

Evidence of Coverage

Your Medicare Health Benefits and Services and
Prescription Drug Coverage as a Member of

January 1 – December 31, 2023

Evidence of Coverage:

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

This document gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2023. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Customer Care at (800) 776-4466 for additional information. (TTY users should call 711). Hours are 8 a.m. to 8 p.m., seven days a week.

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

This document is available for free in Spanish.

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

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2024.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

Blue Shield of California's pharmacy network includes limited lower-cost, preferred pharmacies in California. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call (800) 776-4466 [TTY: 711], 8 a.m. to 8 p.m., seven days a week or consult the online pharmacy directory at blueshieldca.com/medpharmacy2023.

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

- Your plan premium and cost sharing;

- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

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CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1	You are enrolled in Blue Shield 65 Plus, which is a Medicare HMO
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You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Blue Shield 65 Plus. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

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

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.

Section 1.2	What is the <i>Evidence of Coverage</i> document about?
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This *Evidence of Coverage* document tells you how to get your medical care and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words “coverage” and “covered services” refer to the medical care and services and the prescription drugs available to you as a member of Blue Shield 65 Plus.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned, or just have a question, please contact Customer Care.

Section 1.3	Legal information about the <i>Evidence of Coverage</i>
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This *Evidence of Coverage* is part of our contract with you about how Blue Shield 65 Plus covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive 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 months in which you are enrolled in Blue Shield 65 Plus between January 1, 2023 and December 31, 2023.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Blue Shield 65 Plus after December 31, 2023. We can also choose to stop offering the plan in your service area, after December 31, 2023.

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

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States

Section 2.2 Here is the plan service area for Blue Shield 65 Plus

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

Our service area includes these counties in California: San Bernardino County.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Care to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.3 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Blue Shield 65 Plus if you are not eligible to remain a member on this basis. Blue Shield 65 Plus must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:



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

If your plan membership card is damaged, lost, or stolen, call Customer Care right away and we will send you a new card.

Section 3.2 Provider Directory

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

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

The most recent list of providers is available on our website at blueshieldca.com/find-a-doctor.

Chapter 1 Getting started as a member

If you don't have your copy of the *Provider Directory*, you can request a copy from Customer Care.

Section 3.3 Pharmacy Directory

The pharmacy directory lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

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

If you don't have the *Pharmacy Directory*, you can get a copy from Customer Care. You can also find this information on our website at blueshieldca.com/medpharmacy2023.

Section 3.4 The plan's List of Covered Drugs (Formulary)

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in Blue Shield 65 Plus. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Blue Shield 65 Plus Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (blueshieldca.com/medformulary2023) or call Customer Care.

SECTION 4 Your monthly costs for Blue Shield 65 Plus

Your costs may include the following:

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

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for Blue Shield 65 Plus.

Section 4.2	Monthly Medicare Part B Premium
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Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

Section 4.3	Optional Supplemental Benefit Premium
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If you signed up for extra benefits, also called “optional supplemental benefits,” then you pay an additional premium each month for these extra benefits. See Chapter 4, Section 2.2 for details. If you have any questions about your plan premiums, please call Customer Care (phone numbers are printed on the back cover of this document). Blue Shield 65 Plus is offering two optional supplemental dental plans: dental HMO and dental PPO. The monthly premium for the optional supplemental dental HMO plan is \$12.50, and the monthly premium for the optional supplemental dental PPO plan is \$42.30.

Section 4.4	Part D Late Enrollment Penalty
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Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. “Creditable prescription drug coverage” is coverage that meets Medicare’s minimum standards since it is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

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

You **will not** have to pay it if:

- You receive “Extra Help” from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

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- **Note:** Any notice must state that you had “creditable” prescription drug coverage that is expected to pay as much as Medicare’s standard prescription drug plan pays.
- **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then, Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2023, this average premium amount is \$32.74.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times \$32.74, which equals \$4.58. This rounds to \$4.60. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty.**

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don’t have coverage after your initial enrollment period for aging into Medicare.

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

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

Section 4.5	Income Related Monthly Adjustment Amount
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Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit <https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans>.

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

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

SECTION 5	More information about your monthly premium
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Section 5.1	If you pay a Part D late enrollment penalty, there are several ways you can pay your penalty
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There are three ways you can pay the penalty.

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

Option 1: Paying by check

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

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

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

Option 2: Electronic Payments

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

Option 3: Having your Part D late enrollment penalty taken out of your monthly Social Security check

Changing the way you pay your premium. If you decide to change the way you pay your Part D late enrollment penalty, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your part D late enrollment penalty is paid on time. To change your payment method, please call Customer Care at the number on the back of this document.

What to do if you are having trouble paying your Part D late enrollment penalty

Your Part D late enrollment penalty is due in our office by the last day of the month prior to your coverage period month. If we have not received your penalty payment by the last day of the month prior to your coverage month, we will send you a notice telling you that your plan membership will end if we do not receive your Part D late enrollment penalty within a 3-month grace period. If you are required to pay a Part D late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are having trouble paying your Part D late enrollment penalty, if owed, on time, please contact Customer Care to see if we can direct you to programs that will help with your costs.

If we end your membership because you did not pay your Part D late enrollment penalty, if owed, you will have health coverage under Original Medicare. In addition, you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. (If you go without “creditable” drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for the penalty you have not paid. We have the right to pursue collection of the amount you owe. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 9 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your Part D late enrollment

penalty, if owed, within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 9, Section 10 of this document tells how to make a complaint, or you can call us at (800) 776-4466 between 8 a.m. to 8 p.m., seven days a week. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

Section 5.2	Can we change your monthly plan premium during the year?
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No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

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

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

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6	Keeping your plan membership record up to date
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Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Physician/Medical Group/IPA.

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medi-Cal (Medicaid))
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room

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- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in, but we encourage you to do so)

If any of this information changes, please let us know by calling Customer Care.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 7 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Care. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
 - If you're under 65 and disabled and you or your family member is 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 that has more than 100 employees.

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- If you're over 65 and you or your spouse is 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 that 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:

*Important phone numbers
and resources*

SECTION 1 Blue Shield 65 Plus contacts (how to contact us, including how to reach Customer Care)

How to contact our plan's Customer Care

For assistance with claims, billing, or member card questions, please call or write to Blue Shield 65 Plus Customer Care. We will be happy to help you.

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

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions or appeals about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions Medical Care – Contact Information
CALL	(800) 776-4466 Calls to this number are free. 8 a.m. to 8 p.m., 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 with hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m., seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
FAX	(877) 251-6671
WRITE	Blue Shield 65 Plus P.O. Box 927, Woodland Hills, CA 91365-9856
WEBSITE	<u>blueshieldca.com/medicare</u>

How to contact us when you are making an appeal about your medical care or your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care or your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Appeals For Medical Care or Part D Prescription Drugs – Contact Information
CALL	(800) 776-4466 Calls to this number are free. 8 a.m. to 8 p.m., 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.

Method	Appeals For Medical Care or Part D Prescription Drugs – Contact Information
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m., seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
FAX	(916) 350-6510
WRITE	Blue Shield 65 Plus Appeals & Grievances Department P.O. Box 927, Woodland Hills, CA 91365-9856
WEBSITE	blueshieldca.com/medappeals

How to contact us when you are making a complaint about your medical care or Part D prescription drugs

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care or your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints About Medical Care or Part D Prescription Drugs – Contact Information
CALL	(800) 776-4466 Calls to this number are free. 8 a.m. to 8 p.m., 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.

