Evidence of Coverage and Disclosure Form

Effective January 1, 2027

Blue Shield of California
Blue Shield Medicare with Dental and Vision

Blue Shield Group Medicare Advantage (PPO)

Contracted by the CalPERS Board of Administration Under the
Public Employees' Medical & Hospital Care Act (PEMHCA)

January 1 – December 31, 2027

Evidence of Coverage for 2027:

Your Medicare Health Benefits and Services as a Member of Blue Shield Group Medicare Advantage (PPO)

This document gives the details of your Medicare health coverage from January 1 – December 31, 2027. **This is an important legal document. Keep it in a safe place.**

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

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

For questions about this document, call Customer Service at (888) 802-4599 (TTY users call 711). Hours are 7 a.m. to 8 p.m. PT, seven days a week. This call is free.

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

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

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2028.

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

CalPERS

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OMB Approval 0938-1051 (Expires: July 31, 2029)

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CHAPTER 1:
Get started as a member

SECTION 1 You're a member of Blue Shield Group Medicare Advantage

Section 1.1 You're enrolled in Blue Shield Group Medicare Advantage, which is a Medicare PPO

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

Blue Shield Group Medicare Advantage is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. This plan **doesn't** include Part D drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Blue Shield Group Medicare Advantage covers your care. Other parts of this contract include your enrollment form and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in Blue Shield Group Medicare Advantage between January 1, 2027, and December 31, 2027.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of Blue Shield Group Medicare Advantage after December 31, 2027. We can also choose to stop offering our plan in your service area, after December 31, 2027.

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

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

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

- You have both Medicare Part A and Medicare Part B.
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be in the geographic service area even if they're physically located in it.
- You're a United States citizen or national, or an eligible noncitizen.
- You meet your Plan Sponsor's eligibility requirements.

Section 2.2 Plan service area for Blue Shield Group Medicare Advantage

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

Our service area includes all 50 states, the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

If you move out of our plan's service area, you can't stay a member of this plan. Please reach out to your Plan Sponsor to see what plans they may offer.

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

Section 2.3 U.S. citizen or national, or an eligible noncitizen

You must be a U.S. citizen or national, or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Blue Shield Group Medicare Advantage if you're not eligible to stay a member of our plan on this basis. Blue Shield Group Medicare Advantage must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan. You should also show the provider your Medicaid card, if you have one. Sample membership card:

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

If our plan membership card is damaged, lost, or stolen, call Customer Service at **(888) 802-4599** (TTY users call **711**) right away and we'll send you a new card.

Section 3.2 Provider Directory

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

As a member of our plan, you can choose to get care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the provider accepts the plan and has not opted out of or been excluded or precluded from the Medicare Program, and the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your benefits are the same in/out-of-network for Medicare approved services. Go to Chapter 3 for more specific information.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Customer Service at **(888) 802-4599** (TTY users call **711**). Requested paper *Provider Directories* will be mailed to you within 3 business days.

SECTION 4 Summary of Important Costs for 2027

	Your Costs in 2027
Monthly plan premium* * Your premium can be higher or lower. Go to Section 4.1 for details.	**If you are responsible for any contribution to the monthly premium, your Plan Sponsor will tell you the amount and where to send payment.**
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out-of-pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1 for details.)	**From in-network and out-of-network providers combined: $1,500**
Primary care office visits	**From in-network and out-of-network providers: $0 copayment per visit**
Specialist office visits	**From in-network and out-of-network providers: $0 copayment per visit**
Inpatient hospital stays Includes various inpatient hospital stays such as acute care rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	**From in-network and out-of-network providers: $0 copayment per admission**

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Optional Supplemental Benefit Premium (Section 4.3)

Section 4.1 Plan premium

Your coverage is provided through a contract with your Plan Sponsor. Contact the Plan Sponsor for information about our plan premium.

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of *Medicare & You 2027* handbook in the section called *2027 Medicare Costs*. Download a copy from the Medicare website (Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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

Section 4.3 Optional Supplemental Benefit Premium

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

Blue Shield Group Medicare Advantage offers an optional supplemental combined dental and vision PPO plan. The monthly premium for the optional supplemental combined dental and vision PPO plan is $40.31.

If you have any questions about your plan premiums, please call your Plan Sponsor.

SECTION 5 More information about your monthly premium

Section 5.1 Your monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year we, or your Plan Sponsor, will tell you prior to your Plan Sponsor's open enrollment period and the new premium will take effect on January 1.

SECTION 6 Keep your plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage.

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

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

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

If any of this information changes, let us know by calling Customer Service at **(888) 802-4599** (TTY users call **711**).

*Contact your Plan Sponsor with these changes also.

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

SECTION 7 How other insurance works with our plan

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

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that is not listed, call Customer Service at **(888) 802-4599** (TTY users call **711**). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

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

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

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

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

CHAPTER 2:
Phone numbers and resources

SECTION 1 Blue Shield Group Medicare Advantage contacts

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

Customer Service – Contact Information	
Call	**(888) 802-4599** Calls to this number are free. 7 a.m. to 8 p.m. PT, seven days a week. Customer Service **(888) 802-4599** (TTY users call **711**) also has free language interpreter services for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 7 a.m. to 8 p.m. PT, seven days a week.
Fax	(877) 251-6671
Write	Blue Shield Group Medicare Advantage P.O. Box 927, Woodland Hills, CA 91365-9856
Website	**blueshieldca.com/calpers**

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care, go to Chapter 7.

Coverage Decisions and Appeals for Medical Care – Contact Information	
Call	**(888) 802-4599** Calls to this number are free. 7 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and

	the time that you called, and a representative will return your call no later than one business day.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 7 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
Fax	(888) 697-8122
Write	Blue Shield Group Medicare Advantage P.O. Box 2080, Oakland, CA 94604-9716
Website	**blueshieldca.com/calpers**

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how make a complaint about your medical care, go to Chapter 7.

Complaints about Medical Care – Contact Information	
Call	**(888) 802-4599** Calls to this number are free. 7 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.] Calls to this number are free. 7 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day
Fax	(916) 350-6510

Write	Blue Shield Group Medicare Advantage Appeals & Grievances Department P.O. Box 927, Woodland Hills, CA 91365-9856
Medicare website	To submit a complaint about Blue Shield Group Medicare Advantage directly to Medicare, go to Medicare.gov/my/medicare-complaint.

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

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill, go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

Payment Requests – Contact Information	
Call	**(888) 802-4599** Calls to this number are free. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 7 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
Fax	(877) 251-6671
Write	Blue Shield Group Medicare Advantage P.O. Box 927 Woodland Hills, CA 91365
Website	**blueshieldca.com/calpers**

SECTION 2 Get help from Medicare

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

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

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

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

SECTION 3 State Health Insurance Assistance Program (SHIP)

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

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit https://www.shiphelp.org (Click on SHIP LOCATOR in middle of page) and select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.
- Go to **Exhibit 1** at the end of this document for a list of phone numbers and resources specific to your state.

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. Refer to **Exhibit 2** at the end of this document for a list of the Quality Improvement Organizations in each state we serve.

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

Contact your state's QIO in any of these situations:

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

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

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

SECTION 6 Medicaid

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

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

To find out more about Medicaid and Medicare Savings Programs, contact your state Medicaid agency found in **Exhibit 3** at the end of this document.

SECTION 7 Railroad Retirement Board (RRB)

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

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press "1" to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.
Website	https://RRB.gov

SECTION 8 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner’s) employer or retiree group as part of this plan, call the Plan Sponsor or Customer Service at **(888) 802-4599** (TTY users call **711**) with any questions. You can ask about your (or your spouse or domestic partner’s) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

CHAPTER 3:
Using our plan for your medical services

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

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

Section 1.1 Network providers and covered services

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

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

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

Blue Shield Group Medicare Advantage will generally cover your medical care as long as:

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

- **You get your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can get care from either a network provider or an out-of-network provider (go to Section 2 for more information).
  - The providers in our network are listed in the *Provider Directory* **blueshieldca.com/find-a-doctor**.
  - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
  - While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you'll be responsible for the full cost of the services you receive. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.

SECTION 2 Use network and out-of-network providers to get medical care

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

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

When you become a member of our plan, you may choose a provider to be your Primary Care Physician (PCP). Choosing a PCP is optional and not a requirement of this plan. You can see your PCP regularly for your primary care, and they can help you stay healthy, treat illnesses and coordinate your care with other health care providers.

The physicians who practice in any of the medical fields below are considered those who provide primary care:

- Family practice;
- General practice;
- Internal medicine; and
- In some cases, gynecologists who provide care for women

You may choose to see your PCP first for most of your primary care and routine health care needs. In some cases, you will pay a lower out-of-pocket cost for services when you see a PCP. You can still obtain services on your own without contacting your PCP first. Some types of services may require approval in advance from our plan (this is called getting prior authorization). If the service you need requires prior authorization, your PCP (if you have one) or other network provider will request the authorization from our plan. It is very important that our plan approves the prior authorization before you get the service, or you may have to pay for the service yourself or your benefits could be reduced. Please see Chapter 4 for the specific benefits that require prior authorization.

How to choose a PCP

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

When you choose your PCP, you may also be choosing the hospitals and specialty network associated with your PCP.

You can select your PCP or any other network physician by using the Provider Directory or by accessing our website at **blueshieldca.com/find-a-doctor**. You can also contact Customer Service for assistance (phone numbers are printed on the back cover of this document.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP.

Section 2.2 How to get care from specialists and other network providers

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

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions
- You can select your network specialist by using the Provider Directory or by accessing our website at blueshieldca.com/find-a-doctor. You can also contact Customer Service for assistance (phone numbers are printed on the back cover of this document).
- You can get care from providers not in our plan network for most of your covered benefits without getting our approval first. If you want to know if services are covered by Blue Shield Group Medicare Advantage before you get them, you can ask us. Your provider can ask us, too. This way, you'll know if your care is considered medically necessary per the coverage guidelines. Again, you don't have to get our prior approval but we may still review claims to see if they were medically necessary before we pay

them. When we give our decision, we base it on two things. First, there are Medicare's rules. Second, there are generally accepted standards of medical practice. These standards are proven and accepted by those who practice and study medicine. We also need to make sure you get the most cost-effective care. This means it doesn't cost more than another option that will work just as well. But we also need it to be right for you. And that you get it in the right place and the right number of times. Finally, we cannot approve a service just because it is more convenient than another option.

- In some cases, your PCP or other provider may need to get approval in advance from Blue Shield Group Medicare Advantage for certain types of services or tests that you receive in-network (this is called getting prior authorization). Obtaining prior authorization is the responsibility of the PCP or treating provider. Services and items requiring prior authorization are listed in the Medical Benefits Chart in Chapter 4, Section 2.1.
- Prior authorization is not required for covered services received out-of-network; however, if we later determine that the services you received were not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. You or your doctor may ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary by calling Customer Service (phone numbers are on the back cover of this document.

When a specialist or another network provider leaves our plan

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

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.

- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network. Depending on the covered benefit, prior authorization may be required and is the responsibility of your provider.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 7).

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

As a member of our plan, you can choose to get care from out-of-network providers. However, providers that don't contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. Because you are a member of the Blue Shield Group Medicare Advantage plan, you can see any provider (network or out-of-network) that accepts the plan and has not opted out of or been excluded or precluded from the Medicare Program, at the same cost share. Here are more important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If you get care from a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you receive. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.
- You don't need a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, ask for a pre-visit coverage decision to confirm that the services you get are covered and medically necessary. (Go to Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
    - Without a pre-visit coverage decision, and if our plan later determines that the services aren't covered or were not medically necessary, our plan may deny coverage and you'll be responsible for the entire cost. If we say we won't cover the services you got, you have the right to appeal our decision not to cover your care (go to Chapter 7 to learn how to make an appeal).

- It's best to ask an out-of-network provider to bill our plan first. But, if you've already paid for the covered services, we'll reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill you think we should pay, you can send it to us for payment (go to Chapter 5).
- If you're using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount (go to Section 3).

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

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network. Our plan covers emergency care and urgently needed services outside of the United States and its territories with no combined annual dollar limit. See *Emergency care* and *Urgently needed services* in the Medical Benefits Chart in Chapter 4 of this document for more information on how much you pay.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call is on the back of your Blue Shield Group Medicare Advantage member ID card.

Covered services in a medical emergency

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

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

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

What if it wasn't a medical emergency?

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

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

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

Our plan covers worldwide emergency care and urgently needed services outside the United States and its territories with no combined annual dollar limit. See "*Emergency care*" and "*Urgently needed services*" in the Medical Benefits Chart in Chapter 4 of this document for more information on how much you pay.

If you need urgently needed services while outside of the United States and its territories, call the Blue Shield Global Core Services Center toll-free at **(800) 810-2583** (TTY: **711**), or call collect at (804) 673-1177 (TTY: 711), 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. As part of this service, for inpatient hospital care, you can contact the Blue Shield Global Core Services Center to arrange for cashless access. If you arrange for cashless access, you are responsible for the usual out-of-pocket expenses such as non-covered charges and copayments. If you do not arrange for cashless access, you will have to pay the entire bill for your medical care and submit a request for reimbursement (see Chapter 2, *Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received*).

Section 3.3 Get care during a disaster

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

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

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

If you paid more than our plan cost sharing for covered services, or if you got a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 5 for information about what to do.

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

Blue Shield Group Medicare Advantage covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan that are not emergency or urgently needed services, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. Once a benefit limit has been reached, whatever you pay for services will not count toward your out-of-pocket maximum. See Chapter 4 for more information on benefit limits and out-of-pocket maximums. You can call Customer Service when you want to know how much of your benefit limit you have already used.

SECTION 5 Medical services in a clinical research study?

Section 5.1 What is a clinical research study

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

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

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

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

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

Section 5.2 Who pays for services in a clinical research study

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

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

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

> *Example of cost sharing in a clinical trial:* Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare

would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would then notify our plan that you got a qualified clinical trial service and submit documentation (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you'd pay under our plan's benefits.

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

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

Get more information about joining a clinical research study

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

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

Section 6.1 A religious non-medical health care institution

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

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

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

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

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

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

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

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of Blue Shield Group Medicare Advantage, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances we'll transfer ownership of the DME item to you. Call Customer Service at **(888) 802-4599** (TTY users call **711**) for more information.

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

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

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

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage Blue Shield Group Medicare Advantage will cover:

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

If you leave Blue Shield Group Medicare Advantage or no longer medically require oxygen equipment, the oxygen equipment must be returned.

