete. I understand that coverage may be canceled or rescinded if Blue Shield determines that information on this application is materially inaccurate, not true, or incomplete. I further understand that I must provide Blue Shield with any new information that arises after the submission of this application but before my enrollment with Blue Shield begins.

Signature†:	**Date (MM/DD/YYYY):**

†Your signature is required in this section only if completing the Statement of Health.

Authorization for release of medical information

By signing below, you are authorizing the release of your healthcare information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent, to Blue Shield of California for the purpose of reviewing your application for Blue Shield coverage.

Further, by signing below you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization, health plan, or your insurance agent for the purpose of investigating or valuating any claim for benefits.

You have the right to refuse to sign this authorization. However, Blue Shield has the right to condition your eligibility for coverage and enrollment determinations if you choose not to sign the authorization below unless you qualify for enrollment on the basis of guaranteed acceptance.

You are entitled to a copy of this authorization after you sign it.

Expiration: This authorization will remain valid until 1) for 30 months from the date of this authorization for the purposes of processing your application, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health services agreement/policy.

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation.

If you qualify for guaranteed acceptance, do not sign this release. (See the Guaranteed Acceptance Guide for qualifying information.)

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

Payment information

To determine the monthly dues amount, refer to Blue Shield's rate tables included in the enrollment kit or visit **blueshieldca.com/MedSupp2025**. If you are not approved, Blue Shield will refund your payment amount. If your application is approved, you will receive a monthly bill indicating the amount and the date your next payment is due. Blue Shield will also send you an approval letter, an *Evidence of Coverage and Health Service Agreement*, and a member identification card as proof of approval.

Save $3 a month by paying dues through automatic monthly debit from your checking or savings account using our AutoPay program[1]. **To enroll, after receiving and paying for your first bill, register for and log into your Blue Shield account at blueshieldca.com and access the Billing and Payment tab.** You may also call Customer Service at **(800) 248-2341 (TTY: 711)**, 8 a.m. – 8 p.m., seven days a week, year-round. Requests to enroll in the AutoPay program may take up to two billing cycles for completion. Members should pay all paper bills received until an email confirming registration in the AutoPay program is received.

[1] Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed along to the subscriber.

NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

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

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

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

Servicios de asistencia en idiomas y avisos de no discriminación

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

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

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

非歧視通知和語言協助服務

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

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

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

Guaranteed acceptance guide

Blue Shield of California Medicare Supplement plans

If you have recently become eligible for Medicare or lost or ended your health coverage with another plan, you may qualify for guaranteed acceptance in a Blue Shield Medicare Supplement plan in certain situations. This guide will help you determine whether you qualify for guaranteed acceptance. **If you are age 64 or younger with end-stage renal disease, you are not eligible to enroll.**

Important: Please note this guide is only a summary and is intended to help you identify the different situations that may qualify you for guaranteed acceptance in a Blue Shield Medicare Supplement plan. It does not contain all the details of each situation. Please remember that the laws regulating guaranteed acceptance plans change frequently. Please ask your sales representative or your attorney to confirm that you qualify for guaranteed acceptance.

If you and other members of your household are age 65 or older and are accepted in the same benefit plan type, you will save 7% on your monthly dues if coverage is issued under one agreement. Under a household savings agreement, each of you must either qualify for guaranteed acceptance, or be subject to underwriting.

For more information about guaranteed acceptance, please contact your agent or call your Blue Shield sales representative at **(855) 217-1539 (TTY: 711**) for the hearing impaired, 8 a.m. to 8 p.m., seven days a week from October 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday, from April 1 to September 30.

If you are already a subscriber, call Customer Service at **(800) 248-2341 (TTY: 711**) for the hearing impaired, 8 a.m. to 8 p.m., seven days a week, year-round.

You may also contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP offers health insurance counseling for California senior citizens. Call HICAP toll-free at (800) 434-0222 for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

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How to use this guide:

1. If you believe a situation applies to you, review your plan choices and when you can apply.
2. Decide which plan type you want to apply for, based on plan descriptions found in Blue Shield's Summary of Benefits and Provisions booklet.
3. Write the corresponding situation number in the Guaranteed Acceptance section of your application.