Method	Complaints About Medical Care or Part D Prescription Drugs – Contact Information
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m., seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
FAX	(916) 350-6510
WRITE	Blue Shield 65 Plus Appeals & Grievances Department P.O. Box 927, Woodland Hills, CA 91365-9856
MEDICARE WEBSITE	You can submit a complaint about Blue Shield 65 Plus directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx .

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	(800) 776-4466 Calls to this number are free. 8 a.m. to 8 p.m., 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.

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m., seven days a week. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day.
FAX	(888) 697-8122
WRITE	Blue Shield 65 Plus P.O. Box 2080, Oakland, CA 94612-0850
WEBSITE	blueshieldca.com/medicare

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Requests – Contact Information
CALL	(800) 776-4466 8 a.m. to 8 p.m., 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. Calls to this number are free.

Method	Payment Requests – Contact Information
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m., 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.
Method	Payment Requests for Medical Care – Contact Information
FAX	(877) 251-6671
WRITE	Blue Shield 65 Plus P.O. Box 927 Woodland Hills, CA 91365-9856
Method	Payment Requests for Part D Prescription Drugs – Contact Information
WRITE	Blue Shield of California P.O. Box 52066 Phoenix, AZ 85072-2066
WEBSITE	blueshieldca.com/medicare

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

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 (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.

Method	Medicare – Contact Information
TTY	<p>1-877-486-2048</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
WEBSITE	<p>www.medicare.gov</p> <p>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state.</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none">• Medicare Eligibility Tool: Provides Medicare eligibility status information.• Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p>You can also use the website to tell Medicare about any complaints you have about Blue Shield 65 Plus:</p> <ul style="list-style-type: none">• Tell Medicare about your complaint: You can submit a complaint about Blue Shield 65 Plus directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p>If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</p>

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

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

HICAP is an independent (not connected with any insurance company or health plan) 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 understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. HICAP counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit www.medicare.gov
- Click on “**Talk to Someone**” in the middle of the homepage
- You now have the following options
 - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
 - Option #2: You can select your **STATE** from the dropdown menu and click **GO**. This will take you to a page with phone numbers and resources specific to your state.

Method	HICAP (California’s SHIP) – Contact Information
CALL	(800) 434-0222
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	California Department of Aging 1300 National Drive, Suite 200, Sacramento, CA 95834-1992
WEBSITE	https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For California, the Quality Improvement Organization is called Livanta.

Livanta 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. Livanta is an independent organization. It is not connected with our plan.

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you have received.
- 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 are ending too soon.

Method	Livanta (California's Quality Improvement Organization) – Contact Information
CALL	(877) 588-1123 9 a.m. to 5 p.m., Monday through Friday; 11 a.m. to 3 p.m., Saturday, Sunday and Federal holidays.
TTY	(855) 887-6668 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

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

Method	Social Security– Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can 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 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

The programs offered through Medicaid 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 its programs, contact your local Medi-Cal office or the California Department of Health Care Services.

Method	California Department of Health Care Services – Contact Information – Contact Information
CALL	(800) 541-5555 Available 8:00 am to 5:00 pm, Monday through Friday.
TTY	(800) 735-2922 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	California Department of Health Care Services P.O. Box 997413, MS 4400 Sacramento, CA 95899-7413
WEBSITE	www.dhcs.ca.gov

SECTION 7 Information about programs to help people pay for their prescription drugs

The Medicare.gov website (<https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs>) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare’s “Extra Help” Program

Medicare provides “Extra Help” to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan’s monthly premium, yearly deductible, and prescription copayments. This “Extra Help” also counts toward your out-of-pocket costs.

If you automatically qualify for “Extra Help” Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify you may be able to get “Extra Help” to pay for your prescription drug premiums and costs. To see if you qualify for getting “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 to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications). (See Section 6 of this chapter for contact information.).

If you believe you have qualified for “Extra Help” and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- For assistance in obtaining evidence of your proper copayment level, you may call Customer Care (phone numbers are printed on the back cover of this document) and we can either mail or fax you a list of acceptable documents of evidence or read you the list over the phone. Once you obtain the evidence, or if you already have it, you may send it to us either by fax ((877) 251-6671) or by mail (Blue Shield 65 Plus, P.O. Box 927, Woodland Hills, CA 91365-9856).
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment, or we will offset future copayments. If the pharmacy hasn’t collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make the payment directly to the state. Please contact Customer Care if you have questions.

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

What is the AIDS Drug Assistance Program (ADAP)?

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

Note: To be eligible for the ADAP operating in your State, 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. If you change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call You can contact the California ADAP at (844) 421-7050, 8 a.m. to 5 p.m., Monday through Friday or visit their website at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_eligibility.aspx.

SECTION 8 How to contact the Railroad Retirement Board

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 receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press “0,” you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press “1”, you may access the automated RRB HelpLine and 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 with hearing or speaking. Calls to this number are <i>not</i> free.
WEBSITE	rrb.gov/

SECTION 9 Do you have “group insurance” or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse’s) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Care if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Care are printed on the back cover of this document.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

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

CHAPTER 3:

Using the plan for your medical services

SECTION 1 Things to know about getting your medical care as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, prescription drugs, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are “network providers” and “covered services”?
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- **“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 have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **“Covered services”** include all the medical care, health care services, supplies, equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2 Basic rules for getting your medical care covered by the plan

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

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

- **The care you receive is included in the plan’s Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care physician (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).

Chapter 3 Using the plan for your medical services

- In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.
- Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*
 - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
 - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
 - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.

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

Section 2.1	You must choose a Primary Care Physician (PCP) to provide and oversee your medical care
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What is a “PCP” and what does the PCP do for you?

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

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

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

How do you choose your PCP?

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

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

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

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

Changing your PCP

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

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

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

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

Section 2.2	What kinds of medical care can you get without a referral from your PCP?
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You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers
- Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Customer Care before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.)

Section 2.3	How to get care from specialists and other network providers
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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. Here are a few examples:

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

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

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

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

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

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

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.

- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

Section 2.4	How to get care from out-of-network providers
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If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. If this happens, your PCP will refer you to the out-of-network provider. Be sure you get a referral (approval in advance) from your PCP before you use an out-of-network provider.

SECTION 3	How to get services when you have an emergency or urgent need for care or during a disaster
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Section 3.1	Getting care if you have a medical emergency
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What is a “medical emergency” and what should you do if you have one?

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 your loss of life (and, if you are 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 is 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 do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may 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 are not part of our network. Our plan covers emergency and urgent care outside of the United

States and its territories with no annual combined 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 that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call is on the back of your Blue Shield 65 Plus member ID card.

What is covered if you have 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 who are giving you emergency care will decide when your condition is stable, and the medical emergency is over.

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

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

What if it wasn't a medical emergency?

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

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- *or* – The additional care you get is considered “urgently needed services” and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

Section 3.2	Getting care when you have an urgent need for services
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What are “urgently needed services”?

An urgently needed service is a non-emergency situation requiring immediate medical care but given your circumstances, it is not possible or not reasonable to obtain these services from a

network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

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

Our plan covers worldwide emergency and urgent care outside the United States and its territories under the following circumstances with a \$50,000 combined annual dollar limit. See “Emergency care” and “Urgently needed services” in the Medical Benefits Chart in Chapter 4 of this document for more information on how much you pay.

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**, or call collect at (804) 673-1177, 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. You should also call the Customer Care number on the back of your member ID card. 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	Getting care during a disaster
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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 are still entitled to care from your plan.