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

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

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

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

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

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

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

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

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

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

Under our plan, there is one limit on what you pay out-of-pocket for covered medical services:

- Your **combined maximum out-of-pocket amount** is $1,500. This is the most you pay during the calendar year for covered Medicare Part A and Part B services you got from both in-network and out-of-network providers. The amounts you pay for copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for our plan premiums don't count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you pay $1,500 for covered services, you'll have 100% coverage and won't have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay our plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Providers aren't allowed to balance bill you

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

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider. You'll generally have higher copayments when you get care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
  - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- If you think a provider has balance billed you, call Customer Service at **(888) 802-4599** (TTY users call **711**).

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

The Medical Benefits Chart on the next pages lists the services Blue Shield Group Medicare Advantage covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare-covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization).
    - Covered services that need approval in advance to be covered as in-network services are marked in italics in the Medical Benefits Chart.
    - You never need approval in advance for out-of-network services from out-of-network providers.
    - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.]
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you get the services from:
    - If you get the covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).

  - If you get the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2027* handbook. View it online at Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.

This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.	
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.) • Not associated with surgery • Not associated with pregnancy An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Provider Requirements:** Physicians may furnish acupuncture in accordance with applicable state requirements.	You pay $10 per visit for all Medicare-covered services.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Acupuncture for chronic low back pain (cont'd) Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations. Covered services are provided through a contract with American Specialty Health Plans of California, Inc. (ASH Plans). ASH Plans administers the delivery of services through a network of contracted providers. ASH Plans also contracts with Blue Shield to serve as the claims administrator for services received from in- and out-of-network providers. For more information or to locate an ASH Plans participating provider, you may call ASH Plans at (800) 678-9133 [TTY: 711], Monday through Friday, 5 a.m. to 8 p.m. PT, April 1st through September 30th and Sunday through Saturday, 8 a.m. to 8 p.m. PT, October 1st through March 31st. You can also call Blue Shield Group Medicare Advantage Customer Service or go to blueshieldca.com/find-a-doctor to locate an ASH Plans participating provider.		

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Acupuncture for chronic low back pain (cont'd) For Acupuncture services performed outside of California, contact the Blue Shield Group Medicare Advantage Customer Service at **(888) 802-4599** for assistance.		
Acupuncture (non-Medicare covered)* Benefits are provided for acupuncture evaluation and treatment by a Doctor of Medicine, licensed acupuncturist, or other appropriately licensed or certified Health Care Provider. Covered services include: • Initial and subsequent examinations • Acupuncture • Adjunctive therapies Covered services are provided through a contract with American Specialty Health Plans of California, Inc. (ASH Plans). ASH Plans administers the delivery of services through a network of contracted providers. ASH Plans also contracts with Blue Shield to serve as the claims administrator for services received from in- and out-of-network providers. **Note:** Out-of-Network Providers do not agree to accept the plan's allowed cost-sharing amount as payment in full for covered services. When you see an out-of-network provider, you are responsible for: • Your cost share; and • All charges over the allowed amount. The allowed amount for an out-of-network provider is the amount ASH would have allowed for an in-network provider performing the same service.	You pay $15 per visit (limited to 20 visits combined, per year) for routine chiropractic services and routine acupuncture services.	You pay $15 per visit plus all charges above the allowed amount (limited to 20 visits combined, per year) for routine chiropractic services and routine acupuncture services.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Acupuncture (non-Medicare covered)* (cont'd) For more information, or to locate an ASH Plans participating provider you may call ASH Plans at (800) 678-9133 [TTY: 711], Monday through Friday, 5 a.m. to 8 p.m. PT, April 1st through September 30th and Sunday through Saturday, 8 a.m. to 8 p.m. PT, October 1st through March 31st. You can also call Blue Shield Group Medicare Advantage Customer Service or use Find a Doctor on **blueshieldca.com/find-a-doctor** to locate an ASH Plans participating provider. For Acupuncture services performed outside of California, contact the Blue Shield Group Medicare Advantage Customer Service at **(888) 802-4599** for assistance. *Services do not apply to the plan's maximum out-of-pocket limit.		
Additional telehealth services* Teladoc Health provides Physician consultations by phone or video 24/7/365. Teladoc Health Physicians can diagnose and treat basic medical conditions and can also prescribe certain medication. Teladoc Health is a supplemental service that is not intended to replace care from your Primary Care Physician. Please log into blueshieldca.com/teladochealth or the Blue Shield of California app to request a visit. If you have questions, you may contact Teladoc Health by phone at 1-800-Teladoc (1-800-835-2362) [TTY: 711], 24 hours a day, 7 days a week, 365 days a year. *Services do not apply to the plan's maximum out-of-pocket limit.	You pay $0.	Not covered.

<table>
<tr><th>Covered Service</th><th>What you pay when you get these services In-Network</th><th>What you pay when you get these services Out-of-Network</th></tr>
<tr><td>Ambulance services
Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.

Prior authorization may be required and is the responsibility of your provider.</td><td colspan="2">You pay $0 for each Medicare-covered one-way trip.
Although most providers collect the applicable cost-sharing at the time of service, this may not occur for ambulance services.
You may receive a bill for the entire cost of the ambulance service. If this occurs, simply submit your bill to:
Blue Shield Group Medicare Advantage Customer Service
P.O. Box 927
Woodland Hills, CA 91365-9856
Blue Shield will reimburse you for the cost of the covered services, less the applicable cost-sharing. You will receive a separate bill from the provider for the applicable cost-sharing.</td></tr>
<tr><td>Annual physical exam*
You are covered for one routine physical exam every 12 months in addition to your annual wellness visit. This visit includes a comprehensive review of your medical and family history, a detailed head-to-toe assessment and other services, referrals and recommendations that may be appropriate.</td><td colspan="2">You pay $0.</td></tr>
</table>

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Annual physical exam* (cont'd) Any labs, diagnostic procedures, or other types of services ordered are not covered under this benefit and you pay your plan cost-sharing amount for each of those services separately. *Services do not apply to the plan's maximum out-of-pocket limit.		
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.	
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.	
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39	There is no coinsurance, copayment, or deductible for covered screening mammograms.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Breast cancer screening (mammograms) (cont'd) • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months		
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan covers these comprehensive programs if you've had at least one of these conditions: • Heart attack in the last 12 months • Coronary artery bypass surgery • Stable angina pectoris (chest pain) • Heart valve repair or replacement • Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • Heart or heart and lung transplant • Stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period. *Prior authorization may be required and is the responsibility of your provider.*	You pay $10 per visit.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.	
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.	
Cervical and vaginal cancer screening Covered services include: • Pap tests and pelvic exams once every 24 months for all women • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	
Chiropractic services Covered services include: • Manual manipulation of the spine to correct a vertebral subluxation Covered services are provided through a contract with American Specialty Health Plans of California, Inc. (ASH Plans). ASH Plans administers the delivery of services through a network of contracted providers. ASH Plans also contracts with Blue Shield to serve as the claims	You pay $10 per visit for Medicare-covered services.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Chiropractic services (cont'd) administrator for services received from in- and out-of-network providers. For more information, or to locate an ASH Plans participating provider you may call ASH Plans at (800) 678-9133, [TTY: 711], Monday through Friday, 5 a.m. to 8 p.m. PT, April 1st through September 30th and Sunday through Saturday, 8 a.m. to 8 p.m. PT, October 1st through March 31st. You can also call Blue Shield Customer Service or go to blueshieldca.com/find-a-doctor to locate an ASH Plans participating provider. For Chiropractic services performed outside of California, contact Blue Shield Group Medicare Advantage Customer Service at (888) 802-4599 for assistance.		
Chiropractic services (non-Medicare covered)* Covered services include: • Initial and subsequent examinations • Chiropractic adjustments • Adjunctive therapies • X-rays (chiropractic only) Covered services are provided through a contract with American Specialty Health Plans of Calfornia, Inc. (ASH Plans. ASH Plans administers the delivery of services through a network of contracted providers. ASH Plans also contracts with Blue Shield to serve as the claims administrator for services received from in- and out-of-network providers. **Note:** Out-of-Network Providers do not agree to accept the plan's allowed cost-sharing amount as payment in full for covered services. When you see an out-of-network	You pay $15 per visit (limited to 20 visits combined, per year) for routine chiropractic services and acupuncture services.	You pay $15 per visit plus all charges above the allowed amount (limited to 20 visits combined, per year) for routine chiropractic services and acupuncture services.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Chiropractic services (non-Medicare covered)* (cont'd) provider, you are responsible for: • Your cost share; and • All charges over the allowed amount. The allowed amount for an out-of-network provider is the amount ASH would have allowed for an in-network provider performing the same service. For more information, or to locate an ASH Plans participating provider you may call ASH Plans at (800) 678-9133, TTY: 711, Monday through Friday, 5 a.m. to 8 p.m. PT, April 1st through September 30th and Sunday through Saturday, 8 a.m. to 8 p.m. PT, October 1st through March 31st. You can also call Blue Shield Group Medicare Advantage Customer Service or use Find a Doctor on **blueshieldca.com/find-a-doctor** to locate an ASH Plans participating provider. For Chiropractic services performed outside of California, contact Blue Shield Group Medicare Advantage Customer Service at (888) 802-4599 for assistance. *Services do not apply to the plan's maximum out-of-pocket limit.		
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Colorectal cancer screening (cont'd) colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage of a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result.	screening exam becomes a diagnostic exam and is subject to copays for physician services and services in a hospital outpatient setting or ambulatory surgical center. See the *Physician/ Practitioner services, including doctor's office visits* section and the *Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* section later in this Medical Benefits Chart.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Colorectal cancer screening (cont'd) • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.		
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.	For Medicare-covered Dental services, please see the *Physician/Practitioner services, including doctor's office visits* section later in the Medical Benefits Chart.	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.	
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Diabetes screening (cont'd) you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.		
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes) including fitting • Diabetes self-management training under certain conditions For test strips and blood glucose monitors, the preferred manufacturer is Roche Diagnostics. ACCU-CHEK® (made by Roche Diagnostics test strips and blood glucose monitors will not require your doctor to get approval in advance (sometimes called prior authorization) from the plan. Test strips and blood glucose monitors from all other manufacturers will require your doctor to get approval in	You pay $0 for diabetes supplies (except blood glucose monitors and continuous glucose monitors), diabetic services and diabetes self-management training. For blood glucose monitors and continuous glucose monitors, please see the *Durable medical equipment and related supplies* section of this Medical Benefits Chart.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Diabetes self-management training, diabetic services, and supplies (cont'd) advance (sometimes called prior authorization) from the plan. Continuous glucose monitors and supplies (i.e., sensors, receivers) from preferred and non-preferred manufacturers will require medical rationale submitted via the plan's prior authorization process. *Prior authorization may be required and is the responsibility of your provider*		
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 10 and Chapter 3.) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. *Prior authorization may be required and is the responsibility of your provider.*	You pay $0 for each Medicare-covered item, including Medicare-covered oxygen equipment. Blood glucose monitors: You pay $0 for ACCU-CHEK® blood glucose monitors and a 20% coinsurance for blood glucose monitors from all other manufacturers. Continuous glucose monitors: You pay $0 for Dexcom and Freestyle Libre continuous glucose monitors and a 20% coinsurance for continuous glucose monitors from all other manufacturers. See the *Medicare Part B Prescription Drugs* section of	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Durable medical equipment (DME) and related supplies (cont'd)	this Medical Benefits Chart for more information on drugs taken using durable medical equipment.	
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. Worldwide coverage* *Services do not apply to the plan's maximum out-of-pocket limit.	You pay $50 per visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition). You have no combined annual limit for covered emergency care or urgently needed services outside the United States and its territories.	
Health and wellness education programs **NurseHelp 24/7** Have a confidential one-on-one online dialogue with a registered nurse, 24 hours a day. When you have a medical concern, one call to our toll-free hotline puts you in touch with a registered nurse who will listen to your concerns and	You pay $0.	Not covered.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Health and wellness education programs (cont'd) help you toward a solution. Call 1-877-304-0504 (TTY: 711) 24 hours a day, 7 days a week.		
LifeReferrals 24/7 Consultants are available 24 hours a day, 7 days a week to offer objective, confidential guidance on personal issues including relationships and stress. Legal, financial and educational resources are available to help balance work and personal matters. Call 1-800-985-2405 (TTY: 800-424-6004) 24 hours a day, 7 days a week.	You pay $0.	Not covered.
SilverSneakers® Fitness You are covered for a fitness benefit through SilverSneakers that includes: • A nationwide network of participating gym and community locations with group fitness classes and amenities at select locations – enroll in as many locations as you like. • Live online classes and workshops through SilverSneakers LIVE™ 7 days/week, morning, afternoon, and evening • On-demand online workouts, wellness and exercise program videos through SilverSneakers GO™ 24 hours a day, 7 days a week. • Mobile app access to fitness programs, activity tracking, and your Member ID through SilverSneakers GO™ 24 hours a day, 7 days a week.	You pay $0.	Not covered.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Health and wellness education programs (cont'd) • Community connection and wellbeing support in-person and virtually through SilverSneakers Community. To start using the benefit, find your SilverSneakers ID number, fitness locations, and classes at silversneakers.com. If you have additional questions about your benefit call 1-888-423-4632 [TTY: 711] Monday through Friday, 5 a.m. to 5 p.m. PT. When you go to the participating fitness location of your choice, the staff will enroll you in their system using your SilverSneakers ID number. You may also ask for a tour of the location to see all the amenities and where the classrooms are located. At-home fitness kits are offered to members who want to start working out at home or for those who can't get to a participating fitness location due to injury, illness or being homebound. Members can choose one kit per year, and each kit includes a quick start guide. Available fitness kits include: • Walking – includes a pedometer. • Toning – includes an exercise ball. • Strength – includes a resistance band. • Yoga – includes a yoga strap. Always talk with your doctor before starting an exercise program.		
Personal Emergency Response System (PERS) Medical alert monitoring system that provides access to help 24/7, at the push of a button. Your PERS benefits are provided by LifeStation® and	You pay $0.	Not covered.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Health and wellness education programs (cont'd) include: • One personal emergency response system • Choice of either an in-home system or mobile device with GPS/WiFi and fall detection • Monthly monitoring • Necessary charges and cords To obtain the PERS and begin receiving services, call LifeStation at 1-855-672-3269 (TTY: 711) Monday through Friday, 5 a.m. to 6 p.m. PT and Saturday, 6 a.m. to 6 p.m. PT or go online at lifestation.com/bscamedicare. You may also visit your member portal at blueshieldca.com/login for more benefit information. *Services do not apply to the plan's maximum out-of-pocket limit.		
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. Routine (non-Medicare covered) hearing exam* One routine (non-Medicare covered) hearing exam which includes a comprehensive pure-tone audiometry test with air and bone conduction as well as speech reception and understanding testing. *Services do not apply to the plan's maximum out-of-pocket limit.	You pay $10 per visit for Medicare-covered diagnostic hearing exams. You pay $0 (limited to one in- or out-of-network visit per plan year).	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Hearing aids* Hearing aids allowance which covers: • Up to two hearing aids and two hearing aid fittings and evaluations (applies to both ears combined) • Hearing aid supplies and accessories (including batteries) • Hearing aid repairs and modifications You may obtain these services at the hearing aid provider of your choice. This allowance cannot be rolled over from year to year. *Services do not apply to the plan's maximum out- of-pocket limit.	You will be reimbursed up to $1,000 every 3 years.	
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.	
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home	You pay $0.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Home health agency care (cont'd) health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies *Prior authorization may be required and is the responsibility of your provider.*		
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier *Prior authorization may be required and is the responsibility of your provider.*	You pay $0.	