   If you qualify for guaranteed acceptance, do not complete the Statement of Health or the Authorization for Release of Medical Records sections of the application. If you do not qualify for guaranteed acceptance, you must complete these sections.
4. If you believe you qualify for guaranteed acceptance, please fill out the appropriate supporting information in the Current Insurance Coverage information section of the enrollment form, or attach proof of prior coverage as outlined in the table below.
5. Do not return this guide with your application. Keep it for your reference along with your other important Blue Shield materials.

1

Situation
You are:
- Enrolled in Medicare and age 65 or older; or
- New to Medicare, age 64 or younger, and do not have end-stage renal disease

Your plan choices: Plan A, F Extra[1], G, G Extra, or N

When to apply
- If you are age 65 or older: Blue Shield must receive your application prior to or within six (6) months, beginning with the first day of the first month in which you are both age 65 or older, and you are enrolled for benefits under Medicare Part B.
- If you are age 64 or younger: Blue Shield must receive your application prior to or within six (6) months of your enrollment in Medicare Part B, or if you are notified retroactively of eligibility for Medicare, within six (6) months of notice of eligibility.

You must supply this documentation
Be sure to fill out the following sections of your enrollment application:
- Medicare Parts A and B effective dates and your Medicare number or Medicare Beneficiary Identifier (MBI).
- In addition, if you are age 64 or younger, you are required to complete all questions in the Current Insurance Coverage information section.

2

Situation
You currently have a Medicare Supplement with Blue Shield or another carrier and want to transfer to a different Medicare Supplement plan 60 days prior to or starting on the first day of your birthday month and ending sixty (60) days after your birthday.

Your plan choices
You have an annual open enrollment period, during which you may transfer to any Blue Shield Medicare Supplement plan that offers benefits equal to or lesser than those provided in your current plan. Call Blue Shield at the number on the previous page to see which plans you qualify for.

When to apply
Blue Shield must receive your application 60 days prior to or starting on the first day of your birthday month and ending sixty (60) days after your birthday.

You must supply this documentation
If you are new to Blue Shield, you must complete the Notice to Applicant Regarding Replacement of Medicare Supplement or Medicare Advantage Coverage (located in the application). You must provide proof of your current plan type/insurance carrier ID card. If you are an existing Blue Shield member, you must complete the Medicare Supplement Plan Transfer Application. Please call Blue Shield (see phone numbers on the first page of this document) to request the Transfer Application.

3

Situation
You enrolled with one of the following:
- A Medicare Advantage Plan;
- A Medicare Cost Plan or similar organization operating under demonstration project authority before April 1, 1999;
- A healthcare prepayment plan; *or*
- Medicare Select policy;

and any of the following apply:
- The certification of the organization or plan is being terminated;
- The organization is terminating or discontinuing the plan in the service area in which you reside; or
- You are no longer eligible because you moved outside the plan service area.

Your plan choices: Plan A, F Extra,[1] G, G Extra, or N

When to apply
If your coverage is being involuntarily terminated, you may submit your application any time after you receive the notice of termination, but no later than sixty-three (63) days after the date coverage is terminated. However, if you are enrolled in a Medicare Advantage Plan, you must apply within one hundred twenty-three (123) days of the date your coverage is terminated.

You must supply this documentation
Be sure to complete the Current Insurance Coverage information section (including the end date and reason for coverage ending) of your signed Medicare Supplement plan application.[2] You must provide a copy of the prior coverage termination notice with your name, termination date, and reason or a Certificate of Prior Coverage.

4

Situation
You received notice of termination, or your coverage was terminated from any employer-sponsored health plan, including an employer-sponsored retiree health plan. This includes termination for loss of eligibility due to divorce or death of a spouse.

Your plan choices: Plan A, F Extra,[1] G, G Extra, or N

When to apply
Blue Shield must receive your application within six (6) months of the notice of termination, or if no notice is received, within six (6) months of the date your employer-sponsored health coverage ended.