Please visit the following website: **blueshieldca.com/medicare** for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

SECTION 4 What if you are billed directly for the full cost of your services?

Section 4.1	You can ask us to pay our share of the cost of covered services
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If you have paid more than your plan cost-sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

Section 4.2	If services are not covered by our plan, you must pay the full cost
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Blue Shield 65 Plus covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are 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 have used up your benefit for that type of covered service. Once a benefit limit has been reached, whatever you pay for services will not count toward your out-of-pocket maximum. See Chapter 4 for more information on benefit limits and out-of-pocket maximums.

SECTION 5 How are your medical services covered when you are in a “clinical research study”?

Section 5.1	What is a “clinical research study”?
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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 request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study, *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are 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

will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may 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 want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get 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 that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

Section 5.2	When you participate in a clinical research study, who pays for what?
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Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you receive 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 is part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare has paid 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 will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs \$100 as part of the research study. Let's also say that your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan's benefits. 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 your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you \$10. Therefore, your net payment is \$10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

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

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication “Medicare and Clinical Research Studies.” (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 6.1	What is a religious non-medical health care institution?
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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 will instead provide coverage for 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	Receiving Care from a Religious Non-Medical Health Care Institution
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To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is “non-excepted.”

- “Non-excepted” medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- “Excepted” medical treatment is medical care or treatment that you get that is *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's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
 - *and* – you must get approval in advance from our plan before you are admitted to the facility, or your stay will not 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	Will you own the durable medical equipment after making a certain number of payments under our plan?
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Durable medical equipment (DME) includes items such as 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 use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Blue Shield 65 Plus, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Customer Care for more information.

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

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

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 do not count. You will have to make 13 consecutive new payments after you return to Original Medicare to own the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You

then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

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

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

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

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

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

CHAPTER 4:

Medical Benefits Chart

*(what is covered and
what you pay)*

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

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Blue Shield 65 Plus. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services
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To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A **“copayment”** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **“Coinsurance”** is 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 in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments, or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?
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Because you are enrolled in a Medicare Advantage Plan, there is a limit on the total amount you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2023 this amount is \$2,900.

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of \$2,900, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to “balance bill” you

As a member of Blue Shield 65 Plus, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add 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 is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).
 - If you receive 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. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
 - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or urgently needed services.)
- If you believe a provider has “balance billed” you, call Customer Care.

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

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

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription 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.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered, unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care physician (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan’s network. This is called giving you a “referral.”
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart by a footnote (†).

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2023* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.

Important Benefit Information for Enrollees with Chronic Conditions

- If you are diagnosed with one or more of the following chronic condition(s) identified below and meet certain criteria, you may be eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI):
 - Cardiovascular disorders limited to:
 - Cardiac arrhythmias (also known as abnormal heart rhythm)
 - Coronary artery disease (also known as history of chest pains, heart attacks, or hardening of the arteries of the heart)

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

- Peripheral vascular disease (also known as hardening of the arteries of the legs)
- Chronic venous thromboembolic disorder (also known as blood clots in the legs)
- Diabetes mellitus (also known as Diabetes Type I or Type II)
- Autoimmune disorders limited to:
 - Polyarteritis nodosa
 - Polymyalgia rheumatica
 - Polymyositis
 - Rheumatoid arthritis
 - Systemic lupus erythematosus


To determine your eligibility, you must complete and submit to Blue Shield an Attestation Form documenting your eligibility for the SSBCI. The completed Attestation Form requires both your signature and your physician's signature. To obtain a copy of the Attestation Form, please visit blueshieldca.com/healthygrocery or contact Customer Care (phone numbers are printed on the back cover of this document).

- Please go to the “Special Supplemental Benefits for the Chronically Ill” row in the below Medical Benefits Chart for further detail.
- Please contact us to find out exactly which benefits you may be eligible for.



You will see this apple next to the preventive services in the benefits chart.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Acupuncture for chronic low back pain</p> <p>Covered services include:</p> <p>Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:</p> <p>For the purpose of this benefit, chronic low back pain is defined as:</p> <ul style="list-style-type: none"> • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.); • not associated with surgery; and • not associated with pregnancy. <p>An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.</p> <p>Treatment must be discontinued if the patient is not improving or is regressing.</p> <p>Provider Requirements:</p> <p>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.</p>	<p>You pay \$0 for all Medicare-covered services.</p>



Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Acupuncture for chronic low back pain (cont'd)</p> <p>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:</p> <ul style="list-style-type: none"> • a masters 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. <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p> <p>Benefits are provided through a contract with American Specialty Health Plans of California, Inc. (ASH Plans). For more information, or to locate an ASH Plans participating provider you may call ASH Plans at (800) 678-9133 [TTY: (877) 710-2746], Monday through Friday, 5 a.m. to 6 p.m. You can also call Blue Shield 65 Plus Customer Care or go to blueshieldca.com/find-a-doctor to locate an ASH Plans participating provider.</p>	
<p>Additional telehealth services</p> <p>Teladoc provides Physician consultations by phone or video 24/7/365. Teladoc Physicians can diagnose and treat basic medical conditions and can also prescribe certain medication. Teladoc is a supplemental service that is not intended to replace care from your Primary Care Physician. Please log into blueshieldca.com/teladoc or the Blue Shield of California app to request a visit. If you have questions, you may contact Teladoc by phone at 1-800-Teladoc (1-800-835-2362) [TTY: 711], 24 hours a day, 7 days a week, 365 days a year.</p>	<p>You pay \$0.</p>
<p>*Services do not apply to the plan's maximum out-of-pocket limit.</p>	





Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Ambulance services</p> <ul style="list-style-type: none"> • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is 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. 	<p>You pay \$200 per trip, each way for Medicare-covered ground ambulance services.</p> <p>You pay 20% coinsurance per trip, each way for Medicare-covered air ambulance services.</p> <p>Although most providers collect the applicable cost-sharing at the time of service, this may not occur for ambulance services.</p> <p>You may receive a bill for the entire cost of the ambulance service. If this occurs, simply submit your bill to:</p> <p>Blue Shield 65 Plus Customer Care P.O. Box 927 Woodland Hills, CA 91365-9856.</p> <p>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.</p>


Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Annual physical exam</p> <p>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.</p> <p>Any lab, 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.</p> <p>*Services do not apply to the plan’s maximum out-of-pocket limit.</p>	<p>You pay \$0.</p>
<p> Annual wellness visit</p> <p>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.</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>
<p> Bone mass measurement</p> <p>For qualified individuals (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.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p>


Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months 	<p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p>
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>You pay \$20 per visit.</p>
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>
<p> Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>
<p> Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p>



Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Only manual manipulation of the spine to correct subluxation 	<p>You pay \$0 for all Medicare-covered services.</p>
<p> Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months <p>One of the following every 12 months:</p> <ul style="list-style-type: none"> Guaiaac-based fecal occult blood test (gFOBT) Fecal immunochemical test (FIT) <p>DNA based colorectal screening every 3 years</p> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy 	<p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam or barium enema.</p>