<table>
<tr><th>Covered Service</th><th>What you pay when you get these services In-Network</th><th>What you pay when you get these services Out-of-Network</th></tr>
<tr><td>Home meal delivery
Upon discharge from an inpatient hospital or skilled nursing facility (SNF) stay, we cover:
• 22 meals and 10 snacks per discharge
• Meals and snacks will be divided into up to two separate deliveries as needed.
• Coverage is limited to two discharges per year.
For more information, including information about home meal delivery outside of California, call Blue Shield Group Medicare Advantage Customer Service.</td><td>You pay $0.</td><td>Not covered.</td></tr>
<tr><td>Hospice care
You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.
Covered services include:
• Drugs for symptom control and pain relief
• Short-term respite care
• Home care

When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums.</td><td colspan="2">When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Blue Shield Group Medicare Advantage.
You pay $0 for the hospice consultation services (one-time only).</td></tr>
</table>

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Hospice care (cont'd) **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, your share of the costs for covered services may be higher **For services covered by Blue Shield Group Medicare Advantage but not covered by Medicare Part A or B:** Blue Shield Group Medicare Advantage will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services. Our plan covers hospice consultation services (one time		

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Hospice care (cont'd) only) for a terminally ill person who hasn't elected the hospice benefit. *Prior authorization may be required and is the responsibility of your provider.*		
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.	
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. There is no limit to the number of days per hospital stay. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets	You pay $0 for each Medicare-covered stay.	You pay $0 for each Medicare-covered stay. If you get authorized inpatient care at an out-of-network hospital after your

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Inpatient hospital care (cont'd) • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Blue Shield Group Medicare Advantage provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood, packed red cells and all other components of blood begins with the first pint used. • Physician services		emergency condition is stabilized, your cost is the same cost sharing you'd pay at a network hospital.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Inpatient hospital care (cont'd) **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. †Transplants are covered only if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from us. *Prior authorization may be required and is the responsibility of your provider.*		
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. Medicare covers up to 90 days of medically necessary hospitalization. Medicare also covers up to 60 additional lifetime reserve days that can be used only once during your lifetime for care provided in either an acute care hospital or a psychiatric hospital. Medicare covers up to 40 additional days in a Psychiatric hospital. The 40 additional days are offered once during your lifetime. Payment may not be made for more than a total of 190 days of inpatient psychiatric care in a freestanding psychiatric hospital during your lifetime.	You are covered for 150 days each benefit period, up to the 190-day lifetime limit. For each Medicare-covered stay you pay: • $0 per stay for days 1 to 150 • 100% of the cost for days 151 and over.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Inpatient services in a psychiatric hospital (cont'd) Prior usage under Medicare is included in the lifetime maximum (this includes our plan, any other Medicare Advantage plan, or Original Medicare). *Prior authorization may be required and is the responsibility of your provider.*		
Inpatient stay: Covered services received in a SNF during a non-covered skilled nursing facility (SNF) stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear,	• You pay $0. • You pay $0. • See the *Outpatient diagnostic tests and therapeutic services section* below. • You pay $0. • You pay $0. • You pay $0. • You pay $0.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Inpatient stay: Covered services received in a SNF during a non-covered skilled nursing facility (SNF) stay (cont'd) loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy *Prior authorization may be required and is the responsibility of your provider.*	• You pay $0.	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.	
Medicare Diabetes Prevention Program (MDPP) **MDPP services are covered for eligible people under all Medicare health plans.** MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustain weight loss	There is no coinsurance, copayment, or deductible for the MDPP benefit.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Medicare Diabetes Prevention Program (MDPP) (cont'd) and a healthy lifestyle. *Prior authorization may be required and is the responsibility of your provider.*		
Medicare Part B drugs **These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab) is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs	You pay $0. Insulin obtained under Part B (when taken with an insulin pump) will not exceed a $35 copay for a one-month supply.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Medicare Part B drugs (cont'd) • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®,		

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Medicare Part B drugs (cont'd) Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) This link will take you to a list of Part B drugs that may be subject to Step Therapy: **blueshieldca.com/medicare/member-resources/prior-authorization** We also cover some vaccines under our Part B drug benefit. *Prior authorization may be required and is the responsibility of your provider.*		
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.	
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted	You pay $0.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Opioid treatment program services (cont'd) treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments *Prior authorization may be required and is the responsibility of your provider.*		
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood, packed red cells and all other components of blood begins with the first pint used. • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem • Other outpatient diagnostic tests.	What you pay depends on the type of services obtained. You pay $0 for basic diagnostic tests, X-ray services, EKGs, supplies, blood and laboratory services. You pay $0 for each diagnostic radiology service. Diagnostic radiology services include, but are not limited to, ultrasound, MRI scans, PET scans, nuclear medicine studies, CT scans, cardiac stress tests, SPECT, myelogram cystogram, and angiogram. The copay is applicable to the global, technical and professional	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies (cont'd) *Prior authorization may be required and is the responsibility of your provider.*	components of the diagnostic radiology services only. You pay $0 for therapeutic radiology services. Therapeutic radiology services include, but are not limited to, radiation therapy, radium and isotope therapy. The copay is applicable to the global, technical and professional components of the therapeutic radiology services.	
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.	You pay $0.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Outpatient hospital observation (cont'd) Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. *Prior authorization may be required and is the responsibility of your provider.*		
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital	• You pay $50 per visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition). You pay $0 per visit to an outpatient hospital facility. You pay $0 for observation services. • You pay $0.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Outpatient hospital services (cont'd) • Mental health care, including care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. *Prior authorization may be required and is the responsibility of your provider.*	• You pay $0. • See the *Outpatient diagnostic tests and therapeutic services* section above. • You pay $0 for items covered by Medicare. • You pay $0	
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	You pay $0 for each individual or group therapy visit.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	You pay $0.	
Outpatient substance use disorder services Coverage under Medicare Part B is available for treatment services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance use or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. *Prior authorization may be required and is the responsibility of your provider.*	You pay $0 for each individual or group therapy visit.	
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. *Prior authorization may be required and is the responsibility of your provider.*	You pay $0 per visit to an ambulatory surgical center. You pay $0 per visit to an outpatient hospital facility.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Over-the-counter (OTC) items* Benefits include: • You have an allowance of $80 per quarter for the purchase of eligible OTC items for health-related use such as aspirin, vitamins, cold and cough medicines, and bandages. • This benefit does not cover OTC items for non-health related use. Refer to the OTC Items Catalog for a list of eligible items. • You can purchase eligible OTC items through the OTC Items Catalog (limited to two orders per quarter). • This benefit becomes effective on the first day of each quarter (January 1, April 1, July 1, and October 1) and any unused allowance cannot be rolled over from quarter to quarter. • Once you have used up your quarterly allowance, you are responsible for all costs of your purchases until the next quarter begins. You can purchase eligible OTC items in the OTC Items Catalog: • By phone - call (866) 778-6710 [TTY: 711], 8 a.m. to 8 p.m. PT, Monday through Friday. • Online – go online at BSConlineOTC.com. • Through the mobile app – search your app store for "myTotal Benefits" and download the application. Refer to the OTC Items Catalog for a list of eligible OTC items, ordering instructions, and limitations. Orders will be shipped to you at no extra charge. Please allow approximately 5-7 business days for delivery. If you use a P.O. Box as your shipping address, please allow approximately 7-10 business days for delivery.	You pay $0.	Not covered.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Over-the-counter (OTC) items* (cont'd) If you have questions, call (866) 778-6710 [TTY: 711], 8 a.m. to 8 p.m. PT, Monday through Friday. *Services do not apply to the plan's maximum out-of-pocket.		
Partial hospitalization services and intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally Qualified Health Center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization. *Prior authorization may be required and is the responsibility of your provider.*	You pay $0.	
Physician/practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory	For all Medicare-covered services: You pay $0.	

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

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network

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

Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	You pay $10 for each Medicare-covered visit.	

<table>
<tr><th>Covered Service</th><th>What you pay when you get these services In-Network</th><th>What you pay when you get these services Out-of-Network</th></tr>
<tr><td>Routine (non-Medicare covered) foot care* covers:
• The cutting or removal of corns and calluses
• The trimming, cutting, clipping, or debriding of nails
*Services do not apply to the plan's maximum out-of-pocket limit.</td><td colspan="2">You have an allowance of $100 per visit for routine (non-Medicare covered) foot care (limited to 6 visits per year, combined in- and out-of-network).</td></tr>
<tr><td>Pre-exposure prophylaxis (PrEP) for HIV prevention
If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services.
If you qualify, covered services include:
• FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable
• Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months
• Up to 8 HIV screenings every 12 months.
• A one-time hepatitis B virus screening</td><td colspan="2">There is no coinsurance, copayment, or deductible for the PrEP benefit.</td></tr>
<tr><td>Prostate cancer screening exams
For men aged 50 and older, covered services include the following once every 12 months:
• Digital rectal exam
• Prostate Specific Antigen (PSA) test</td><td colspan="2">There is no coinsurance, copayment, or deductible for an annual PSA test or digital rectal exam.</td></tr>
<tr><td>Prosthetic and orthotic devices and related supplies
Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly</td><td colspan="2">You pay $0 for Medicare-covered prosthetic and orthotic devices and related supplies.</td></tr>
</table>

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Prosthetic and orthotic devices and related supplies (cont'd) related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail. *Prior authorization may be required and is the responsibility of your provider.*		
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. *Prior authorization may be required and is the responsibility of your provider.*	You pay $10 per visit.	
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, an LDCT is covered every 12 months. **Eligible members are** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.	
Screening for Hepatitis C virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we cover a screening once. If you're at high risk	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
🍎 **Screening for Hepatitis C virus infection (cont'd)** (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.		
🍎 **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs** We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	
Services to treat kidney disease Kidney disease and dialysis services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as	• You pay $0. • You pay $0.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Services to treat kidney disease (cont'd) explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table**.** *Prior authorization may be required and is the responsibility of your provider.*	• Included in your costs for inpatient hospital care. Please see the *Inpatient hospital care* section of this chart for more information about what you must pay. • You pay $0. • You pay $0. • You pay $0.	
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) Covered services include but aren't limited to:	For each stay in a Medicare-certified skilled nursing	For each stay in a Medicare-certified skilled nursing

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Skilled nursing facility (SNF) care (cont'd) • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech therapy • Drugs administered to you as part of our plan of care (this includes substances naturally present in the body, such as blood clotting factors) • Blood - including storage and administration. Coverage of whole blood, packed red cells and all other components of blood begins with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	facility, you pay: • $0 per day for days 1 to 100 There is a limit of 100 days for each benefit period if your condition requires additional rehabilitation services, other types of daily skilled nursing, or other skilled care. If you go over the 100-day limit, you will be responsible for all costs. When a network provider coordinates your	facility, you pay: • $0 per day for days 1 to 100 There is a limit of 100 days for each benefit period if your condition requires additional rehabilitation services, other types of daily skilled nursing, or other skilled care. If you go over the 100-day limit, you will be responsible for all costs.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Skilled nursing facility (SNF) care (cont'd) *Prior authorization may be required and is the responsibility of your provider.*	admission, Blue Shield Group Medicare Advantage waives the 3-day prior hospital stay required by Medicare to qualify for coverage	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.	
Supervised exercise therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.	You pay $10 per visit.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Supervised exercise therapy (SET) (cont'd) The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. *Prior authorization may be required and is the responsibility of your provider.*		
Transportation services (non-Medicare covered)* Blue Shield of California provides transportation for plan members. Transportation is provided on an as-needed basis to facilitate non-emergent access to healthcare, e.g., physician office visits. **Note:** Arrangements for transportation are handled by Call the Car. Contact Call the Car at (855) 200-7544 [TTY: 711] 24 hours a day, seven days a week. Arrangements for transportation must be made at least 24 hours in advance. Call the Car offers a mobile application (CTC-Go) that can be used by Blue Shield Group Medicare Advantage	You pay $0 for each one-way trip to plan-approved health-related locations (limited to 24 one-way trips per year, combined in-	Not covered

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Transportation services (non-Medicare covered)* (cont'd) members to coordinate healthcare transportation. CTC-Go allows you to review upcoming or past reservations, rate your ride, track your driver, cancel an existing reservation, and to schedule a new reservation. CTC-Go is available on iOS and Android. Search your app store for "CTC-Go" and download the application. *Services do not apply to the plan's maximum out-of-pocket limit.	and out-of-network and each trip may not exceed 70 miles).	
Travel benefit for medically necessary care (non-Medicare covered)* The plan will cover travel and lodging for eligible medically necessary services including, but not limited to, the services listed below that cannot be accessed within 50 miles from the member's permanent residence up to $5,000 per occurrence. This includes transportation, lodging, and meals for the member and a companion. • Abortion services • Bariatric surgery • Organ and tissue transplants • Gender-affirming care For travel expense reimbursement, you must contact Blue Shield Group Medicare Advantage Customer Service at **(888) 802-4599** (TTY: **711**), 7 a.m. to 8 p.m. PT, seven days a week to request a Travel Reimbursement form and submit receipts, claim forms, and any other documentation required by the plan. You must also have a claim or proof of claim for the eligible covered service for which you traveled on file with the plan prior to reimbursement. Please submit claims documentation to:	You pay $0.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Travel benefit for medically necessary care (non-Medicare covered)* (cont'd) Blue Shield of California P.O. Box 272530 Chico, CA 95927 Expenses must be reasonably necessary. Reimbursable expenses include, if appropriate: • Transportation to and from the facility to receive eligible covered services; • Hotel accommodations if one or more overnight stays are required to obtain eligible covered services. Limited to 1 double occupancy room up to $200 per day. Only the room is covered. All other hotel expenses are excluded. • Meals are limited to $100 per day. Expenses for tobacco, alcohol, drugs, phone, television, and recreation are excluded; and • Companion expenses for reimbursable expenses as listed above. For more details, refer to the Travel and Lodging Benefit description online at **blueshieldca.com/calpers**. Certain travel expense reimbursements may be tax reportable. When required, we will issue a Form 1099-MISC to you, reporting travel expense reimbursements. We do not provide tax advice. If you have tax questions about travel expense reimbursements, consult with your tax advisor. *Services do not apply to the plan's maximum out-of-pocket limit.		