You must supply this documentation
Be sure to complete the Current Insurance Coverage information section (including the end date) of your signed Medicare Supplement plan application.[2]

Please supply proof of termination from the employee sponsored health plan.

5

Situation
You enrolled in a Medicare Supplement plan, but you lost coverage because you moved outside the plan's service area.

Your plan choices: Plan A, F Extra,[1] G, G Extra, or N

When to apply
Blue Shield must receive your application within six (6) months of the date coverage is terminated.

You must supply this documentation
Be sure to complete the Current Insurance Coverage information section of your signed Medicare Supplement plan application.[2] You must also provide documentation to support the reason for termination, and a copy of the prior coverage termination notice with your name, termination date, and reason or a Certificate of Prior Coverage.

6

Situation
During your initial six (6)-month enrollment period for Medicare Part A, you enrolled in a Medicare Advantage Plan,or in a Program of All-Inclusive Care for the Elderly (PACE) provider, and then disenrolled from the plan or program within twelve (12) months of the effective date of that enrollment.

Your plan choices: Plan A, F Extra,[1] G, G Extra, or N

When to apply
If you are voluntarily terminating your coverage, you may submit an application sixty (60) days before the effective date of termination, but no later than sixty-three (63) days after the date coverage is terminated.

You must supply this documentation
Be sure to complete the Current Insurance Coverage information section (including the end date) of your signed Medicare Supplement plan application.[2] To expedite processing, include documentation of Medicare Advantage Plan termination.

7

Situation
You were enrolled in a Medicare Supplement plan and subsequently enrolled in a Medicare Advantage Plan or with a PACE provider, *and*:
- Your coverage was involuntarily terminated within twelve (12) months of the effective date of enrollment; and
- You then enrolled in another Medicare Advantage Plan or PACE provider plan and disenrolled from that plan within twenty-four (24) months of the effective date with the first plan.

Your plan choices: Plan A, F Extra,[1] G, G Extra, or N; *or*
- The Medicare Supplement plan you had previously, if it is still offered for sale by that insurer.

When to apply
If your coverage is being involuntarily terminated, you may submit your application any time after you receive the notice of termination, but no later than sixty-three (63) days after the date coverage is terminated; however, if you are enrolled in a Medicare Advantage Plan, you must apply within one hundred twenty-three (123) days of the date coverage is terminated.

You must supply this documentation
Be sure to complete the Current Insurance Coverage information section (including the end date and reason for coverage ending) of your signed Medicare Supplement plan application.

Include documentation (prior ID card or billing statement) of prior Medicare Supplement plan type and prior Medicare Advantage Plans when the application is submitted. Provide Medicare Advantage Plan termination after the application is approved.

8

Situation
You are age 65 or older, are enrolled with a PACE provider, and any of the following situations that permit termination of enrollment apply:
- The certification of the organization is being terminated;
- The organization is terminating or discontinuing services in the service area where you reside;
- You are no longer eligible, because you moved outside the service area;
- The organization substantially violated a material provision of the contract with the Centers for Medicare & Medicaid Services (CMS); or
- The organization or its agent materially misrepresented a provision of the program in marketing the contract to you.

Your plan choices: Plan A, F Extra,[1] G, G Extra, or N

When to apply
- If your coverage is being involuntarily terminated, you may submit your application any time after you receive the notice of termination, but no later than sixty-three (63) days after the date coverage is terminated.
- If you are voluntarily terminating your coverage, you may submit an application sixty (60) days before the effective date of termination, but no later than sixty-three (63) days after the date coverage is terminated.

You must supply this documentation
Be sure to complete the Current Insurance Coverage information section (including the end date and reason for coverage ending) of your signed Medicare Supplement plan application. Please supply proof of termination.

9

Situation
You terminated enrollment in a Medicare Supplement plan and subsequently enrolled, for the first time, in any of the following:
- A Medicare Advantage Plan;
- A Medicare Cost Plan or similar organization operating under demonstration project authority before April 1, 1999;
- A PACE provider; or
- A Medicare Select policy.

