Important information

About changes to your Medicare drug and health plan

blue california

Blue Shield TotalDual Plan (HMO D-SNP) offered by California Physicians' Service (dba Blue Shield of California)

Annual Notice of Changes for 2023

You are currently enrolled as a member of Blue Shield TotalDual Plan. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at blueshieldca.com/MAPDdocuments2023. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan
    - If you don't join another plan by December 7, 2022, you will stay in Blue Shield TotalDual Plan.
    - To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with Blue Shield TotalDual Plan.
    - Look in section 3.2, page 14 to learn more about your choices.
    - If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Care number at (800) 452-4413 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., seven days a week.
- If you would like to receive your plan materials online, log in to your account at blueshieldca.com/login**,** click *My profile* on the top right under your initials, go to Communication preferences and select "Go paperless" as your delivery preference. If you do not have an account, go to blueshieldca.com/login and click *Create account* and you can select your delivery preference as you create your account.
- This information may be available in a different format, including large print. Please call Customer Care at the number listed above if you need plan information in another format.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Blue Shield TotalDual Plan

- Blue Shield of California is an HMO and an HMO D-SNP plan with a Medicare contract. The plan also has a written agreement with the California Medi-Cal (Medicaid) program to coordinate your Medi-Cal (Medicaid) benefits.
- When this document 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 TotalDual Plan.

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Annual Notice of Changes for 2023
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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Blue Shield TotalDual Plan in several important areas. **Please note this is only a summary of costs**. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0 for your doctor office visits and inpatient hospital stays.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$33.20	$38.90
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit	Primary care visits: $0 per visit Specialist visits: $0 per visit
Inpatient hospital stays	You pay: • $1,556 deductible per benefit period. • $0 copay per day for days 1 to 60 of each benefit period. • $389 copay per day for days 61 to 90 of each benefit period. • $778 copay per “lifetime reserve day” for days 91 to 150 of each benefit period (up to 60 days over your lifetime). • 100% of all costs beyond day 151 of each benefit period. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0.	You pay: • $1,600 deductible per benefit period. • $0 copay per day for days 1 to 60 of each benefit period. • $400 copay per day for days 61 to 90 of each benefit period. • $800 copay per “lifetime reserve day” for days 91 to 150 of each benefit period (up to 60 days over your lifetime). • 100% of all costs beyond day 151 of each benefit period. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0.

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $480 (does not apply to Tier 1 drugs) Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: 25% coinsurance • Drug Tier 3: 25% coinsurance • Drug Tier 4: 25% coinsurance • Drug Tier 5: 25% coinsurance	Deductible: $505 (does not apply to Tier 1 drugs) Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: 25% coinsurance • Drug Tier 3: 25% coinsurance • Drug Tier 4: 25% coinsurance • Drug Tier 5: 25% coinsurance
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$6,700 If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$8,300 If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medi-Cal (Medicaid).)	$33.20	$38.90

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay "out-of-pocket" for the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medi-Cal (Medicaid), very few members ever reach this out-of-pocket maximum.** If you are eligible for **Medi-Cal (Medicaid)** assistance with Part A and Part B copays, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$8,300 Once you have paid $8,300 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are also located on our website at blueshieldca.com/MAPDdocuments2023 for Provider Directories and blueshieldca.com/medpharmacy2023 for Pharmacy Directories. You may also call Customer Care for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2023 Pharmacy Directory to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are a part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Care so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Acupuncture services (non-Medicare covered)	You pay a $0 copay per visit for up to 24 visits per year.	You pay a $0 copay per visit for up to 12 visits per year.
Chiropractic services (non-Medicare covered)	You pay a $0 copay per visit for up to 24 visits per year.	You pay a $0 copay per visit for up to 12 visits per year.