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Dental services, routine*</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare.</p> <p>For a list of covered dental procedures, see the Routine Dental Benefits Procedure Chart (which is located in this chapter following the Medical Benefits Chart) for more information on how to access these services.</p> <p>The copayments listed in the Routine Dental Benefits Procedure Chart (which is located in this chapter following the Medical Benefits Chart) apply to services only when prescribed by a network dentist as a necessary, adequate and appropriate procedure for your dental condition.</p> <p>Not all covered services may be appropriate for everyone. You should rely on your network dentist to determine the appropriate care for you. The dental provider network is a general dentist network only; there are no specialists in the network.</p> <p>*Services do not apply to the plan's maximum out-of-pocket limit.</p>	<p>See the Routine Dental Benefits Procedure Chart at the end of the Medical Benefits Chart for a list of the covered dental procedures and what you pay for each covered dental procedure.</p>
<p> Depression screening</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.</p>
<p> Diabetes self-management training, diabetic services, and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • 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 two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. <p>For test strips and blood glucose monitors, the preferred manufacturer is Roche Diagnostics. ACCU-CHEK® (made by Roche Diagnostics) test strips and blood glucose monitors will not require your doctor to get approval in advance (sometimes called “prior authorization”) from the plan. Test strips and blood glucose monitors from all other manufacturers will require your doctor to get approval in advance (sometimes called “prior authorization”) from the plan.</p>	<p>You pay \$0 for all training, services and supplies, except blood glucose monitors.</p> <p>For blood glucose monitors, please see the “Durable medical equipment and related supplies” section of this Medical Benefits Chart.</p>


Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Durable medical equipment (DME) and related supplies (For a definition of “durable medical equipment,” see Chapter 12 as well as Chapter 3, Section 7 of this document.)</p> <p>Covered items include, but are not 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.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.</p> <p>Durable medical equipment will require approval in advance (sometimes called “prior authorization”) from us if you or your provider want to request durable medical equipment provided by a non-preferred supplier.</p>	<p>You pay 20% coinsurance.</p> <p>Blood glucose monitors:</p> <ul style="list-style-type: none"> • You pay \$0 for ACCU-CHEK® monitors. • You pay 20% coinsurance for blood glucose monitors from all other manufacturers. <p>See “Medicare Part B Prescription Drugs” in this Medical Benefits Chart for more information on drugs you take using durable medical equipment.</p>


Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>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 are 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 is quickly getting worse.</p> <p>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>World-wide coverage.*</p> <p>*Services do not apply to the plan's maximum out-of-pocket limit.</p>	<p>You pay \$125 per visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition).</p> <p>You have a \$50,000 combined annual limit for covered emergency care or urgently needed services outside the United States and its territories. Services outside the United States and its territories do not apply to the plan's maximum out-of-pocket limit.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital.</p>


Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
 Health and wellness education programs*	
NurseHelp 24/7	You pay \$0.
<p>Have a confidential one-on-one online dialogue with a registered nurse, 24 hours a day. When you have a medical concern, one call to our toll-free hotline puts you in touch with a registered nurse who will listen to your concerns and help you toward a solution.</p>	
<p>Call 1-877-304-0504 (TTY: 711) 24 hours a day, 7 days a week.</p>	
SilverSneakers® Fitness	You pay \$0.
<p>SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations¹. You have access to instructors who lead specially designed group exercise classes². At participating locations nationwide¹, you can take classes² plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, mall and parks). SilverSneakers also connects you to a support network and virtual classes through SilverSneakers LIVE™, SilverSneakers On-Demand™ videos and our mobile app, SilverSneakers GO™. You also get access to Stitch³, an online social site for seniors, where you can join in-person and online activities and events. All you need to get started is your personal SilverSneakers ID number. Go to silversneakers.com to learn more about your benefit or call 1-888-423-4632 [TTY: 711] Monday through Friday, 8 a.m. to 8 p.m. ET.</p>	
<p>Always talk with your doctor before starting an exercise program.</p>	

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Health and wellness education programs (cont'd)*</p> <p>¹Participating locations (“PL”) are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.</p> <p>²Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.</p> <p>³Stitch is a third-party provider and is not owned or operated by Tivity Health or its affiliates. SilverSneakers members must have internet service to access Stitch service. Internet service charges are responsibility of SilverSneakers member.</p>	
<p>Hearing aids*</p> <p>You may obtain hearing aids from the provider of your choice.</p> <p>*Services do not apply to the plan’s maximum out-of-pocket limit.</p>	<p>You will be reimbursed up to \$500 every two years for hearing aids, hearing aid fitting and evaluation (applies to both ears combined).</p>
<p>Hearing services</p> <p>Diagnostic hearing and balance evaluations performed by your PCP to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p> <p>Routine (non-Medicare covered) hearing exams (requires prior approval from your PCP).*</p> <p>*Services do not apply to the plan’s maximum out-of-pocket limit.</p>	<p>You pay \$0.</p>


Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>
<p>Home health agency care</p> <p>Prior to receiving 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.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies 	<p>You pay \$0 for each Medicare-covered home health visit.</p>
<p>Home infusion therapy</p> <p>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual 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).</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Professional services, including nursing services, furnished in accordance with the 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 	<p>You pay \$0 for each Medicare-covered home infusion therapy visit.</p>

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Hospice care</p> <p>You are 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 may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p>When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums.</p> <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> 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 are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing</p> <p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not 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 (such as if there is a requirement to obtain prior authorization).</p> <ul style="list-style-type: none"> • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services 	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Blue Shield 65 Plus.</p> <p>You pay \$0 for the hospice consultation services (one time only).</p>

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
Hospice care (cont'd)	
<ul style="list-style-type: none"> If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare) 	
<p><u>For services that are covered by Blue Shield 65 Plus but are not covered by Medicare Part A or B:</u> Blue Shield 65 Plus will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.</p>	
<p><u>For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition, then you pay Original Medicare cost sharing.</u> Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (<i>What if you're in Medicare-certified hospice</i>).</p>	
<p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p>	
<p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	
 Immunizations	
<p>Covered Medicare Part B services include:</p>	
<ul style="list-style-type: none"> Pneumonia vaccine Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B COVID-19 vaccine Other vaccines if you are at risk and they meet Medicare Part B coverage rules 	
<p>We also cover some vaccines under our Part D prescription drug benefit.</p>	
<p>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.</p>	

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Inpatient hospital care</p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p> <p>There is no limit to the number of days per hospital stay. Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services <p>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 will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Blue Shield 65 Plus provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.†</p>	<p>For each Medicare-covered stay in a network hospital, you pay:</p> <ul style="list-style-type: none"> • \$0 per admission. <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.</p>


Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care (cont'd)	
<ul style="list-style-type: none"> • 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 	
<p>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 are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p>	
<p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
<p>†Transplants are covered only if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us.</p>	


Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Inpatient services in a psychiatric hospital</p> <p>Covered services include mental health care services that require a hospital stay.</p> <p>Medicare covers up to 90 days of medically necessary hospitalization.</p> <p>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.</p> <p>Medicare covers up to 40 additional days in a psychiatric hospital. The 40 additional Psychiatric days are offered once during your lifetime. Payment may not be made for more than a total of 190 days of inpatient psychiatric care in a freestanding psychiatric hospital during your lifetime.</p> <p>Prior usage under Medicare is included in the lifetime maximum (this includes our plan, any other Medicare Advantage plan, or Original Medicare).</p>	<p>For each Medicare-covered stay in a network hospital, you pay:</p> <ul style="list-style-type: none"> • \$900 per stay for days 1 to 150. • 100% of the cost of the hospital stay for days 151 and over.
<p>Inpatient stay: Covered services received in a SNF during a non-covered skilled nursing facility (SNF) stay</p> <p>If you have exhausted your skilled nursing facility (SNF) benefits or if the skilled nursing facility (SNF) stay is not reasonable and necessary, we will not cover your skilled nursing facility (SNF) stay. However, in some cases, we will cover certain services you receive while you are in the skilled nursing facility (SNF). Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services 	<ul style="list-style-type: none"> • You pay \$0. • You pay \$0. • See “Outpatient diagnostic tests and therapeutic services and supplies”.


Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
Inpatient stay: Covered services received in a SNF during a non-covered skilled nursing facility (SNF) stay (cont'd)	
<ul style="list-style-type: none"> • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy 	<ul style="list-style-type: none"> • You pay \$0 for items covered by Medicare. • You pay \$0 for items covered by Medicare. • You pay 20% coinsurance. • You pay 20% coinsurance. • You pay \$0.
 Medical nutrition therapy <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive 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 receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p>

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</p>	<p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p>
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases <p>We also cover some vaccines under our Part B and Part D prescription drug benefit.</p>	<p>You pay 20% coinsurance.</p> <p>For your exact cost, you may call Customer Care at the number on your plan ID card.</p>

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Medicare Part B prescription drugs (cont'd)</p> <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.</p>	
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>
<p>Opioid treatment program services</p> <p>Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:</p> <ul style="list-style-type: none"> • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments 	<p>You pay \$0.</p>

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 • Other outpatient diagnostic tests 	<p>What you pay depends on the type of services obtained.</p> <p>1) You pay \$0 for basic diagnostic tests, X-ray services, EKGs, supplies, blood and laboratory services.</p> <p>2) You pay \$20 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.</p> <p>The copay is applicable to the global, technical and professional components of the diagnostic radiology services only.</p> <p>3) You pay 20% coinsurance for therapeutic radiology services. Therapeutic radiology services</p>

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Outpatient diagnostic tests and therapeutic services and supplies (cont'd)</p>	<p>include, but are not limited to, radiation therapy, radium and isotope therapy. The 20% coinsurance is applicable to the global, technical and professional components of the therapeutic radiology services.</p>
<p>Outpatient hospital observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are 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 are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>You pay \$0.</p>

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services	
<p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p>	
<p>Covered services include, but are not limited to:</p>	
<ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery 	<ul style="list-style-type: none"> • You pay \$125 per visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition).
	<p>You pay \$150 per visit to an outpatient hospital facility.</p>
	<p>You pay \$0 for Medicare-covered observation services.</p>
<ul style="list-style-type: none"> • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it 	<ul style="list-style-type: none"> • You pay \$0. • You pay \$30 per visit.
<ul style="list-style-type: none"> • X-rays and other radiology services billed by the hospital 	<ul style="list-style-type: none"> • See “Outpatient diagnostic tests and therapeutic services”.

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Outpatient hospital services (cont'd)</p> <ul style="list-style-type: none"> • Medical supplies such as splints and casts • Certain screenings and preventive services • Certain drugs and biologicals that you can't give yourself <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are 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 are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<ul style="list-style-type: none"> • You pay \$0 for items covered by Medicare. • You pay \$0. • You pay 20% coinsurance.
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>You pay \$30 for each individual or group therapy visit.</p>
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>You pay \$0.</p>

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Outpatient substance abuse services</p> <p>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 abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting.</p>	<p>You pay \$30 per Medicare-covered individual or group therapy visit.</p>
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are 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.”</p>	<p>You pay \$0 per visit to an ambulatory surgical center.</p> <p>You pay \$150 per visit to an outpatient hospital facility.</p>
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>You pay \$30 per visit.</p>


Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Physician/Practitioner services, including doctor's office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory 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 services to treat non-emergency conditions such as cold and flu symptoms, allergies, bronchitis, respiratory infection, sinus problems, rash, eye infection, migraine, and more. <ul style="list-style-type: none"> ○ 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. ○ Refer to the "Additional telehealth services" section in the Medical Benefits Chart for more information. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> ○ You have an in-person visit within 6 months prior to your first telehealth visit ○ You have an in-person visit every 12 months while receiving these telehealth services ○ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers 	<p>For all covered services:</p> <p>You pay \$0 (visits to your PCP do NOT require prior authorization).</p>



Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits (cont'd)	
<ul style="list-style-type: none"> • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: <ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ○ 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 • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) 	


Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 <p>*Services do not apply to the plan's maximum out-of-pocket limit.</p>	<p>You pay \$0 for each Medicare-covered visit.</p>
<p> Prostate cancer screening exams</p> <p>For men aged 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test <p>You can get these services on your own, without a referral from your PCP, as long as you get the service from a network provider.</p>	<p>There is no coinsurance, copayment, or deductible for an annual PSA test or digital rectal exam.</p>
<p>Prosthetic devices and related supplies</p> <p>Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p>	<p>You pay 20% coinsurance.</p>
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p>	<p>You pay \$20 per visit.</p>

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent.</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>Eligible members are: people aged 50 – 77 years 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 receive a written 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.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.</p>

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>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 physician. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>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 will only cover these counseling sessions as a preventive service if they are provided by a primary care physician and take place in a primary care setting, such as a doctor's office.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>
<p>Services to treat kidney disease</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) 	<ul style="list-style-type: none"> • You pay \$0. • You pay 10% coinsurance for each treatment billed by a qualified, Medicare-approved dialysis provider. You pay 20% coinsurance for any drugs used during the procedure.


Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
Services to treat kidney disease (cont'd)	
<ul style="list-style-type: none"> • Inpatient dialysis treatments (if you are 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) 	<ul style="list-style-type: none"> • 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 10% coinsurance for self-dialysis training. • You pay 20% coinsurance. • You pay 20% coinsurance.
<p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."</p>	

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Skilled nursing facility (SNF) care (For a definition of “skilled nursing facility care,” see Chapter 12 of this document. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • 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 your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood, packed red cells and all other components of blood begins with the first pint used • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services <p>Generally, you will get your SNF care from network facilities. However, 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.</p> <ul style="list-style-type: none"> • 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 is living at the time you leave the hospital 	<p>For each stay in a Medicare-certified skilled nursing facility, you pay:</p> <ul style="list-style-type: none"> • \$0 per day for days 1 to 20. • \$100 per day for days 21 to 100. <p>If you go over the 100-day limit, you will be responsible for all costs.</p> <p>When a network provider coordinates your admission, Blue Shield 65 Plus waives the 3-day prior hospital stay required by Medicare to qualify for coverage.</p>


Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>
<p>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques <p>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.</p>	<p>You pay \$20 per visit.</p>

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Urgently needed services</p> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network.</p>	<p>You pay \$5 per visit to a network urgent care center within your plan service area (waived if you are admitted to the hospital within one day for the same condition).</p>
<p>World-wide coverage.*</p>	<p>You pay \$5 per visit to an urgent care center outside of your plan service area but within the United States and its territories (waived if you are admitted to the hospital within one day for the same condition).</p>
<p>* Services do not apply to the plan's maximum out-of-pocket limit.</p>	<p>You pay \$125 for each visit to an emergency room outside of your plan service area but within the United States and its territories (waived if you are admitted to the hospital within one day for the same condition).</p>
	<p>You pay \$125 for each visit to an emergency room or urgent care center that is outside of the United States and its territories (waived if you are admitted to the hospital within one day for the same condition).</p>

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
Urgently needed services (cont'd)	<p>You have a \$50,000 combined annual limit for covered emergency care or urgently needed services outside the United States and its territories.</p> <p>Services outside the United States and its territories do not apply to the plan's maximum out-of-pocket limit.</p>
<p> Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 of glaucoma, we will 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 two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) 	<ul style="list-style-type: none"> • You pay \$0. • You pay \$0. • You pay \$0. • You pay \$0.


Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Vision care, non-Medicare covered (obtained from a network provider)*</p>	<p>Prior authorization (approval in advance) is NOT required.</p> <p>Use the <i>Vision Directory</i> 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.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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. • Eyeglass frames and eyeglass lenses (including single, lined bifocal, lined trifocal, and lenticular lenses) or contact lenses <p>* Services do not apply to the plan's maximum out-of-pocket limit.</p>
<ul style="list-style-type: none"> • You pay \$0 for one exam every 12 months when you use a network provider. • You pay \$20 for eyeglass frames (priced up to a regular retail value of \$125) every 24 months when you use a network provider. If you choose eyeglass frames priced above \$125, you are responsible for the difference. • You pay \$20 for <u>either</u> one pair of prescription eyeglass lenses (regardless of size or power) OR for contact lenses (priced up to \$125 for contact lens services and materials) every 12 months when you use a network 	

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
Vision care, non-Medicare covered (obtained from a network provider)* (cont'd)	provider. If the service and materials price above \$125, you are responsible for the difference.
Vision care, non-Medicare covered (obtained by a non-network provider)*	
<p>You may, if you choose, see an optometrist or an optician who is not a Blue Shield 65 Plus network provider. However, you may not obtain the same services from both a network and a non-network provider. If you choose a non-network provider, you are eligible for a partial reimbursement for the services rendered, unless you've already reached your benefit limit for the vision service you are seeking. Call Customer Care to request a reimbursement form and for more information on requesting a reimbursement. Prior authorization is NOT required.</p>	
<ul style="list-style-type: none"> • Routine eye exam, refraction and prescription for eyeglass lenses. • Eyeglass frames and eyeglass lenses including single, bifocal, trifocal, and lenticular lenses or contact lenses. 	<ul style="list-style-type: none"> • You are reimbursed up to \$30 for one exam every 12 months. • You are reimbursed up to \$35 for one pair of eyeglass frames every 24 months. • You are reimbursed up to \$35 for <u>either</u> one pair of prescription eyeglass lenses (regardless of size or power) OR for contact lenses every 12 months.
<p>* Services do not apply to the plan's maximum out-of-pocket limit.</p>	

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
 “Welcome to Medicare” preventive visit The 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 the preventive services you need (including certain screenings and shots), 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 would like to schedule your “Welcome to Medicare” preventive visit.	There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.

Routine Dental Benefits Procedure Chart

Routine dental benefits are included for all Members in this plan.

The following Routine Dental Benefits Procedure Chart 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.

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

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” and “General exclusions” listed after this benefits chart for more information.

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;

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

- 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 5 a.m. and 8 p.m. (excluding holidays).

ADA Code	ADA description of services covered for you	What you must pay
Diagnostic Services		
D0120	Periodic oral evaluation - established patient	\$0
D0140	Limited oral evaluation - problem focused	\$5
D0150	Comprehensive oral evaluation - new or established patient	\$16
D0160	Detailed and extensive oral evaluation - problem focused, by	\$5
D0170	Re-evaluation - limited, problem focused (not post-operative	\$5
D0180	Comprehensive periodontal evaluation – new or established patient	\$15
D0210	Intraoral complete series (including bitewings)	\$5
D0220	Intraoral - periapical, first film	\$0
D0230	Intraoral - periapical, each additional film	\$0
D0240	Intraoral - occlusal film	\$0
D0250	Extraoral X-ray - first film	\$0
D0270	Bitewing - single film	\$0
D0272	Bitewings - two films	\$0
D0273	Bitewings - three films	\$0
D0274	Bitewings - four films	\$0
D0277	Vertical bitewings - 7 to 8 films	\$0
D0330	Panoramic film	\$10
D0460	Pulp vitality tests	\$5
D0470	Diagnostic casts	\$15
D0701	Panoramic radiographic - image capture only	\$10
D0702	2-D cephalometric radiographic image - image capture only	\$10

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

ADA Code	ADA description of services covered for you	What you must pay
D0706	Intraoral - occlusal radiographic image - image capture only	\$0
D0707	Intraoral - periapical radiographic image - image capture only	\$0
D0708	Intraoral - bitewing radiographic image - image capture only. Image axis may be horizontal or vertical	\$0
D0709	Intraoral - complete series of radiographic images - image capture only	\$5
D9995	Teledentistry – synchronous; real-time encounter	\$0
D9996	Teledentistry – asynchronous; information stored and forwarded	\$0
Preventive Services		
D1110	Prophylaxis – adult	\$0
D1206	Topical fluoride varnish	\$5
D1310	Nutritional counseling for control of dental disease	\$0
D1330	Oral hygiene instruction	\$0
D1351	Sealant - per tooth	\$15
D1510	Space maintainer – fixed unilateral	\$40
D1516	Spacer maintainer – fixed bilateral, maxillary	\$80
D1517	Spacer maintainer – fixed bilateral, mandibular	\$80
D1520	Spacer maintainer – removable unilateral	\$50
D1526	Spacer maintainer – removable bilateral, maxillary	\$70
D1527	Spacer maintainer – removable bilateral, mandibular	\$70
D1551	Re-cement or re-bond bilateral space maintainer maxillary	\$9
D1552	Re-cement or re-bond bilateral space maintainer maxillary	\$9
D1553	Re-cement or re-bond unilateral space maintainer per quadrant	\$9
D1556	Removal of fixed unilateral space maintainer per quadrant	\$11
D1557	Removal of fixed bilateral space maintainer maxillary	\$11
D1558	Removal of fixed bilateral space maintainer mandibular	\$11
Minor Restorative Services		
D2140	Amalgam - one surface, primary or permanent	\$25
D2150	Amalgam - two surfaces, primary or permanent	\$30
D2160	Amalgam - three surfaces, primary or permanent	\$40
D2161	Amalgam - four or more surfaces, primary or permanent	\$55
D2330	Resin-based composite - one surface, anterior	\$40
D2331	Resin-based composite - two surfaces, anterior	\$45
D2332	Resin-based composite - three surfaces, anterior	\$50
D2335	Resin-based composite - four or more surfaces or involving incisal angle, anterior	\$65
Major Restorative Services		
D2710	Crown – resin-based composite, indirect	\$115