You then disenrolled within the first 12 months.

Your plan choices: Plan A, F Extra,[1] G, G Extra, or N
- The Medicare Supplement plan you had previously, if it is still offered for sale by that insurer.

When to apply
If you are voluntarily terminating your coverage, you may submit an application sixty (60) days before the effective date of termination, but no later than sixty-three (63) days after the date coverage is terminated.

You must supply this documentation
Be sure to complete the Current Insurance Coverage information section (including the end date) of your signed Medicare Supplement plan application.

Include documentation (prior ID card or billing statement) of prior Medicare Supplement plan type when the application is submitted. Provide Medicare Advantage Plan termination after the application is approved.

10

Situation
You terminated enrollment in a Medicare Supplement plan and subsequently enrolled, for the first time, with any of the following:
- A Medicare Advantage Plan;
- A Medicare Cost Plan or similar organization operating under demonstration project authority before April 1, 1999;
- A PACE provider plan; or
- A Medicare Select policy.

However, your coverage was involuntarily terminated within twelve (12) months of the effective date of enrollment. You then enrolled in another similar plan and disenrolled from that plan within twenty-four (24) months of the effective date of the first plan.

Your plan choices: Plan A, F Extra,[1] G, G Extra, or N; *or*
- The Medicare Supplement plan you had previously, if it is still offered by that issuer.

When to apply
If your coverage is being involuntarily terminated, you may submit your application any time after you receive the notice of termination, but no later than sixty-three (63) days after the date coverage is terminated. However, if you are enrolled in a Medicare Advantage Plan, you must apply within one hundred twenty-three (123) days of the date coverage is terminated.

You must supply this documentation
Be sure to complete the Current Insurance Coverage information section (including the name and end date of your three previous carriers) of your signed Medicare Supplement plan application.

Include documentation (prior ID card or billing statement) of prior Medicare Supplement plan type and prior Medicare Advantage Plans when the application is submitted. Provide Medicare Advantage Plan termination after the application is approved.

11

Situation
You enrolled in an employer-sponsored health plan that supplements Medicare, and either of the following apply:
- The plan either terminates or ceases to provide all of those supplemental health benefits to you; *or*
- The employer no longer provides you with insurance that covers all of the payment for the 20% coinsurance.

Your plan choices: Plan A, F Extra,[1] G, G Extra, or N

When to apply
You may submit an application to Blue Shield during the guaranteed acceptance period, which starts from the later of the following two dates, and ends sixty-three (63) days after the date coverage is terminated:
- The date you received a notice of termination, or if no notice is received, on the date you received notice denying the claim because of termination of benefits; or
- The date coverage is terminated.

You must supply this documentation
Be sure to complete the Current Insurance Coverage information section (including the end date and reason for coverage ending) of your signed Medicare Supplement plan application.[2]

Please supply proof of reduction or termination of benefits.

12

Situation
You are a Medicare-eligible military retiree, spouse, or dependent, and you lost access to healthcare services because:
- The military base closed;
- The military base no longer offers services; or
- You relocated.

Your plan choices: Plan A, F Extra,[1] G, G Extra, or N

When to apply
Blue Shield must receive your application within six (6) months of the date you lost access to healthcare services at the military base.

You must supply this documentation
Documentation to support the reason you no longer have access to healthcare services at the military base.

13

Situation
You enrolled in one of the following:
- A Medicare Advantage Plan;
- A Medicare Cost Plan or similar organization operating under demonstration project authority before April 1, 1999;
- A healthcare prepayment plan;
- A Medicare Supplement plan; or
- A Medicare Select policy;

but coverage terminated because you demonstrated:
- The company substantially violated a material provision of the contract; *or*
- The company or its agent materially misrepresented a provision of the plan in marketing the contract to you.

Your plan choices: Plan A, F Extra,[1] G, G Extra, or N

When to apply
You may submit an application sixty (60) days before the effective date of termination, but no later than sixty-three (63) days after the date coverage is terminated.