Cost	2022 (this year)	2023 (next year)
Dental services, routine	The Routine Dental Benefits Procedure Chart in Chapter 4, Section 2.1 (below the Medical Benefit Chart) of the EOC shows specific dental procedures covered by the routine dental benefit and what you will pay for those procedures. The services listed are covered benefits when provided by an in-network, licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice.	The specific routine dental procedures and what you will pay for those procedures as well as the network of dental providers will change. The dental coverage provided supplements the Medi-Cal Dental Program offered to beneficiaries with full Medi-Cal eligibility. You will be assigned a new in-network dentist. You will be mailed a Dental ID card. You must show the Dental ID card at the time of service. See more information on what is covered in Chapter 4 of your 2023 EOC.

Cost	2022 (this year)	2023 (next year)
Inpatient hospital care	You pay a: • $1,556 deductible per benefit period. • $0 copay per day for days 1 to 60 of each benefit period. • $389 copay per day for days 61 to 90 of each benefit period. • $778 copay per "lifetime reserve day" for days 91 to 150 of each benefit period (up to 60 days over your lifetime). • 100% of all costs beyond day 151 of each benefit period. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0.	You pay a: • $1,600 deductible per benefit period. • $0 copay per day for days 1 to 60 of each benefit period. • $400 copay per day for days 61 to 90 of each benefit period. • $800 copay per "lifetime reserve day" for days 91 to 150 of each benefit period (up to 60 days over your lifetime). • 100% of all costs beyond day 151 of each benefit period. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0.

Cost	2022 (this year)	2023 (next year)
Inpatient mental health care	You pay a: • $1,556 deductible per benefit period. • $0 copay per day for days 1 to 60 of each benefit period. • $389 copay per day for days 61 to 90 of each benefit period. • $778 copay "lifetime reserve day" for days 91 to 150 of each benefit period (up to 60 days over your lifetime). • 100% of all costs after day 150. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copay.	You pay a: • $1,600 deductible per benefit period. • $0 copay per day for days 1 to 60 of each benefit period. • $400 copay per day for days 61 to 90 of each benefit period. • $800 copay "lifetime reserve day" for days 91 to 150 of each benefit period (up to 60 days over your lifetime). • 100% of all costs after day 150. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copay.

Cost	2022 (this year)	2023 (next year)
Skilled nursing facility (SNF) care	You pay a: • $0 copay for days 1 to 20 of each benefit period. • $194.50 copay per day for days 21 to 100 of each benefit period. • 100% of all costs for days 101 and beyond. 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. A benefit period begins the day you go into a hospital or skilled nursing facility (SNF) and ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copay.	You pay a: • $0 copay for days 1 to 20 of each benefit period. • $200 copay per day for days 21 to 100 of each benefit period. • 100% of all costs for days 101 and beyond. 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. A benefit period begins the day you go into a hospital or skilled nursing facility (SNF) and ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay a $0 copay.

Cost	2022 (this year)	2023 (next year)
Vision care, non-Medicare covered (obtained from a network provider)		
Contact lenses or eyeglasses (frames and lenses)	You pay $0 for either contact lenses **OR** for one pair of eyeglasses (frames and lenses) priced up to $300 every year. If you choose contact lenses or eyeglasses (frames and lenses) priced above $300, you are responsible for the difference.	You pay $0 for either contact lenses **OR** for one pair of eyeglasses (frames and lenses) priced up to $295 every year. If you choose contact lenses or eyeglasses (frames and lenses) priced above $295, you are responsible for the difference.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Care for more information.

Changes to Prescription Drug Costs

If you receive "Extra Help" to pay your Medicare prescription drugs, you may qualify for a reduction or elimination of your cost sharing for Part D drugs. Some of the information described

in this section may not apply to you. **Note:** If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2022, please call Customer Care and ask for the "LIS Rider."

There are four "drug payment stages."