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. Worldwide coverage* *Services do not apply to the plan's maximum out-of-pocket limit.	You pay $0 for each visit to an urgent care center within your plan service area. You pay $0 for each visit to an urgent care center outside your plan service area. You pay $50 per visit to an emergency room within your plan service area (waived if you are admitted to the hospital within one day for the same condition). You pay $50 per visit to an emergency room outside your plan service area (waived if you are admitted to the hospital within one day for the same condition). There is no combined annual limit for covered emergency or urgently needed care outside the United States and its territories. Services outside the United States and its territories do not apply to the plan's maximum out-of-pocket limit.	

<table>
<tr><th>Covered Service</th><th>What you pay when you get these services In-Network</th><th>What you pay when you get these services Out-of-Network</th></tr>
<tr><td>Vision care
Covered services include:
• Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts
• For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older
• For people with diabetes, screening for diabetic retinopathy is covered once per year
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery

Prior authorization may be required and is the responsibility of your provider.</td><td colspan="2">• You pay $10 per visit.
• You pay $0.
• You pay $10 per visit.
• You pay $0.</td></tr>
<tr><td>Vision care, (non-Medicare covered)*
• Routine eye exam, including refraction and prescription for eyeglass lenses. If the provider recommends additional procedures, you are responsible for paying the additional costs. Contact lens exams require additional fees. You are responsible for paying the additional cost.</td><td colspan="2">You pay $10 for one exam every year when you use a network or out-of-network provider.</td></tr>
</table>

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Vision care, (non-Medicare covered)* (cont'd) Prior authorization (approval in advance) is NOT required. Use the *Vision Directory* or go to **blueshieldca.com/find-a-doctor** to locate a provider participating in the Vision Service Plan (VSP) (Blue Shield Vision Plan Administrator) network. *Services do not apply to the plan's maximum out-of-pocket limit.		
Welcome to Medicare preventive visit Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (and vaccines)), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit.	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.	

Section 2.1 Extra optional supplemental benefits you can buy

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

Blue Shield offers an optional supplemental dental PPO and vision plan package (dental/vision plan) to Blue Shield Group Medicare Advantage members. The dental/vision plan lets you choose from in- and out-of-network providers, for a monthly Premium of **$40.31**.

Tip: There are several ways you can pay your Premium. You can pay in all the same ways listed in Chapter 1, Section 4.2.

Blue Shield Group Medicare Advantage optional supplemental dental/vision plan

The Blue Shield Group Medicare Advantage optional supplemental dental/vision plan is administered by two separate service plans licensed to deliver dental and vision services.

The Dental Plan Administrator (DPA) is an entity that contracts with Blue Shield to administer the delivery of dental services through a network of contracted dentists. The Vision Plan Administrator (VPA) is an entity that contracts with Blue Shield to administer the delivery of eyewear and eye exams through a network of contracted providers.

Both administrators also contract with Blue Shield to serve as claims administrators for the processing of claims for services received from in- and out-of-network providers.

Enrolling in the Blue Shield Group Medicare Advantage optional supplemental dental/vision plan

To enroll in the optional supplemental dental/vision plan, you should have indicated your choice to purchase the plan on your enrollment form at the time of enrollment in Blue Shield Group Medicare Advantage. With the optional supplemental dental/vision plan, you don't have to select a network dentist or vision care provider in order to enroll.

Disenrolling from the Blue Shield Group Medicare Advantage optional supplemental dental/vision plan

You can disenroll from the optional supplemental dental/vision plan during the Plan Sponsor's open enrollment period.

You can be disenrolled from the optional supplemental dental/vision plan for failure to pay the required monthly Premium, when due. Your plan Premium is due by the last day of the month prior to your coverage period month. If we have not received your Premium by the last day of the month, we will send you a notice telling you that your optional supplemental dental/vision plan membership will end if all Premium payments due are not received within a 3-month grace period. You will be liable for the Premium accrued during this 3-month grace period.

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

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

Disenrollment from the optional supplemental dental/vision plan will not result in disenrollment from Blue Shield Group Medicare Advantage. Non-payment of plan Premiums for your optional supplemental dental/vision plan will not result in disenrollment from Blue Shield Group Medicare Advantage, only the loss of the optional supplemental dental/vision plan.

Re-enrolling

If you are disenrolled from the optional supplemental dental/vision plan for non-payment of Premiums, you must wait until the Plan Sponsor's open enrollment period to re-enroll.

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

The following **Summary of Benefits Chart** shows the specific dental procedures covered by the optional supplemental dental PPO plan (within the optional supplemental dental/vision plan package) and what you will pay for those procedures. The services listed are covered benefits when provided by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice. As a member of the optional supplemental dental PPO plan (within the optional supplemental dental/vision plan package), you can go directly to a dental specialist without a referral.

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

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

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

Important: Some dental services are not covered under any conditions (also known as Exclusions) and some dental services are only covered under specific conditions (also known as Limitations).

Please refer to the "General Limitations" column in the ***Summary of Benefits Chart*** below and to the "General exclusions" listed after the ***Summary of Benefits Chart*** for more information.

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

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

Conditions characterized by acute pain or infection include the following:

- Acute pain requiring immediate root canal;
- Acute pain requiring tooth extraction or removal and/or incision and drainage;
- Acute periodontal abscess requiring emergency periodontal procedures.

Emergent restorative conditions include the following:

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

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

Summary of Benefits Chart

	Dental PPO	
Network Access	**In-Network Dentists**	**Out-of-Network Dentists**
Calendar year Deductible (not applicable to diagnostic and preventive services provided by in-network and out-of-network dentists)	$100	
Calendar year maximum	$1,500 for covered preventive and comprehensive dental services combined, no matter if the services are performed by an in- or out-of-network general dentist or a dental specialist. You pay any amount above the $1,500 calendar year benefit maximum.	

There is no waiting period for any covered services in the optional supplemental dental PPO plan.

		What you must pay	
		Dental PPO	
ADA Code	**ADA description of services covered for you**	**In-Network Dentists** **Out-of-Network Dentists**	**General Limitations**
Oral Exams			
D0120	Periodic oral evaluation - established patient	0%	2 per plan year
D0140	Limited oral evaluation - problem focused	0%	2 per plan year
D0150	Comprehensive oral evaluation - new or established patient	0%	2 per plan year

		What you must pay	
		Dental PPO	
ADA Code	**ADA description of services covered for you**	**In-Network Dentists Out-of-Network Dentists**	**General Limitations**
D0160	Detailed and extensive oral evaluation - problem focused, by report	0%	2 per plan year
Dental X-rays			
D0210	Intraoral - comprehensive series of radiographic images	0%	1 every 3 years from last date of service
D0220	Intraoral - periapical first radiographic image	0%	2 per plan year
D0230	Intraoral - periapical each additional radiographic image	0%	2 per plan year
D0270	Bitewing - single radiographic image	0%	4 per plan year
D0272	Bitewings - two radiographic images	0%	1 per plan year
D0273	Bitewings - three radiographic images	0%	1 per plan year
D0274	Bitewings - four radiographic images	0%	1 per plan year
D0277	Vertical bitewings – 7 to 8 radiographic images	0%	No frequency limitation
D0330	Panoramic radiographic image	0%	1 every 3 years from last date of service
D0372	Intraoral tomosynthesis - comprehensive series of radiographic images	0%	1 every 3 years from last date of service
D0373	Intraoral tomosynthesis - bitewing radiographic image	0%	1 every 3 years from last date of service
D0374	Intraoral tomosynthesis - periapical radiographic image	0%	2 per plan year

		What you must pay	
		Dental PPO	
ADA Code	ADA description of services covered for you	In-Network Dentists Out-of-Network Dentists	General Limitations
D0387	Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only	0%	1 every 3 years from last date of service
D0388	Intraoral tomosynthesis - bitewing radiographic image - image capture only	0%	1 per plan year
D0389	Intraoral tomosynthesis - periapical radiographic image - image capture only	0%	2 per plan year
Prophylaxis (Cleaning)			
D1110	Prophylaxis – adult	0%	2 per plan year
Fluoride Treatment			
D1206	Topical application of fluoride varnish	0%	2 per plan year
D1208	Topical application of fluoride – excluding varnish	0%	2 per plan year
Other Preventive Dental Services			
D1354	Application of caries arresting medicament – per tooth	20%	No frequency limitation
Restorative Services			
D2140	Amalgam - one surface, primary or permanent	20%	1 per month from last date of service
D2150	Amalgam - two surfaces, primary or permanent	20%	1 per month from last date of service
D2160	Amalgam - three surfaces, primary or permanent	20%	1 per month from last date of service
D2161	Amalgam - four or more surfaces, primary or permanent	20%	1 per month from last date of service
D2330	Resin-based composite - one surface, anterior	20%	1 per month from last date of service
D2331	Resin-based composite - two surfaces, anterior	20%	1 per month from last date of service

		What you must pay	
		Dental PPO	
ADA Code	**ADA description of services covered for you**	**In-Network Dentists** **Out-of-Network Dentists**	**General Limitations**
D2332	Resin-based composite - three surfaces, anterior	20%	1 per month from last date of service
D2335	Resin-based composite - four or more surfaces, anterior	20%	1 per month from last date of service
D2391	Resin-based composite - one surface, posterior	20%	1 per month from last date of service
D2392	Resin-based composite - two surfaces, posterior	20%	1 per month from last date of service
D2393	Resin-based composite - three surfaces, posterior	20%	1 per month from last date of service)
D2394	Resin-based composite - four or more surfaces, posterior	20%	1 per month from last date of service
D2510	Inlay - metallic - one surface	80%	1 every 5 years from last date of service
D2520	Inlay - metallic - two surfaces	80%	1 every 5 years from last date of service
D2530	Inlay - metallic - three or more surfaces	80%	1 every 5 years from last date of service
D2542	Onlay - metallic - two surfaces	80%	1 every 5 years from last date of service
D2543	Onlay - metallic - three surfaces	80%	1 every 5 years from last date of service
D2544	Onlay - metallic - four or more surfaces	80%	1 every 5 years from last date of service
D2610	Inlay - porcelain/ceramic - one surface	80%	No frequency limitation
D2620	Inlay - porcelain/ceramic - two surfaces	80%	No frequency limitation
D2630	Inlay - porcelain/ceramic - three or more surfaces	80%	No frequency limitation
D2642	Onlay - porcelain/ceramic - two surfaces	80%	1 every 5 years from last date of service
D2643	Onlay - porcelain/ceramic - three surfaces	80%	1 every 5 years from last date of service

		What you must pay	
		Dental PPO	
ADA Code	**ADA description of services covered for you**	**In-Network Dentists Out-of-Network Dentists**	**General Limitations**
D2644	Onlay - porcelain/ceramic - four or more surfaces	80%	1 every 5 years from last date of service
D2740	Crown – porcelain/ceramic	80%	1 every 5 years from last date of service
D2750	Crown - porcelain fused to high noble metal	80%	1 every 5 years from last date of service
D2751	Crown - porcelain fused to predominantly base metal	80%	1 every 5 years from last date of service
D2752	Crown - porcelain fused to noble metal	80%	1 every 5 years from last date of service
D2790	Crown - full cast high noble metal	80%	1 every 5 years from last date of service
D2791	Crown - full cast predominantly base metal	80%	1 every 5 years from last date of service
D2792	Crown - full cast noble metal	80%	1 every 5 years from last date of service
D2794	Crown – titanium and titanium alloys	80%	1 every 5 years from last date of service
D2920	Re-cement or re-bond crown	80%	1 every 6 months from last date of service
D2940	Placement of interim direct restoration	80%	1 every 6 months from last date of service
D2950	Core buildup, including any pins when required	80%	1 every 5 years from last date of service
D2952	Cast post and core in addition to crown, indirectly fabricated	80%	1 every 5 years from last date of service
D2953	Each additional indirectly fabricated post, same tooth	80%	1 every 5 years from last date of service
D2954	Prefabricated post and core in addition to crown	80%	1 every 5 years from last date of service
D2989	Excavation of a tooth resulting in the determination of non-restorability	80%	No frequency limitation
Endodontics			

		What you must pay	
		Dental PPO	
ADA Code	**ADA description of services covered for you**	**In-Network Dentists** **Out-of-Network Dentists**	**General Limitations**
D3110	Pulp cap - direct (excluding final restoration)	80%	1 every year from last date of service
D3120	Pulp cap - indirect (excluding final restoration)	80%	No frequency limit
D3310	Endodontic therapy - anterior tooth (excluding final restoration)	80%	1 every year from last date of service
D3320	Endodontic therapy - premolar tooth (excluding final restoration)	80%	No frequency limitation
D3330	Endodontic therapy - molar tooth (excluding final restoration)	80%	1 every year from last date of service
D3346	Retreatment of previous root canal - anterior	80%	1 every year from last date of service
D3347	Retreatment of previous root canal - bicuspid	80%	1 every year from last date of service
D3348	Retreatment of previous root canal - molar	80%	1 every year from last date of service
Periodontics			
D4341	Periodontal scaling and root planing - four or more teeth - per quadrant	80%	1 every 24 months from last date of service
D4342	Periodontal scaling and root planing - one to three teeth - per quadrant	80%	1 every 24 months from last date of service
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	80%	1 per plan year
D4381	Localized delivery of antimicrobial agents, via a controlled release vehicle into diseased crevicular tissue, per tooth	80%	No frequency limitation

		What you must pay	
		Dental PPO	
ADA Code	ADA description of services covered for you	In-Network Dentists Out-of-Network Dentists	General Limitations
D4910	Periodontal maintenance	80%	2 per plan year
Prosthodontics, removable			
D5110	Complete denture - maxillary	80%	1 every 5 plan years
D5120	Complete denture - mandibular	80%	1 every 5 plan years
D5130	Immediate denture - maxillary	80%	1 per plan year
D5140	Immediate denture - mandibular	80%	1 per plan year
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	80%	1 every 5 plan years
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	80%	1 every 5 plan years
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	80% 80%	1 every 5 plan years
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	80%	1 every 5 plan years
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	80%	1 every 5 years from last date of service
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	80%	1 every 5 plan years from last date of service