You must supply this documentation
Be sure to complete the Current Insurance Coverage information section (including the end date and reason for coverage ending) of your signed Medicare Supplement plan application.[2]

Include a detailed letter describing misrepresentation. If enrolled in a Medicare Advantage Plan, include documentation of termination.

14

Situation
You enrolled in a Blue Shield Medicare Advantage Plan, and Blue Shield either:
- Reduced any of its benefits;
- Increased the amount of cost-sharing or premium; or
- Discontinued (for other than quality of care) a contract with a provider currently furnishing services to you.

Your plan choices: Plan A, F Extra,[1] G, G Extra, or N

When to apply
You may submit an application sixty (60) days before the effective date of termination, but no later than sixty-three (63) days after the date coverage is terminated.

Blue Shield must obtain this verification
You must terminate the Medicare Advantage Plan after the Medicare Supplement application is approved. Blue Shield will verify Medicare Advantage Plan termination within Blue Shield's eligibility system.

15

Situation
You enrolled in a Medicare Supplement plan, but coverage stopped because:
- The company filed for bankruptcy or is insolvent; or
- Of other involuntary termination of coverage under the contract.

Your plan choices: Plan A, F Extra,[1] G, G Extra, or N

When to apply
You may submit an application to Blue Shield during the guaranteed acceptance period, which starts from the earlier of the following two dates, and ends sixty-three (63) days after coverage terminates:
- The date you receive notice of termination, bankruptcy, insolvency, or other similar notice; or
- The date coverage is terminated.

You must supply this documentation
Be sure to complete the Current Insurance Coverage information section of your signed Medicare Supplement plan application. You must provide a copy of the prior coverage termination notice with your name, termination date, and reason or a Certificate of Prior Coverage.

16

Situation
You are enrolled in Medicare Part B and have been notified that because of an increase in your income or assets, you meet one of the following:
- You are no longer eligible for Medi-Cal benefits.
- You are eligible only for Medi-Cal benefits with a share-of-cost (and you certify at the time of application with Blue Shield you have not met the share of the cost).

Your plan choices: Plan A, F Extra,[1] G, G Extra, or N

When to apply
Blue Shield must receive your application within six (6) months of the notice of termination or notice is issued that your share-of-cost is increasing due to a change in income/assets.

You must supply this documentation
A copy of the notice of termination or a copy of the notice that your share-of-cost is increasing due to a change in income/assets from the Medi-Cal program. Please certify at the time of application that you have not met the share-of-cost by answering "NO" to question #2 under the "Current insurance coverage information" section of the Medicare Supplement plan application.

17

Situation
You enrolled in a Medicare Advantage Plan and that plan either:
- Reduced any of its benefits;
- Increased the amount of cost-sharing or premium; or;
- Discontinued (for other than quality of care) a contract with a provider currently furnishing services to you.

In addition, no Medicare Supplement plan is available from that issuer, a subsidiary of the parent company of the issuer, or a network that contracts with the parent company of the issuer.

Your plan choices: Plan A, F Extra,[1] G, G Extra, or N

When to apply
You may submit an application sixty (60) days before the effective date of termination, but no later than sixty-three (63) days after the date coverage is terminated only during the annual election period (AEP) for a Medicare Advantage plan, except where the Medicare Advantage plan has discontinued its relationship with a provider currently furnishing services to the individual.

You must supply this documentation
Be sure to complete the Current Insurance Coverage information section (including the end date) of your signed Medicare Supplement plan application. You must terminate the Medicare Advantage Plan after the Medicare Supplement application is approved.

To expedite processing include a copy of the annual notice of changes letter.

For discontinued provider relationships, please provide a termination letter from the provider.

Endnotes

1. Plan F Extra is only available to applicants who attained age 65 or first became eligible for Medicare benefits due to disability before January 1, 2020.
2. Blue Shield reserves the right to request a copy of the prior coverage termination notice with your name and termination date, or a Certificate of Prior Coverage.