The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 2: Generic Drugs, Tier 3: Preferred Brand Drugs, Tier 4: Non-Preferred Drugs and Tier 5: Specialty Tier Drugs until you have reached the yearly deductible.	The deductible is $480 (does not apply to Tier 1: Preferred Generic Drugs). During this stage, you pay $0 cost sharing for drugs on Tier 1 and the full cost of drugs on Tier 2: Generic Drugs, Tier 3: Preferred Brand Drugs, Tier 4: Non-Preferred Drugs and Tier 5: Specialty Tier Drugs until you have reached the yearly deductible. Your deductible amount is either $0 or $99 or $480, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)	The deductible is $505 (does not apply to Tier 1: Preferred Generic Drugs). During this stage, you pay $0 cost sharing for drugs on Tier 1 and the full cost of drugs on Tier 2: Generic Drugs, Tier 3: Preferred Brand Drugs, Tier 4: Non-Preferred Drugs and Tier 5: Specialty Tier Drugs until you have reached the yearly deductible. Your deductible amount is either $0 or $104 or $505, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply; at a network pharmacy that offers preferred cost sharing; or for mail service prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 Preferred Generic Drugs:** You pay $0 per prescription. **Tier 2 Generic Drugs**: You pay 25% of the total cost. **Tier 3 Preferred Brand Drugs**: You pay 25% of the total cost. **Tier 4 Non-Preferred Drugs:** You pay 25% of the total cost. **Tier 5 Specialty Tier Drugs:** You pay 25% of the total cost. Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 Preferred Generic Drugs:** You pay $0 per prescription. **Tier 2 Generic Drugs**: You pay 25% of the total cost. **Tier 3 Preferred Brand Drugs**: You pay 25% of the total cost. **Tier 4 Non-Preferred Drugs:** You pay 25% of the total cost. **Tier 5 Specialty Tier Drugs:** You pay 25% of the total cost. Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Care for more information.

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

SECTION 2 Administrative Changes

Description	2022 (this year)	2023 (next year)
Your Customer Care phone number is changing.	(800) 776-4466 (TTY: 711), 8 a.m. to 8 p.m., seven days a week.	(800) 452-4413 (TTY: 711), 8 a.m. to 8 p.m., seven days a week.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Blue Shield TotalDual Plan

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Blue Shield TotalDual Plan.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, California Physician's Service (dba Blue Shield of California) offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Blue Shield TotalDual Plan.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Blue Shield TotalDual Plan.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Care if you need more information on how to do so.
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

  If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 4 Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2023.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medi-Cal (Medicaid), those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2023, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare and Medi-Cal (Medicaid)

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In California, the SHIP is called Health Insurance Counseling and Advocacy Program (HICAP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. HICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call HICAP at 1-800-434-0222. You can learn more about HICAP by visiting their website (http://www.cahealthadvocates.org/hicap/).

For questions about your Medi-Cal benefits, contact the California Department of Health Care Services/Health Care Options, at 1-800-430-4263 (TTY users should call 1-800-430-7077), 8:00 am to 6:00 pm, Monday thru Friday, except holidays. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

"Extra Help" from Medicare. Because you have Medi-Cal (Medicaid), you are already enrolled in "Extra Help," also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help", call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
- Your State Medi-Cal (Medicaid) Office (applications).

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the ADAP in California. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the California ADAP Call Center at (844) 421-7050, 8 a.m. to 5 p.m., Monday through Friday, or visit their website at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_eligibility.aspx.

SECTION 7 Questions?

Section 7.1 – Getting Help from Blue Shield TotalDual Plan

Questions? We're here to help. Please call Customer Care at (800) 452-4413. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m., seven days a week. Calls to these numbers are free.

Read your *2023 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2023. For details, look in the *2023 Evidence of Coverage* for Blue Shield TotalDual Plan. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at blueshieldca.com/MAPDdocuments2023. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at blueshieldca.com/medicare. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 7.3 – Getting Help from Medi-Cal (Medicaid)

To get information from Medi-Cal (Medicaid) you can call the California Department of Health Care Services/Medi-Cal Managed Care at 1-888-452-8609. TTY users should call 711.

Blue Shield of California 6300 Canoga Avenue, Woodland Hills, CA 91367-2555