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

ADA Code	ADA description of services covered for you	What you must pay
D2712	Crown – 3/4 resin-based composite, indirect	\$115
D2720	Crown – resin with high noble metal	\$185
D2721	Crown – resin with predominantly base metal	\$185
D2722	Crown – resin with noble metal	\$185
D2740	Crown – porcelain/ceramic	\$335
D2750	Crown – porcelain fused to high noble metal	\$430
D2751	Crown – porcelain fused to predominantly base metal	\$430
D2752	Crown – porcelain fused to noble metal	\$430
D2753	Crown – porcelain fused to titanium and titanium alloys	\$430
D2780	Crown – 3/4 cast high noble metal	\$430
D2781	Crown – 3/4 cast predominantly base metal	\$430
D2782	Crown – 3/4 cast noble metal	\$430
D2790	Crown – full cast high noble metal	\$430
D2791	Crown – full cast predominantly base metal	\$430
D2792	Crown – full cast noble metal	\$430
D2910	Recement inlay, onlay or partial coverage restoration	\$19
D2915	Recement cast or prefabricated post and core	\$19
D2920	Recement crown	\$25
D2940	Protective restoration	\$20
D2951	Pin retention - per tooth - in addition to restoration	\$20
D2952	Post and core in addition to crown, indirectly fabricated	\$100
D2953	Each additional indirectly fabricated post, same tooth	\$100
D2954	Prefabricated post and core in addition to crown	\$100
Endodontic Services		
D3110	Pulp cap (direct) excluding final restoration	\$25
D3120	Pulp cap (indirect) excluding final restoration	\$25
D3310	Endodontic therapy - anterior tooth (excluding final restoration)	\$240
D3320	Endodontic therapy - premolar tooth (excluding final restoration)	\$297
D3330	Endodontic therapy - molar tooth (excluding final restoration)	\$373
D3346	Retreatment of previous root canal – anterior	\$240
D3347	Retreatment of previous root canal – bicuspid	\$297
D3348	Retreatment of previous root canal – molar	\$373
Periodontic Services		
D4341	Periodontal scaling and root planning - four or more teeth - per	\$60
D4342	Periodontal scaling and root planning - one to three teeth – per	\$60
D4346	Scaling in presence of generalized moderate or severe gingival inflammation	\$40

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

ADA Code	ADA description of services covered for you	What you must pay
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	\$50
D4910	Periodontal maintenance	\$40
Removable Prosthetic Services		
D5110	Complete denture - maxillary	\$475
D5120	Complete denture - mandibular	\$475
D5130	Immediate denture - maxillary	\$475
D5140	Immediate denture - mandibular	\$475
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	\$340
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	\$340
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$525
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$525
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary	\$350
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular	\$350
D5284	Removable unilateral partial denture – one-piece flexible base (including retentive/clasping materials, rests and teeth) – per quadrant	\$350
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests and teeth) – per quadrant	\$350
D5410	Adjust complete denture - maxillary	\$28
D5411	Adjust complete denture - mandibular	\$28
D5421	Adjust partial denture - maxillary	\$28
D5422	Adjust partial denture - mandibular	\$28
D5511	Repair broken complete denture base, mandibular	\$45
D5512	Repair broken complete denture base, maxillary	\$45
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$30
D5621	Repair cast partial framework, mandibular	\$45
D5622	Repair cast partial framework, maxillary	\$45
D5630	Repair or replace broken retentive/clasping materials – per tooth	\$50
D5640	Replace broken teeth - per tooth	\$45
D5650	Add tooth to existing partial denture	\$45
D5660	Add clasp to existing partial denture	\$49

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

ADA Code	ADA description of services covered for you	What you must pay
D5670	Replace all teeth and acrylic on cast framework - maxillary	\$306
D5671	Replace all teeth and acrylic on cast framework – mandibular	\$306
D5710	Rebase complete maxillary denture	\$135
D5711	Rebase complete mandibular denture	\$135
D5720	Rebase maxillary partial denture	\$95
D5721	Rebase mandibular partial denture	\$95
D5725	Rebase hybrid prosthesis	\$135
D5730	Reline complete maxillary denture (direct)	\$95
D5731	Reline complete mandibular denture (direct)	\$95
D5740	Reline maxillary partial denture (direct)	\$95
D5741	Reline mandibular partial denture (direct)	\$95
D5750	Reline complete maxillary denture (indirect)	\$150
D5751	Reline complete mandibular denture (indirect)	\$150
D5760	Reline maxillary partial denture (indirect)	\$140
D5761	Reline mandibular partial denture (indirect)	\$140
D5765	Soft liner for complete or partial removable denture – indirect	\$35
D5850	Tissue conditioning - maxillary	\$35
D5851	Tissue conditioning - mandibular	\$35
Fixed Prosthodontic Services		
D6205	Pontic – indirect resin-based composite	\$177
D6210	Pontic – cast high noble metal	\$311
D6211	Pontic – cast predominantly base metal	\$311
D6212	Pontic – cast noble metal	\$311
D6240	Pontic – porcelain fused to high noble metal	\$299
D6241	Pontic – porcelain fused to predominantly base metal	\$299
D6242	Pontic – porcelain fused to noble metal	\$299
D6243	Pontic – porcelain fused to titanium and titanium alloys	\$299
D6250	Pontic – resin with high noble metal	\$177
D6251	Pontic – resin with predominantly base metal	\$177
D6252	Pontic – resin with noble metal	\$177
D6710	Crown – indirect resin-based composite	\$185
D6720	Crown – resin with high noble metal	\$185
D6721	Crown – resin with predominantly base metal	\$185
D6722	Crown – resin with noble metal	\$185
D6750	Crown – porcelain fused to high noble metal	\$299
D6751	Crown – porcelain fused to predominantly base metal	\$299
D6752	Crown – porcelain fused to noble metal	\$299
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	\$299

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

ADA Code	ADA description of services covered for you	What you must pay
D6780	Crown – 3/4 cast high noble metal	\$291
D6781	Crown – 3/4 cast predominantly base metal	\$430
D6782	Crown – 3/4 cast noble metal	\$430
D6784	Retainer crown ¾ - titanium and titanium alloys	\$430
D6790	Crown – full cast high noble metal	\$291
D6791	Crown – full cast predominantly base metal	\$291
D6792	Crown – full cast noble metal	\$291
D6930	Recement fixed partial denture	\$40
Oral Surgery Services		
D7111	Extraction coronal remnants – primary tooth	\$23
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$35
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$60
D7220	Removal of impacted tooth - soft tissue	\$80
D7510	Incision and drainage of abscess - intraoral soft tissue	\$80
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated	\$80
D7520	Incision and drainage of abscess - extraoral soft tissue	\$80
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated	\$80
Adjunctive General Services		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	\$35
D9120	Fixed partial denture sectioning	\$80
D9215	Local anesthesia in conjunction with outpatient surgical procedures	\$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	\$10
D9440	Office visit, after regularly scheduled hours	\$50
D9450	Case presentation	\$0
D9951	Occlusal adjustment - limited	\$25

NOTE: Removable or fixed prosthodontics such as complete dentures, removable partial dentures and bridgework are covered when performed by a contracted general dentist. Prosthodontic specialists are not included in the contracted network.

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

NOTE: If noble or high noble metals are used for fillings, crowns, bridges, or prosthetic devices, there will be an additional charge based on the amount of metal used.

NOTE: Unless you require non-Medicare covered emergency dental services, the listed Member Cost-Sharing amounts only apply when you receive dental services from a network dentist (See “Non-Medicare covered emergency dental care”).

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

Getting Routine Dental Care**Introduction**

Blue Shield’s dental plans are administered by a contracted Dental Plan Administrator (DPA), an entity that contracts with Blue Shield to administer the delivery of dental services through a network of contracted dentists. If you have any questions regarding the information in this dental section, need assistance, or have any problems, 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).

Before Obtaining Routine Dental Services

You are responsible for assuring that the dentist you choose is an in-network dentist.

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

NOTE: An in-network dentist’s status may change. It is your obligation to verify whether the dentist you choose is currently an in-network dentist in case there have been any changes to the list of contracted dentists. A list of in-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 network dentist and make an appointment. If you have questions about when the office is open, call the dental office directly.

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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.

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 Copayments

Copayments are due and payable at time of service or inception of care.