		What you must pay	
		Dental PPO	
ADA Code	**ADA description of services covered for you**	**In-Network Dentists Out-of-Network Dentists**	**General Limitations**
D5225	Maxillary partial denture - flexible base (including retentive /clasping materials, rests and teeth)	80%	1 every 5 plan years from last date of service
D5226	Mandibular partial denture - flexible base (including retentive /clasping materials, rests and teeth)	80%	1 every 5 plan years from last date of service
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	80%	1 every 5 years from last date of service
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	80%	1 every 5 plan years from last date of service
D5410	Adjust complete denture - maxillary	80%	2 per plan year
D5411	Adjust complete denture - mandibular	80%	2 per plan year
D5421	Adjust partial denture - maxillary	80%	2 per plan year
D5422	Adjust partial denture - mandibular	80%	2 per plan year
D5511	Repair broken complete denture base, mandibular	80%	2 per plan year
D5512	Repair broken complete denture base, maxillary	80%	2 per plan year
D5520	Replace missing or broken teeth - complete denture – per tooth	80%	2 per plan year
D5611	Repair resin partial denture base, mandibular	80%	2 per plan year
D5612	Repair resin partial denture base, maxillary	80%	2 per plan year
D5621	Repair cast partial framework, mandibular	80%	2 per plan year

		What you must pay	
		Dental PPO	
ADA Code	ADA description of services covered for you	In-Network Dentists Out-of-Network Dentists	General Limitations
D5622	Repair cast partial framework, maxillary	80%	2 per plan year
D5630	Repair or replace broken retentive/clasping materials – per tooth	80%	2 per plan year
D5640	Replace missing or broken teeth – partial denture - per tooth	80%	2 per plan year
D5650	Add tooth to existing partial denture - per tooth	80%	2 per plan year
D5660	Add clasp to existing partial denture – per tooth	80%	2 per plan year
D5730	Reline complete maxillary denture (direct)	80%	1 per plan year
D5731	Reline complete mandibular denture (direct)	80%	1 per plan year
D5740	Reline maxillary partial denture (direct)	80%	1 per plan year
D5741	Reline mandibular partial denture (direct)	80%	1 per plan year
D5750	Reline complete maxillary denture (indirect)	80%	1 per plan year
D5751	Reline complete mandibular denture (indirect)	80%	1 per plan year
D5760	Reline maxillary partial denture (indirect)	80%	1 per plan year
D5761	Reline mandibular partial denture (indirect)	80%	1 per plan year
D5765	Soft liner for complete or partial removable denture - indirect	80%	1 every 5 years from last date of service
D5850	Tissue conditioning, maxillary	80%	1 every 5 years from last date of service
D5851	Tissue conditioning, mandibular	80%	1 every 5 years from last date of service
Prosthodontics, fixed			

ADA Code	ADA description of services covered for you	What you must pay Dental PPO In-Network Dentists Out-of-Network Dentists	General Limitations
D6210	Pontic - cast high noble metal	80%	1 every 5 years from last date of service
D6211	Pontic - cast predominantly base metal	80%	1 every 5 years from last date of service
D6212	Pontic - cast noble metal	80%	1 every 5 years from last date of service
D6214	Pontic - Titanium and titanium alloys	80%	1 every 5 years from last date of service
D6240	Pontic - porcelain fused to high noble metal	80%	1 every 5 years from last date of service
D6241	Pontic - porcelain fused to predominately base metal	80%	1 every 5 years from last date of service
D6242	Pontic - porcelain fused to noble metal	80%	1 every 5 years from last date of service
D6245	Pontic - porcelain/ceramic	80%	1 every 5 years from last date of service
D6740	Retainer crown - porcelain/ceramic	80%	1 every 5 years from last date of service
D6750	Retainer crown - porcelain fused to high noble metal	80%	1 every 5 years from last date of service
D6751	Retainer crown - porcelain fused to predominantly base metal	80%	1 every 5 years from last date of service
D6752	Retainer crown - porcelain fused to noble metal	80%	1 every 5 years from last date of service
D6790	Retainer crown - full cast high noble metal	80%	1 every 5 years from last date of service
D6791	Retainer crown - full cast predominantly base metal	80%	1 every 5 years floating from last date of service
D6792	Retainer crown - full cast noble metal	80%	1 every 5 years from last date of service
D6794	Retainer crown – titanium and titanium alloys	80%	1 every 5 years from last date of service

		What you must pay	
		Dental PPO	
ADA Code	ADA description of services covered for you	In-Network Dentists Out-of-Network Dentists	General Limitations
D6930	Recement or re-bond fixed partial denture	80%	1 every 6 months from last date of service
Oral and Maxillofacial Surgery			
D7111	Extraction coronal remnants – primary tooth	80%	1 every year from last date of service
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	80%	1 every year from last date of service
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	80%	1 every year from last date of service
D7250	Removal of residual tooth roots (cutting procedure)	80%	1 every year from last date of service
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	80%	1 every year from last date of service
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	80%	1 every year from last date of service
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	80%	1 every year from last date of service
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	80%	1 every year from last date of service
D7510	Incision & drainage of abscess – intraoral soft tissue	80%	No frequency limitation

ADA Code	ADA description of services covered for you	What you must pay Dental PPO In-Network Dentists Out-of-Network Dentists	General Limitations
D7511	Incision & drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	80%	No frequency limitation
Adjunctive General Services			
D9110	Palliative treatment of dental pain – per visit	20%	No frequency limitation
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	20%	No frequency limitation
D9222	Deep sedation/general anesthesia - first 15 minutes	20%	2 every day from last date of service
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	20%	No frequency limitation
D9230	Inhalation of nitrous oxide/anxiolysis analgesia	20%	1 every day from last date of service
D9239	Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes	20%	No frequency limitation
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	20%	No frequency limitation
D9910	Application of desensitizing medicament	20%	No frequency limitation
D9943	Occlusal adjustment	20%	2 procedures every year from last date of service
D9944	Occlusal guard - hard appliance, full arch	20%	1 per plan year

NOTE: Since Blue Shield of California contracts with Medicare each year, these dental benefits may not be available next year.

Getting dental care

Before Obtaining Dental Services

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

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

Visiting your dentist

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

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

NOTE: Members who have not kept up with their routine dental appointments (once every 6 months) may find that they require services involving periodontal scaling and root planing before routine care such as regular cleanings can or will be provided.

Member Cost-Sharing

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

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

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

OPTIONAL SUPPLEMENTAL DENTAL PPO PLAN MEMBER COST-SHARING EXAMPLE:

You need to visit the dentist for a procedure on your tooth. You have received Covered Services throughout the year and have already met your $100 Deductible.

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

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

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

Deductible: **$100**

Amount paid to date toward Deductible: **$100**

In-Network Dentist Coinsurance: ***80%***

Out-of-Network Dentist Coinsurance: ***80%***

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

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

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

	In-Network Dentist	***Out-of-Network Dentist***
You pay	**$64** (80% Coinsurance)	**$564** (80% Coinsurance + $500 for charges over allowed amount)
Blue Shield DPA pays	$16 (allowed amount – your Coinsurance)	$16 (allowed amount – your Coinsurance)

Total payment to the dentist	$80 (allowed amount)	$580 (billed charge)

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

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

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

Optional dental treatment

Optional dental treatment is any procedure that is:

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

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

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

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

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

Non-Medicare covered emergency dental care

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

In-area non-Medicare covered emergency dental care

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

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

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

You will be reimbursed at the payment percentage listed under the out-of-network dentist's portion of the ***Summary of Benefits Chart***. You will be responsible for the remainder of your dentist's billed charges. Whenever possible, you should ask your dentist to send the bill directly to Blue Shield at the address listed below.

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

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

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

Our DPA will review the non-Medicare covered emergency dental services you received and will process your claim within 30 calendar days of receipt if it is not missing any required information. If your claim is missing any required information, you or your provider will be notified and asked to submit the missing information. The DPA cannot process your claim until we receive the missing information. Once the missing information is received, the DPA will have 30 calendar days to process your claim. Except for non-Medicare covered emergency dental services, you will be responsible for full payment of dental services you receive outside of California.

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

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

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

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

Obtaining a second opinion for dental care

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

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

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

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

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

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

Transferring to another dentist

If you are not satisfied with the dentist you selected or are currently seeing, you may select another dentist of your choice. You are not required to contact Customer Service to change your dentist. However, if you need help selecting another network dentist, simply contact the DPA customer service department toll free at **(888) 679-8928 [TTY: 711]**.

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

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

In cases where the Blue Shield Group Medicare Advantage optional supplemental dental PPO plan allows for transfer in mid-procedure, you may be charged for laboratory charges incurred by the dentist in fabricating the dental appliance. For in-network dentists, the charges may not exceed your percentage of the covered procedure's allowed amount as listed under the In-Network Dentist portion of the ***Summary of Benefits Chart***. For out-of-network dentists, you will be responsible for your cost share of the allowed amount plus the difference between the allowed amount and the billed charge. In addition, you may be charged for laboratory charges for any optional features ordered for you by your dentist.

Since the DPA cannot compel or require a contracted dentist to treat any Member for any reason, the DPA will notify Blue Shield Group Medicare Advantage when a breakdown of a workable dentist-patient relationship occurs or cannot be established.

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

If your dentist no longer contracts with the Blue Shield Group Medicare Advantage DPA

If your selected network dentist is unable to continue under contract with the DPA because he or she is unable to perform or has breached the contract, or if the DPA has terminated the contract, the DPA will notify you at least 30 calendar days prior to the dentist's effective termination date. At that time, you may choose to select another network dentist or continue seeing your current dentist. If you choose to go to an out-of-network dentist, your out-of-pocket costs will be higher.

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

If you have another dental plan

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

Resolving disagreements

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

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

General exclusions for the optional supplemental Dental PPO plan

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

1. X-rays – the following are not covered:
   a. CTs, cephalograms, or MRIs.
   b. intraoral periapical x-rays on the same day as intraoral complete series of radiographs.
   c. bitewing x-rays in the same year as a full mouth set of x-rays.

2. Fillings –
   a. gold foil fillings, sealants, or preventive resin restorations are not covered.
   b. pulp capping for an exposed or nearly exposed pulp is covered, but does not cover bases and liners when all caries has been removed.

3. Crowns – the following are not covered:
   a. crowns for cosmetic reasons or for closing gaps.
   b. veneers.
   c. implant crowns.
   d. "3/4" crowns.

4. Implant supported bridges are not covered.

5. Extraction of impacted (unerupted) teeth are not covered.

6. Localized delivery of chemotherapeutic agents, per tooth, cannot be used the same day as scaling and root planing.

7. Application of desensitizing medicament is not covered for bases, liners or adhesives used under restorations.

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

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

excluded from coverage.

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

11. Implant placement or removal, appliances placed on, or services associated with dental implants, including, but not limited to prophylaxis and periodontal treatment, are not covered.

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

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

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

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

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

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

18. Procedures which are principally cosmetic in nature such as bleaching, veneers, use of porcelain on molar teeth, personalization and characterization of dentures.

19. Dental expenses incurred in connection with any dental procedures started after

termination of eligibility for coverage, and dental expenses incurred for treatment in progress prior to the Member's eligibility with Blue Shield routine dental PPO coverage (for example: teeth prepared for crowns) are not covered. For the purpose of this exclusion, the date on which a procedure shall be considered to have started is defined as follows:

a. For full dentures or partial dentures: on the date the final impression is taken;
b. For fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared;
c. For periodontal surgery: on the date the surgery is actually performed;
d. For all other services: on the date the service is performed.

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

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

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

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

24. Services, procedures, or supplies which are not reasonably necessary for the care of the Member's dental condition according to broadly accepted standards of professional care or which are experimental or investigational in nature or which do not have uniform professional endorsement.

25. Myofunctional therapy; biofeedback procedures; athletic mouthguards; precision or semi- precision attachments; denture duplication; oral hygiene instruction; treatment of jaw fractures.

26. Alloplastic bone grafting materials.

27. Bone grafting done for socket preservation after tooth extraction or in preparation for implants.

28. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable.

29. Extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues).

30. Services for which the Member is not legally obligated to pay, or for services for which no charge is made.

31. Treatment for which payment is made by any governmental agency, including any foreign government.

32. Charges for prosthetic appliances, fixed or removable, which are related to periodontal treatment.

33. Charges for onlays or crowns installed as multiple abutments.

34. Charges for any inlay restoration.

35. Charges for dental appointments which are not kept.

36. Charges for services incident to any intentionally self-inflicted injury.

37. Removal of third molar (wisdom teeth) other than for dental necessity. Dental necessity is defined as a pathological condition which includes horizontal, medial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericornitis alone is not dental necessity.

38. Periodontal splinting of teeth by any method including, but not limited to, crowns, fillings, appliances or any other method that splints or connects teeth together.

39. Services provided by an individual or entity that is not licensed or certified by the state to provide health care services or is not operating within the scope of such license or certification, except as specifically stated herein.

Optional supplemental vision plan benefits chart (what is covered and what you pay)

The following ***Summary of Benefits Chart*** shows the services covered by the optional supplemental vision plan (within the optional supplemental dental/vision plan package) and what you will pay for those services. As a member of the optional supplemental vision plan, you can go directly to any vision care provider of your choice.

Important: Some vision services are not covered under any conditions (also known as Exclusions). Please refer to the "General exclusions" listed after the ***Summary of Benefits Chart*** for more information.

Summary of Benefits Chart

<table>
<tr><th>Services that are covered for you</th><th colspan="2">What you must pay when you get these services</th></tr>
<tr><th></th><th>In-Network Providers</th><th>Out-of- Network Providers</th></tr>
<tr><td>Routine (non-Medicare covered) eye exam, including refraction and prescription for eyeglass lenses.

If the provider recommends additional procedures, you are responsible for paying the additional costs. Contact lens exams require additional fees.</td><td colspan="2">You pay $0 for one exam every year whether you use an in-network or out-of-network provider.</td></tr>
<tr><td>Routine (non-Medicare covered) eyewear –
• Eyeglass frames
• Eyeglass lenses OR contact lenses instead of eyeglass lenses

If you choose eyeglass lenses, you may elect single, lined bifocal, lined trifocal, or lenticular lenses. If you opt for other lens types not listed or add-on treatments, you will be responsible for paying the additional costs, even if the total costs remain within the allowance.

If you choose eyeglasses frames and eyeglass lenses or contact lenses priced above the applicable allowance, you are responsible for the difference.

Important: Please note that services, eyeglass lenses, and lens treatments not listed are not covered.</td><td colspan="2">You pay $0 for <u>either</u> one pair of eyeglass frames and eyeglass lenses (up to a maximum plan benefit coverage amount of $70 OR for contact lenses (up to a maximum plan benefit coverage amount of $105 for contact lens services and materials) every 2 years. The benefits are the same whether you use an in-network or out-of-network provider.</td></tr>
</table>

Notes:

- Prior authorization (approval in advance) is NOT required.

- Benefits are combined for in and out-of-network.
- Services do not apply to the plan's maximum out-of-pocket limit.
- Since Blue Shield of California contracts with Medicare each year, these vision benefits may not be available next year.

Visiting Your Vision Care Provider

Call any in- or out-of-network licensed ophthalmologist, optometrist, or optician to make an appointment, including such providers outside of California when available. Prior to service, the Member should consult their benefit information for coverage details.

This vision plan is specifically designed for you to use network vision care providers. A list of network providers located in your area can be obtained online at **blueshieldca.com/find-a-doctor** or by contacting the VPA customer service department at **(800)-877-7195**.

Payment to In-Network Providers

Blue Shield Group Medicare Advantage will pay for Covered Services rendered by in-network providers up to the allowance.

Payment to Out-of-Network Providers

You or your provider must submit a completed claim form to the VPA. Call the VPA customer service department at **(800) 877-7195** to request a reimbursement form and for more information on requesting a reimbursement.

General exclusions for the vision plan

1. Orthoptics or vision training.
2. Replacement or repair of lost or broken lenses, contact lenses, or frames except as provided under this plan.
3. An eye examination required by an employer as a condition of employment.
4. Medical or surgical treatment of the eyes.
5. Artistically painted lenses.
6. Plano (non-prescription) lenses.

7. Services for or incident to any injury arising out of, or in the course of any employment for salary, wage or profit if such injury or disease is covered by workers' compensation law, occupational disease law or similar legislation. However, if Blue Shield provides payment for such services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield for the treatment of the injury or disease.

8. Services required by any government agency or program, Federal, state, or subdivision thereof.

9. Services and materials for which the Member is not legally obligated to pay, or services or materials for which no charge is made to the Member.

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

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

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

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we made not to cover a medical service, go to Chapter 7, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances Additional coverage as described in the Medical Benefit Chart earlier in this chapter.
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance

Services not covered by Medicare	Covered only under specific conditions
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	Not covered under any condition
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan (Go to Chapter 3, Section 5 for more information on clinical research studies)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Home-delivered meals	Coverage as described in the Medical Benefit Chart earlier in this chapter.
Home health services	Medicare covers medically necessary part-time or intermittent skilled nursing care.
Homemaker services include basic household help, including light housekeeping or light meal preparation.	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease
Personal items in your room at a hospital or a skilled nursing	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
facility, such as a telephone or a television	
Private room in a hospital	Covered only when medically necessary
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered Additional coverage as described in the Medical Benefit Chart earlier in this chapter.
Routine dental care, such as cleanings, fillings, or dentures	Covered only if you have enrolled in the optional supplemental dental PPO/vision plan for an additional plan premium.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. Additional coverage as described in the Medical Benefit Chart earlier in this chapter.
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes) Additional coverage as described in the Medical Benefit Chart earlier in this chapter.
Routine hearing exams, hearing aids, or exams to fit hearing aids	Medicare covers diagnostic hearing exams and balance exams if ordered by a physician. Additional coverage as described in the Medical Benefit Chart earlier in this chapter.
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

CHAPTER 5:
Asking us to pay our share of a bill for covered medical services

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

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

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

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

1. **When you got medical care from a provider who isn't in our plan's network**

   When you get care from a provider who is not part of our network, you're only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill our plan for our share of the cost.

   - Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.

- You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
  - If the provider is owed anything, we'll pay the provider directly.
  - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.
- While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you'll be responsible for the full cost of the services you got.

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

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

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

3. If you're retroactively enrolled in our plan

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

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

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

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

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

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

- You don't have to use the form, but it'll help us process the information faster.
- Download a copy of the form from our website (**blueshieldca.com**) or call Customer Service at **(888) 802-4599** (TTY users call **711**) and ask for the form.

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

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

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

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

- If we decide the medical care is covered and you followed all the rules, we'll pay for our share of the cost. If you already paid for the service, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service yet, we'll mail the payment directly to the provider.
- If we decide the medical care is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision.

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

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For details on how to make this appeal, go to Chapter 7.

CHAPTER 6:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Service at **(888) 802-4599** (TTY users call **711**).

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007

El Dorado Hills, CA 95762-9007
Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

You have the right to choose a provider in our plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

You have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think you aren't getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

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

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, we're *required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.

- We're required to release health information to government agencies that are checking on quality of care.
- Because you're a member of our plan through Medicare, we're required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we'll work with your health care provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your protected health information, call Customer Service at **(888) 802-4599** (TTY users call **711**).

We are always committed to protecting the privacy of your protected health information. Our Notice of Privacy Practices describes both your privacy rights as a member and how we protect your protected health information. To obtain a copy of our privacy notice, you can:

1. Go to blueshieldca.com and click the Privacy link at the bottom of the homepage and print a copy.
2. Call the Customer Service phone number on your Blue Shield member ID card to request a copy.
3. Call the Blue Shield of California Privacy Office toll-free at (888) 266-8080. 8 a.m. to 3p.m. PT, Monday through Friday. TTY users call 711.
4. Email us at: privacy@blueshieldca.com

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

As a member of Blue Shield Group Medicare Advantage, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Customer Service at **(888) 802-4599** (TTY users call **711**):

- **Information about our plan**. This includes, for example, information about our plan's financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

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

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

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

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

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

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

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

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

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Customer Service at **(888) 802-4599** (TTY users call **711**) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.**
  Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

- The hospital will ask whether you signed an advance directive form and whether you have it with you.

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

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the appropriate state-specific agency. See **Exhibit 2** at the end of this document for contact information.

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

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do —ask for a coverage decision, make an appeal, or make a complaint — **we're required to treat you fairly**.

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

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

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

- **Call Customer Service at (888) 802-4599 (TTY users call 711)**
- **Call your local SHIP.** For details, go to **Exhibit 1** at the end of this document.
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Customer Service at (888) 802-4599 (TTY users call 711)**
- **Call your local SHIP**. For details, go to **Exhibit 1** at the end of this document.
- **Contact Medicare**
  - Visit Medicare.gov to read the publication *Medicare Rights & Protections* (available at Medicare Rights & Protections)
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Customer Service at **(888) 802-4599** (TTY users call **711**).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverag*e to learn what's covered and the rules you need to follow to get covered services.
    - Chapters 3 and 4 give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
    - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
    - You must pay your plan premiums, if applicable.
    - You must continue to pay your Medicare Part B premiums to stay a member of our plan.
    - For some of your medical services covered by our plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you**.**
- **If you move *outside* of our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

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

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

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

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says, making a complaint rather than filing a grievance, coverage decision rather than organization determination and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Customer Service at **(888) 802-4599** (TTY users call **711**) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

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

The services of SHIP counselors are free. You will find phone numbers and website URLs in **Exhibit 1** at the end of this document.

Medicare

You can also contact Medicare for help:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit Medicare.gov

SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read parts of this chapter that apply to your situation. The guide that follows will help.

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

Yes.

Go to **Section 4, A guide to the basics of coverage decisions and appeals.**

No.

Go to **Section 9**, **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You may use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover a medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** of this chapter for more information about Level 2 appeals for medical care.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Customer Service at (888) 802-4599 (TTY users call 711)**
- **Get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Customer Service at **(888) 802-4599** (TTY users call **711**) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at **blueshieldca.com/apptofrep**.)

  - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or another person to be your representative, call Customer Service at **(888) 802-4599** (TTY users call **711**) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at **blueshieldca.com/apptofrep**.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
  - We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for your different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines We give the details for each one of these situations in this chapter:

- **Section 5**: Medical care: How to ask for a coverage decision or make an appeal
- **Section 6**: How to ask us to cover a longer inpatient hospital stay if you think you're being discharged you too soon
- **Section 7**: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Customer Service at **(888) 802-4599** (TTY users call **711**). You can also get help or information from your SHIP.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to ask for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an Appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an Appeal. Section 5.3.**

   Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 6 and 7 of this Chapter. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination.**

A fast coverage decision is called an **expedited determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may *only ask* for coverage for medical care items and/or services (not requests for payment for items and/or services you already got).
- You can get a fast coverage decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains that you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 9 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 9 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration**.

A fast appeal is also called an **expedited reconsideration.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a *fast appeal* are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal, and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
    - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
    - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 of this chapter for information on complaints.)
    - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Section 5.4 The Level 2 appeal process

Legal Term:

The formal name for the independent review organization is the **Independent Review Entity.** It's sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.

- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you their answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we get the decision from the independent review organization for **standard requests.** For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization**.**
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter:
    - Explains the decision.
    - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
    - Tells you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay you for our share of a bill you got for medical care

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this coverage decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care is not covered, or you did not follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you have already received and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

Section 6.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Service at **(888) 802-4599** (TTY users call **711**) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns, you have about the quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.
2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. **Keep your copy** of the notice so you'll have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Customer Service at **(888) 802-4599** (TTY users call **711**) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 6.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call Customer Service at **(888) 802-4599** (TTY users call **711**). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an *immediate* review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline,** you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
    - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service at **(888) 802-4599** (TTY users call **711**) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048.) Or you can get a sample notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the independent review organization says *no*, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to *Level 2* of the appeals process.

Section 6.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it's medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 7.1 We'll tell you in advance when your coverage will be ending

Legal Term:

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal.** Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we'll stop covering the care for you.
   - How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 7.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call Customer Service at **(888) 802-4599** (TTY users call **711**). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the federal government to check on and improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-*Coverage) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, **you'll have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – <u>and</u> you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 7.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Levels 3, 4, and 5

Section 8.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way at the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
    - If you decide to accept the decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
    - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making complaints

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Service? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at our plan? o Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Complaint	Example
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms:

A **complaint** is also called a **grievance**.

Making a complaint is called **filing a grievance**.

Using the process for complaints is called **using the process for filing a grievance**.

A **fast complaint** is called an **expedited grievance**.

Step 1: Contact us promptly – either by phone or in writing.

- **Calling Customer Service at (888) 802-4599 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Customer Service will let you know.
- **If you don't want to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- Here's how it works:

- Step 1: File a Grievance

  To begin the process, call a Customer Service representative within 60 calendar days of the event and ask to file a grievance. You may also file a grievance by fax or in writing within 60 calendar days of the event by sending it to:

  Blue Shield Group Medicare Advantage
  Appeals & Grievances Department
  P.O. Box 927, Woodland Hills CA 91365-9856
  FAX: (916) 350-6510

  You may also call us to request a **Blue Shield Group Medicare Advantage Appeals & Grievance Form (**use of this form is optional).

  We will send you a letter within 5 calendar days letting you know that we received the notice of your concern. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

  If you ask for an *expedited grievance* because we decided not to give you a *fast decision* or *fast appeal* or because we asked for an extension on our initial decision or fast appeal, we will forward your request to a medical director who was not involved in our original decision. We may ask if you have additional information that was not available at the time you requested a *fast initial decision* or *fast appeal*.

  The medical director will review your request and decide if our original decision was appropriate. We will send you a letter with our decision within 24 hours of your request for an *expedited grievance*.

- **Step 2: Grievance Hearing**
  If you are not satisfied with the resolution of your grievance related to a quality of care issue, you may make a written request to the Blue Shield Medicare Appeals & Grievances Department for a grievance hearing. Within 31 calendar days of your written request being received, we will assemble a panel to hear your case. You will be invited to attend the hearing, which includes an uninvolved medical director and a representative from the Appeals and Grievance Resolution Department. You may attend in person or by teleconference. After the hearing, we will send you a final resolution letter.

If you are not satisfied with the resolution of your grievance that does not include a quality of care issue, such as waiting time, disrespect, Customer Service or cleanliness, you may contact the Blue Shield Medicare Customer Service department to request an additional review.

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours.**
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization**. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about Blue Shield Group Medicare Advantage directly to Medicare. To submit a complaint to Medicare, go to Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 8:
Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in Blue Shield Group Medicare Advantage may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care, and you'll continue to pay your cost share until your membership ends.

In the event you choose to end your membership in our plan, re-enrollment may not be permitted, or you may have to wait until your Plan Sponsor's next Open Enrollment Period. You should consult with your Plan Sponsor regarding the availability of other coverage prior to ending your plan membership outside of your Plan Sponsor's Open Enrollment Period. It is important to understand your Plan Sponsor's eligibility policies, and the possible impact to your retiree health care coverage options and other retirement benefits before submitting your request to end your membership in our plan.

Enrollment in this plan is generally for the entire year, however, you may leave the plan at any time of the year.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

When is your Plan Sponsor's Open Enrollment Period? Your Plan Sponsor will let you know when your Open Enrollment Period begins and ends, what plan choices are available to you, and the effective date of coverage. In addition to your Plan Sponsor's Open Enrollment

Period, you may also make a change to your health coverage during the Annual Enrollment Period from October 15 to December 7. If you elect to enroll in a product that has a prescription drug plan, you will be disenrolled from this plan.

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.

Section 2.2 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Customer Service at (888) 802-4599 (TTY users call 711)**
- Find the information in the ***Medicare & You 2027*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan. Reach out to your Plan Sponsor prior to making any changes.

To switch from our plan to:	Here's what to do:
Another Medicare health plan, using your Plan Sponsor's open enrollment period.	• Enroll in the new Medicare health plan during your Plan Sponsor's open enrollment period. • You'll automatically be disenrolled from the Blue Shield Group Medicare Advantage Plan and Blue Shield of California Medicare Rx Plan (PDP) when your new plan's coverage starts.
Another Medicare health plan	• Contact your Plan Sponsor to discuss options available to you. • Enroll in the new Medicare health plan. • You'll automatically be disenrolled from the Blue Shield Group Medicare Advantage and Blue Shield of California Medicare Rx Plan (PDP) when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan	• Contact your Plan Sponsor to discuss options available to you.

	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from the Blue Shield Group Medicare Advantage plan and Blue Shield of California Medicare Rx Plan (PDP) when your new plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan	• Contact your Plan Sponsor to discuss options available to you. • **Send us a written request to disenroll.** Contact Customer Service at **(888) 802-4599** (TTY users call **711**) if you need more information on how to do this. • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from the Blue Shield Group Medicare Advantage plan and Blue Shield of California Medicare Rx Plan (PDP) when your new plan's coverage starts.

Note: In accordance with your Plan Sponsor's requirements, if your enrollment in Blue Shield Group Medicare Advantage ends, your Plan Sponsor will also disenroll you from the Blue Shield of California Medicare Rx Plan (PDP). If this happens, and you go 63 days or more in a row without Medicare drug coverage that is creditable, you may have to pay a Medicare Part D late enrollment penalty.

SECTION 4 Until your membership ends, you must keep getting your medical items and services through our plan

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical items services through our plan.

- **Continue to use our network providers to get medical care.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 Blue Shield Group Medicare Advantage must end your plan membership in certain situations

Blue Shield Group Medicare Advantage must end your membership in our plan if any of the following happen:

- If we are notified that you no longer meet the eligibility requirements of your Plan Sponsor.
- If your Plan Sponsor's contract with us is terminated.
- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you're away from our service area for more than 6 months.
    - If you move or take a long trip, call Customer Service at **(888) 802-4599** (TTY users call **711**) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or national, or an eligible noncitizen
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

If you have questions or want more information on when we can end your membership, call Customer Service at **(888) 802-4599** (TTY users call **711**).

Section 5.1 We <u>can't</u> ask you to leave our plan for any health-related reason

Blue Shield Group Medicare Advantage isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9:
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call Customer Service at **(888) 802-4599** (TTY users call **711**). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Blue Shield Group Medicare Advantage, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Administration of the Evidence of Coverage

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this *Evidence of Coverage*.

SECTION 5 Member cooperation

You must complete any applications, forms, statements, releases, authorizations, lien forms and any other documents that we request in the normal course of business or as specified in this *Evidence of Coverage*.

SECTION 6 Assignment

You may not assign this *Evidence of Coverage* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

SECTION 7 Government agency responsibility

For any services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such services we may recover the value of the services from the government agency.

SECTION 8 U.S. Department of Veterans Affairs

For any services for conditions that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such services we may recover the value of the services from the Department of Veterans Affairs.

SECTION 9 Workers' compensation or employer's liability benefits

You may be eligible for payments or other benefits under workers' compensation or employer's liability law. We may recover the value of any Covered Services from the following sources:

1. From any source providing benefits or from whom a benefit is due.

2. From you, to the extent that a benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the benefits under any workers' compensation or employer's liability law.

SECTION 10 Overpayment recovery

We may recover any overpayment that we make for services from anyone who receives such an overpayment or from any person or organization obligated to pay for the services.

SECTION 11 When a third party causes your injuries

If you are injured or becomes ill due to the act or omission of another person (a *third party*), Blue Shield shall, with respect to services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement or other available remedy to recover the amounts Blue Shield paid for services provided to you from any recovery (defined below) obtained by or on behalf of you, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

This right to restitution, reimbursement or other available remedy is against any recovery you receive as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the *Recovery*), without regard to whether you have been made whole by the Recovery. The right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due for the Benefits paid in connection with such injury or illness, calculated in accordance with California Civil Code Section 3040.

You are required to:

1. Notify Blue Shield in writing of any actual or potential claim or legal action which you expect to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,

2. Agree to fully cooperate and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and,

3. Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,

4. Provide a lien calculated in accordance with the California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,

5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield, in writing, within ten (10) days after any Recovery has been obtained.

Your failure to comply with 1. through 5., above shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield.

SECTION 12 Reporting Fraud, Waste, and Abuse

What is fraud, waste, and abuse (FWA)?

- **Fraud** is an intentional misrepresentation that may result in unauthorized costs to a healthcare program.
- **Waste** is the inappropriate use of healthcare funds or resources without a justifiable need to do so.
- **Abuse** is a practice that is inconsistent with sound medical or business practices that may directly or indirectly result in unnecessary costs to a healthcare program.

Protect yourself and your benefits

- Never give out your Social Security, Medicare or health plan numbers or banking information to someone you don't know.
- Do not consent to any lab tests without your doctor's order.
- It is illegal to accept anything of value in exchange for medical services.

Be aware of genetic testing fraud

Scammers approach unsuspecting enrollees at local health fairs, senior housing facilities, community centers, home health agencies, and other trustworthy locations to carry out genetic testing fraud. They falsely promise that Medicare will pay for the test, and you simply need to provide a cheek swab, your ID, and Medicare information in order to receive your test results.

Unfortunately, now these scammers have your health plan or Medicare number, and they can bill Medicare thousands of dollars for tests or even services that you never receive. They also have your personal genetic information.

To report suspected fraud, waste, and abuse, please contact:

- **Blue Shield of California's Medicare fraud hotline: (855) 331-4894 (TTY: 711)** or via email: MedicareStopFraud@blueshieldca.com.

- **Medicare at 1-800 MEDICARE (1-800-633-4227),** 24 hours a day, seven days a week (TTY users call 1-877-486-2048.
- **Medicare at 1-800 MEDICARE (1-800-633-4227),** 24 hours a day, seven days a week (TTY users call 1-877-486-2048).

SECTION 13 Medicare Advantage Disclosure

- **Member Liability Calculation**
  When you receive covered healthcare services outside of our service area from a Medicare Advantage PPO network provider, the cost of the service, on which member liability (copayment/coinsurance) is based, will be either:

  - The Medicare allowable amount for covered services; or

  - The amount the local Blue Medicare Advantage plan negotiates with its provider on behalf of our members. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

- **Non-participating Health Care Providers Outside Our Service Area**
  When covered healthcare services are provided outside of our service area by non-participating healthcare providers, the amount(s) you pay for such services will be based on either Medicare's limiting charge where applicable or the provider's billed charge. Payments for out-of-network emergency services will be governed by applicable federal and state law.

In these above instances the service area refers to the geographic area that we are licensed to sell the Blue brand.

CHAPTER 10: Definitions

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of Blue Shield Group Medicare Advantage, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Benefit Period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. For Inpatient Hospital Care, Medicare-defined hospital benefit periods do not apply. For inpatient hospital care, the cost-sharing described in the Medical Benefits Chart in Chapter 4 applies each time you are admitted to the hospital. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rule.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services.

Combined Maximum Out-of-Pocket Amount – This is the most you'll pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. Go to Chapter 4, Section 1 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are gotten. (This is in addition to our plan's monthly premium, if applicable.) Cost sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services are covered; 2) any fixed copayment amount that a plan requires when a specific service is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is gotten.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Grievance – A type of complaint you make about our plan or providers including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you've been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Open Enrollment Period – The time period that your Plan Sponsor sets when members can change their health or drug plans or switch to Original Medicare. Please contact your Plan Sponsor for specific details.

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and aren't included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits to get them.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services gotten is also referred to as the member's out-of-pocket cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – See Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Preferred Provider Organization (PPO) plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services gotten from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services – Health care services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling, and education to help you take care of your own health.

Primary Care Physician (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get covered services based on specific criteria. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you don't need prior authorization to get out-of-network services. However, you may want to check with our plan before getting services from out-of-network providers to confirm that the service is covered by our plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

Prosthetics and Orthotics –Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

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

EXHIBIT 1: State Health Insurance Assistance Programs (SHIP) – Contact Information

Alabama | State Health Insurance Assistance Program (SHIP) 201 Monroe St., RSA Tower, Suite 350, Montgomery, AL 36130 https://alabamaageline.gov/	1-800-243-5463 TTY 711
Alaska | Medicare Information Office – Alaska Department of Health & Social Services 400 Gambell St., Suite 303, Anchorage, AK 99501 https://health.alaska.gov/en/senior-and-disabilities-services/medicare-office/	1-800-478-6065 TTY 711
Arizona | State Health Insurance Assistance Program (SHIP) 1789 W. Jefferson, Site Code MD6288, Phoenix, AZ 85007 https://azship.org/	1-800-432-4040 TTY 711
Arkansas | Senior Health Insurance Information Program (SHIIP) #1 Commerce Way, Suite 102, Little Rock, AR 72202 https://insurance.arkansas.gov/consumer-assistance/medicare-resources/shiip/	1-800-224-6330 TTY 711
California | Health Insurance Counseling & Advocacy Program (HICAP) 1300 National Dr., Suite 200, Sacramento, CA 95834 https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/	1-800-434-0222 TTY 711
Colorado | Senior Health Insurance Assistance Program (SHIP) 1560 Broadway, Suite 850, Denver, CO 80202 https://doi.colorado.gov/types-of-insurance/health-insurance/senior-health-care-medicare	1-888-696-7213 TTY 711
Connecticut | Connecticut Health Insurance Assistance, Outreach, Information and Referral, Counseling, and Eligibility Screening (CHOICES) 55 Farmington Ave., 12th Floor, Hartford, CT 06105 https://portal.ct.gov/ads/programs-and-services/choices	1-800-994-9422 TTY 711
Delaware | Delaware Medicare Assistance Bureau 1351 W. North St., Suite 101, Dover, DE 19904 https://insurance.delaware.gov/divisions/dmab/	1-800-336-9500 TTY 711

District of Columbia | DC SHIP 500 K St. NE, Washington, DC 20002 https://dacl.dc.gov/service/health-insurance-counseling	1-202-727-8370 TTY 711
Florida | Serving Health Insurance Needs of Elders (SHINE) 4040 Esplanade Way, Suite 280-S, Tallahassee, FL 32399 https://www.floridashine.org/	1-800-963-5337 TTY 711
Georgia | Georgia SHIP 2 Peachtree St. NW, Suite 33-101, Atlanta, GA 30303 https://aging.georgia.gov/georgia-ship	1-866-552-4464 TTY 711
Guam | Guam Medicare Assistance Program (GUAM MAP) 130 University Dr., University Castle Mall, Mangilao, GU 96913 https://dphss.guam.gov/	1-671-735-7415 TTY 711
Hawaii | Hawaii SHIP 250 S. Hotel St., Suite 406, Honolulu, HI 96813 https://www.hawaiiship.org/	1-888-875-9229 TTY 711
Idaho | Senior Health Insurance Benefits Advisors (SHIBA) 700 W. State St., 3rd Floor, Boise, ID 83720 https://doi.idaho.gov/SHIBA/	1-800-247-4422 TTY 711
Illinois | Senior Health Insurance Program (SHIP) One Natural Resources Way, Suite 100, Springfield IL 62702 https://ilaging.illinois.gov/ship	1-800-252-8966 TTY 711
Indiana | State Health Insurance Assistance Program (SHIP) 311 W. Washington St., 2nd Floor, Indianapolis, IN 46204 https://www.in.gov/ship/	1-800-452-4800 TTY 711
Iowa | Senior Health Insurance Information Program (SHIIP) Two Ruan Center, 601 Locust, 4th Floor, Des Moines, IA 50309 https://shiip.iowa.gov/	1-800-351-4664 TTY 711
Kansas | Senior Health Insurance Counseling for Kansas (SHICK) 503 S. Kansas Ave., Topeka, KS 66603 https://www.kdads.ks.gov/services-programs/aging/medicare-programs/senior-health-insurance-counseling-for-kansas-shick	1-800-860-5260 TTY 711
Kentucky | State Health Insurance Assistance Program (SHIP) 275 E. Main St., 3E-E, Frankfort, KY 40621 https://www.chfs.ky.gov/agencies/dail/Pages/ship	1-877-293-7447 TTY 711
Louisiana | Senior Health Insurance Information Program (SHIIP) P.O. Box 94214, Baton Rogue, LA 70804 https://www.ldi.la.gov/consumers/senior-health-shiip	1-800-259-5300 TTY 711
Maine | State Health Insurance Assistance Program (SHIP) 109 Capitol St., 11 State House Station, Augusta, ME 04333 https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance	1-800-262-2232 TTY 711

Maryland | State Health Insurance Assistance Program (SHIP) 301 W. Preston St., Room 1007, Baltimore, MD 21201 https://aging.maryland.gov/programs-and-services/medicare-support/state-health-insurance-assistance-program	1-800-243-3425 TTY 711
Massachusetts | Serving the Health Insurance Needs of Everyone (SHINE) 1 Ashburton Pl., 5th Floor, Boston, MA 02108 https://www.mass.gov/orgs/executive-office-of-aging-independence-age	1-800-243-4636 TTY 711
Michigan | MI Options 400 S. Pine St., 6th Floor, Lansing, MI 48913 https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program	1-800-803-7174 TTY 711
Minnesota | State Health Insurance Assistance Program/Senior LinkAge Line 540 Cedar St., P.O. Box 64976, St. Paul, MD 55164 https://mn.gov/aging-pathways/medicare/	1-800-333-2433 TTY 711
Mississippi | State Health Insurance Assistance Program (SHIP) 750 N. State St., Jackson, MS 39202 https://www.mdhs.ms.gov/post/navigating-medicare-made-easy-with-ship	1-844-822-4622 TTY 711
Missouri | Missouri SHIP 601 W. Nifong Blvd., Suite 3A, Columbia, MO 65203 https://www.missouriship.org	1-800-390-3330 TTY 711
Montana | State Health Insurance Assistance Program (SHIP) P.O. Box 4210, Helena, MT 59604 https://dphhs.mt.gov/sltc/aging/ship	1-406-444-4077 TTY 711
Nebraska | Nebraska SHIP P.O. Box 95087, Lincoln, NE 68509 https://doi.nebraska.gov/nebraska-ship-smp	1-800-234-7119 TTY 711
Nevada | Nevada Medicare Assistance Program (MAP) 3320 W. Sahara Ave., Suite 100, Las Vegas, NV 89102 https://www.adsd.nv.gov/programs/aging-services-medicare-assistance-program	1-800-307-4444 TTY 711
New Hampshire | NH SHIP – ServiceLink Resource Center 105 Pleasant St., Gov. Gallan State Office Park South, Concord, NH 03301 https://www.dhhs.nh.gov/programs-services/adult-aging-care/aging-and-disability-resource-centers	1-866-634-9412 TTY 711
New Jersey | State Health Insurance Assistance Program (SHIP) P.O. Box 807, Trenton, NJ 08625 https://www.nj.gov/humanservices/doas/services/q-z/ship/	1-800-792-8820 TTY 711

New Mexico | New Mexico ADRC-SHIP 2550 Cerrillos Rd., Santa Fe, NM 87505 https://www.aging.nm.gov/consumer-and-elder-rights/medicare/ship-and-smp-volunteer-program/	1-800-432-2080 TTY 711
New York | Health Insurance Information Counseling and Assistance Program (HIICAP) Two Empire State Plaza Agency Building #2 https://aging.ny.gov/health-insurance-information-counseling-and-assistance-programs	1-800-701-0501 TTY 711
North Carolina | Seniors' Health Insurance Information Program (SHIIP) 1201 Mail Service Center, Raleigh, NC 27699 https://www.ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip	1-855-408-1212 TTY 711
North Dakota | Senior Health Insurance Counseling (SHIC) 600 East Blvd., Department 401, Bismarck, ND 58505 https://www.insurance.nd.gov/consumers/medicare	1-888-575-6611 TTY 711
Ohio | Ohio Senior Health Insurance Information Program (OSHIIP) 50 W. Town St., 3rd Floor, Suite 300, Columbus, OH 43215 https://insurance.ohio.gov/consumers/medicare/01-oshiip	1-800-686-1578 TTY 711
Oklahoma | Oklahoma Medicare Assistance Program (MAP) 400 NE 50th St., Oklahoma City, OK 73105 https://www.oid.ok.gov/consumers/information-for-seniors/senior-health-insurance-counseling-program-ship/	1-800-763-2828 TTY 711
Oregon | Senior Health Insurance Benefits Assistance (SHIBA) 350 Winter St. NE, Room 330, Salem, OR 97309 https://shiba.oregon.gov	1-800-722-4134 TTY 711
Pennsylvania | Pennsylvania Medicare Education and Decision Insight (PA MEDI) 555 Walnut St., 5th Floor, Harrisburg, PA 17109 https://www.pa.gov/agencies/aging/aging-programs-and-services/pa-medi-medicare-counseling	1-800-783-7067 TTY 711
Puerto Rico | State Health Insurance Assistance Program (SHIP) P.O. Box 191179, San Juan, PR 00919 https://www.oppea.pr.gov/programas-y-servicios	1-877-725-4300 TTY 711
Rhode Island | Senior Health Insurance Program (SHIP) 25 Howard Ave., Building 57, Cranston, RI 02920 https://oha.ri.gov/Medicare	1-888-884-8721 TTY 711

South Carolina | Insurance Counseling Assistance and Referrals for Elders (I-CARE) 1301 Gervais St., Suite 350, Columbia, SC 29201 https://aging.sc.gov/programs-initiatives/medicare-and-medicare-fraud	1-800-868-9095 TTY 711
South Dakota | Senior Health Insurance & Insurance Education (SHIINE) 700 Governors Dr., Pierre, SD 57501 https://dhs.sd.gov/en/ltss/shiine	1-800-536-8197 TTY 711
Tennessee | TN SHIP Andrew Jackson Bldg., 502 Deaderick St., 9th Floor, Nashville, TN 37243 https://tnmedicarehelp.com	1-877-801-0044 TTY 711
Texas | Department of Aging and Disability Services (HICAP) 701 W. 51st St., MC: W275, Austin, TX 78751 https://www.hhs.texas.gov/services/health/medicare	1-800-252-9240 TTY 711
U.S. Virgin Islands | Virgin Islands State Health Insurance Assistance Program (VISHIP) 4007 Estate Diamond Ruby, 1st Floor, Cristiansted, VI 00820 https://ltg.gov.vi/departments/vi-ship-medicare/	1-344-774-2991 TTY 711
Utah | Senior Health Insurance Information Program (SHIP) 195 N. 1950 West, Salt Lake City, UT 84116 https://daas.utah.gov/seniors/	1-800-541-7735 TTY 711
Vermont | State Health Insurance Assistance Program 476 Main St., Suite 3, Winooski, VT 05404 https://vermont4a.org/medicare-information	1-800-642-5119 TTY 711
Virginia | Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forest Ave., Henrico, VA 23229 https://dars.virginia.gov/aging/home-community/medicare-counseling/	1-800-552-3402 TTY 711
Washington | Statewide Health Insurance Benefits Advisor (SHIBA) 5000 Capitol Blvd., Tumwater, WA 98504 https://www.insurance.wa.gov/insurance-resources/medicare/get-free-medicare-help-shiba	1-800-562-6900 TTY 711
West Virginia | West Virginia State Health Insurance Assistance Program (WV SHIP) 1900 Kanawha Blvd. East, 3rd Floor Town Center Mall, Charleston, WV 25305 http://www.wvship.org/	1-877-987-4463 TTY 711

Wisconsin | WI State Health Insurance Assistance Program (SHIP) 1 W. Wilson St., Room 551, P.O. Box 7851, Madison, WI 53707 https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling	1-800-242-1060 TTY 711
Wyoming | Wyoming State Health Insurance Information Program (WSHIIP) 106 W. Adams Ave., Riverton, WY 82501 https://www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program	1-800-856-4398 TTY 711

EXHIBIT 2: Quality Improvement Organizations (QIO) – Contact Information

Alabama | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0751 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Alaska | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com https://www.commencehealthqio.cms.gov	1-888-305-6759 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
American Samoa | Commence Health BFCC-QIO Program BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-877-588-1123 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Arizona | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-877-588-1123 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Arkansas | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-315-0636 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
California | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-877-588-1123 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Colorado | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0891 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Connecticut | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-319-8452 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Delaware | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-396-4646 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays

District of Columbia | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-396-4646 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Florida | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0751 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Georgia | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0751 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Guam | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-877-588-1123 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Hawaii | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-877-588-1123 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Idaho | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-305-6759 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Illinois | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-524-9900 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Indiana | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-524-9900 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Iowa | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-755-5580 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Kansas | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-755-5580 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays

Kentucky | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0751 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Louisiana | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-315-0636 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Maine | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-319-8452 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Maryland | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-396-4646 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Massachusetts | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-319-8452 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Michigan | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-524-9900 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Minnesota | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-524-9900 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Mississippi | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0751 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Missouri | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-755-5580 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Montana | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0891 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays

Nebraska | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-755-5580 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Nevada | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-877-588-1123 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
New Hampshire | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-319-8452 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
New Jersey | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-866-815-5440 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
New Mexico | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-315-0636 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
New York | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-866-815-5440 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
North Carolina | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0751 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
North Dakota | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0891 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Northern Mariana Islands | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-877-588-1123 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Ohio | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-524-9900 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays

Oklahoma | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-315-0636 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Oregon | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-305-6759 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Pennsylvania | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-396-4646 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Puerto Rico | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-866-815-5440 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Rhode Island | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-319-8452 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
South Carolina | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0751 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
South Dakota | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0891 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Tennessee | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0751 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Texas | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-315-0636 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
U.S. Virgin Islands | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-866-815-5440 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays

Utah | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0891 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Vermont | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-319-8452 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
Virginia | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-396-4646 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Washington | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-305-6759 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays
West Virginia | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-396-4646 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Wisconsin | Commence Health BFCC-QIO Program P.O. Box 2687, Virginia Beach, VA 23454 https://www.commencehealthqio.cms.gov	1-888-524-9900 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 4 p.m. weekends and holidays
Wyoming | Acentra Health BFCC-QIO Program 1650 Summit Lake Dr., Suite 102, Tallahassee, FL 32317 https://acentraqio.com	1-888-317-0891 (TTY 711) 9 a.m. to 5 p.m. weekdays 10 a.m. to 5 p.m. weekends and holidays

EXHIBIT 3: Medicaid – Contact Information

Alabama | Alabama Medicaid https://medicaid.alabama.gov/	1-800-362-1504 TTY 711
Alaska | Department of Health, Division of Public Assistance (DPA) Services https://health.alaska.gov/en/services/division-of-public-assistance-dpa-services/	1-800-478-7788 TTY 711
American Samoa | American Samoa Medicaid Agency https://www.asmsa.gov	1-684-699-4777 TTY 711
Arizona | Arizona Health Care Cost Containment System (AHCCCS) https://www.azahcccs.gov	1-855-432-7587 TTY 711
Arkansas | Arkansas Medicaid https://humanservices.arkansas.gov/divisions-shared-services/medical-services/contact-dms-2/	1-800-482-5431 TTY 711
California | Department of Health Care Services https://www.dhcs.ca.gov/services/medi-cal-resources/medi-cal-contacts/	1-800-541-5555 TTY 711
Colorado | Health First Colorado https://hcpf.colorado.gov/	1-800-221-3943 TTY 711
Connecticut | Connecticut Medicaid https://www.huskyhealthct.org	1-800-859-9889 TTY 711
Delaware | Delaware Medicaid & Medical Assistance https://dhss.delaware.gov/dmma/	1-866-843-7212 TTY 711
District of Columbia | DC Medicaid https://districtdirect.dc.gov	1-855-532-5465 TTY 711
Florida | Agency for Health Care Administration https://ahca.myflorida.com/medicaid/Information	1-877-254-1055 TTY 711
Georgia | Georgia Medicaid https://dch.georgia.gov/	1-866-211-0950 TTY 711
Guam | Department of Public Health & Social Services (DPHSS) https://dphss.guam.gov/	1-877-548-7669 TTY 711
Hawaii | Department of Human Services https://medquest.hawaii.gov/	1-800-316-8005 TTY 711
Idaho | Department of Health & Welfare https://healthandwelfare.idaho.gov/	1-877-456-1233 TTY 711
Illinois | Department of Healthcare and Family Services https://hfs.illinois.gov/medicalclients	1-800-843-6154 TTY 711
Indiana | Indiana Family and Social Services Administration https://www.in.gov/fssa/dfr/medicaid-health-plans/	1-800-403-0864 TTY 711

Iowa | Department of Human Services https://hhs.iowa.gov/medicaid	1-800-338-8366 TTY 711
Kansas | KanCare https://www.kancare.ks.gov/	1-800-792-4884 TTY 711
Kentucky | Kentucky Cabinet for Health and Family Services https://www.chfs.ky.gov/agencies/dms	1-888-317-0751 TTY 711
Louisiana | Healthy Louisiana https://ldh.la.gov	1-888-342-6207 TTY 711
Maine | Department of Health and Human Services https://www.maine.gov/dhhs/oms	1-855-797-4357 TTY 711
Maryland | Department of Health https://health.maryland.gov/mmcp	1-855-642-8572 TTY 711
Massachusetts | MassHealth https://www.mass.gov/topics/masshealth	1-800-841-2900 TTY 711
Michigan | Department of Health & Human Services https://www.michigan.gov/mdhhs/assistance-programs/medicaid	1-833-599-6444 TTY 711
Minnesota | Department of Human Services https://mn.gov/dhs/	1-800-657-3672 TTY 711
Mississippi | Division of Medicaid https://medicaid.ms.gov/medicaid-coverage/	1-800-421-2408 TTY 711
Missouri | Department of Social Services https://dss.mo.gov/	1-800-348-6627 TTY 711
Montana | Department of Public Health and Human Services https://dphhs.mt.gov	1-800-362-8312 TTY 711
Nebraska | Department of Health and Human Services https://dhhs.ne.gov	1-855-632-7633 TTY 711
Nevada | Department of Health and Human Services https://www.dhs.nv.gov/find-assistance/medical-assistance/	1-877-638-3472 TTY 711
New Hampshire | Department of Health and Human Services https://www.dhhs.nh.gov/programs-services/medicaid	1-844-275-3447 TTY 711
New Jersey | Department of Human Services https://www.nj.gov/humanservices/	1-800-701-0710 TTY 711
New Mexico | Human Services Department https://www.hca.nm.gov/	1-800-283-4465 TTY 711
New York | State Department of Health https://info.nystateofhealth.ny.gov/	1-855-355-5777 TTY 711
North Carolina | North Carolina Medicaid https://medicaid.ncdhhs.gov/	1-888-245-0179 TTY 711
North Dakota | Department of Human Services https://www.hhs.nd.gov/applyforhelp	1-800-755-2604 TTY 711
Northern Mariana Islands | Commonwealth Medicaid Agency https://www.cnmimedicaid.org	1-670-664-4880 TTY 711

Ohio | Department of Medicaid https://medicaid.ohio.gov/	1-800-324-8680 TTY 711
Oklahoma | Oklahoma Health Care Authority https://oklahoma.gov/ohca.html	1-800-987-7767 TTY 711
Oregon | OregONEligibility https://one.oregon.gov/	1-800-699-9075 TTY 711
Pennsylvania | Department of Human Services https://www.pa.gov/agencies/dhs	1-800-692-7462 TTY 711
Puerto Rico | Government of Puerto Rico https://www.medicaid.pr.gov/	1-787-641-4224 TTY 711
Rhode Island | Executive Office of Health and Human Services https://eohhs.ri.gov/	1-855-840-4774 TTY 711
South Carolina | Health Connections Medicaid https://www.scdhhs.gov/	1-888-549-0820 TTY 711
South Dakota | Department of Social Services https://dss.sd.gov/medicaid/	1-800-597-1603 TTY 711
Tennessee | Department of Health https://www.tn.gov/tenncare	1-855-259-0701 TTY 711
Texas | Health and Human Services https://www.hhs.texas.gov/services/health/medicaid-chip	1-800-335-8957 TTY 711
U.S. Virgin Islands | Department of Human Services https://dhs.vi.gov/office-of-medicaid/	1-340-715-6929 TTY 711
Utah | Department of Health - Medicaid https://medicaid.utah.gov/	1-866-435-7414 TTY 711
Vermont | Vermont Health Connect https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action	1-855-899-9600 TTY 711
Virginia | Department of Medical Assistance Services https://www.dmas.virginia.gov/	1-833-522-5582 TTY 711
Washington | Washington State Health Care Authority https://www.hca.wa.gov/	1-800-562-3022 TTY 711
West Virginia | Department of Health and Human Services https://dohs.wv.gov/	1-877-716-1212 TTY 711
Wisconsin | Department of Health Services https://www.dhs.wisconsin.gov/	1-800-362-3002 TTY 711
Wyoming | Department of Healthcare Financing https://health.wyo.gov/healthcarefin/medicaid/	1-855-294-2127 TTY 711

Blue Shield Group Medicare Advantage Customer Service

Method	Customer Service – Contact Information
Call	**(888) 802-4599** Calls to this number are free. 7 a.m. to 8 p.m. PT, seven days a week. Customer Service **(888) 802-4599** (TTY users call **711**) also has free language interpreter services available for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 7 a.m. to 8 p.m. PT, seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
Fax	(877) 251-6671
Write	Blue Shield Group Medicare Advantage P.O. Box 927, Woodland Hills, CA 91365-9856
Website	**blueshieldca.com/calpers**

State Health Insurance Assistance Program (SHIP) The SHIP is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

You can call the SHIP in your state at the number listed in **Exhibit 1** at the end of the *Evidence of Coverage*.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

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Blue Shield of California 6300 Canoga Avenue, Woodland Hills, CA 91367-2555