If you need additional assistance in getting information about your treatment plan or if you have any questions about the Copayments 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 the Copayment for the covered benefit as listed in the benefit 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

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

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 is any dental service (provided inside or outside the Blue Shield 65 Plus Service Area) required for treatment of severe pain, swelling, or bleeding, or the diagnosis and treatment of unforeseen dental conditions which, if not given immediate attention, may lead to disability, dysfunction, or permanent damage to your health.

In-area non-Medicare covered emergency dental care

If you feel you need non-Medicare covered emergency dental care and you are in the Blue Shield 65 Plus Service Area, immediately call a network dentist. The dental office personnel will advise you what to do. Network dentists are available in an emergency 24 hours a day, 7 days a week.

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

If you are outside the Blue Shield 65 Plus Service Area and require non-Medicare covered emergency dental care, you may obtain treatment from any licensed dentist. The services you receive from the out-of-area dentist are covered up to \$100 (minus any applicable Member Copayments) as long as transfer to a Network Provider is a risk to your health.

Reimbursement for out-of-area non-Medicare covered emergency dental care

You will be reimbursed up to \$100 (minus any applicable Member Copayments) for the cost of covered out-of-area non-Medicare covered emergency dental services. 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. Generally, bills for services must be submitted to Blue Shield of California within one year of the date of service, unless there is a reason for filing later.

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Our DPA will review the non-Medicare covered emergency dental service you received and notify you within 30 days from receipt of the claim if you qualify for reimbursement. 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 reimbursement claim 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. The notification will include the specific reason for the denial and will inform you that you may request a reconsideration of the denial.

To request reconsideration of the denial or partial denial, submit a written notice to Blue Shield 65 Plus within 60 calendar days from the date on the written denial notice.

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

Obtaining a second opinion for dental care

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

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

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

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

The DPA Director will review your request for a second opinion and, if the request is appropriate, will send you an authorization to visit another network dentist within your area. You will have 30 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.

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

Transferring to another dentist

If you are not satisfied with the in-network dentist you selected, you may select another dentist from the directory. To change your dentist, you must 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 Blue Shield 65 Plus allows for transfer in mid-procedure, you may be charged for laboratory charges incurred by the dentist in fabricating the dental appliance. The charges may not exceed the listed Copayments for the covered procedures. In addition, you may be charged for laboratory charges for any optional features ordered for you by your dentist.

Since the DPA cannot compel or require a contracted dentist to treat any Member for any reason, the DPA will notify Blue Shield 65 Plus when a breakdown of a workable dentist-patient relationship occurs or cannot be established.

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

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

If your selected in-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 canceled the contract, the DPA will notify you at least 30 days prior to the dentist's effective termination date so you may select another dentist.

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

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

If you have another dental plan

If you have two network prepaid plans, you may use the dental benefits administered by the DPA and included as part of your Blue Shield 65 Plus coverage or your other network prepaid plan, but not both.

If your selected dental office is the same for both of your prepaid plans, and the Copayments are different, the office will charge you the Cost-Sharing amounts associated with whichever plan ID card you present at the time of service.

Resolving disagreements

If you have concerns about any aspect of your dental plan benefits, contact the DPA customer service department for assistance toll free at (888) 679-8928 [TTY: 711]. You may also contact Blue Shield 65 Plus Customer Care (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 of California. 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 limitations for the routine dental HMO plan

1. Crowns, bridges, and dentures (including immediate dentures) may be replaced no earlier than 5 years after initial placement regardless of payer. Adjustments to crowns, bridges and dentures are included in the coverage for the appliance for the first 6 months after initial placement.
2. Partial dentures (including interim partial dentures, resin-based partial dentures and metal-framework partial dentures) can only be replaced 5 years after initial placement, unless replacement is due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
3. Denture relines are limited to one per denture (including immediate dentures) every 12 months.
4. Topical fluoride/fluoride varnish application are limited to one (1) visit every six (6) months.
5. Referral to a dental specialist is limited to only those procedures that cannot be performed by a contracted general dentist as determined by the Dental Director prior to service.
6. Prophylaxis is limited to one treatment every 6 months (includes periodontal maintenance following active therapy).
7. Replacement will be provided for an existing denture, partial denture or bridge once

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

- every five (5) years only if it is unsatisfactory and cannot be made satisfactory by reline or repair.
8. Non-surgical periodontal treatments (including but not limited to root planing/subgingival curettage) are limited to four quadrants during any 12 consecutive months. Surgical procedures are limited to one treatment per quadrant or area during any 36 consecutive months.
 9. Full mouth debridement (gross scale) is limited to one treatment in any 24 consecutive month period.
 10. Bitewing x-rays are limited to one series in any six-month period.
 11. Full mouth x-rays and/or panoramic type films are limited to one set every 24 consecutive months. A full mouth x-ray series is defined as a minimum of 6 periapical films plus bitewing x-rays.
 12. Single-unit cast metal and/or ceramic restorations and crowns are covered only when the Member is 17 years of age or older, and the tooth cannot be adequately restored with other restorative materials. Crown build-ups, including pins, are only allowable as a separate procedure when extensive tooth structure is lost and the need for a substructure can be demonstrated by written report and x-rays.
 13. Cosmetic dental care is limited to composite restorations on posterior teeth when a network dentist determines the treatment is appropriate dental care. Composite restorations will be covered on premolar facial surfaces. Crowns on molar teeth are limited to metal materials.
 14. The plan benefits include cast restorations using predominantly base metal. If the Member requests noble or high noble metal be used (for example: gold, semi-precious metals, etc.), the Member may be charged a surcharge based on the increase in laboratory charges for such metals.
 15. Dental services such as crowns, bridges or dentures started in one office (while the Member is covered by the Blue Shield 65 Plus) are considered “in progress” until delivered. Additional benefits will not be provided for such treatment in progress.
 16. Members who are temporarily outside the Blue Shield 65 Plus Service Area and require non-Medicare covered emergency dental care may obtain treatment from any licensed dentist. Services received from an out-of-area dentist are covered up to \$100 (minus any applicable Member Copayments) as long as transfer to a network dentist is a risk to the Member’s health.
 17. Sealants are limited to the first and second molars and bicuspid up to age 14.
 18. Cosmetic crowns (such as resin-based, noble metals, and porcelain) and pontics are not a covered benefits for molar teeth. Crowns on molar teeth are limited to base metal materials.

General exclusions for the routine dental HMO plan

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

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2. Services for which it is the professional opinion of Blue Shield's attending dentist or the Dental Director that a satisfactory result cannot be obtained, or the prognosis is poor or guarded, i.e., without a minimum service expectancy of 3 years, are excluded from coverage.
3. Removal of asymptomatic teeth, non-pathological teeth, extractions for orthodontic purposes, surgical orthognathic procedures, and crown exposure are excluded from coverage. Third- molar ("wisdom teeth") extraction is limited to only those instances where the teeth cannot be treated in a minimally invasive manner.
4. 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.
5. 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.
6. 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.).
7. Treatment/removal of malignancies, cysts, tumors, or neoplasms are not covered.
8. 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.
9. Treatment of fractures and dislocations of the jaws are not covered.
10. 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.
11. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage, and dental expenses incurred for treatment in progress prior to Member's eligibility with Blue Shield 65 Plus' coverage (for example: teeth prepared for crowns, root canals in progress, fixed and removable prosthetics) are

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not covered. For the purpose of this exclusion, the date on which a procedure shall be considered to have started is defined as follows:

- a. For full dentures or partial dentures: on the date the final impression is taken;
 - b. For fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared;
 - c. For root canal therapy: on the later of the date the pulp chamber is opened or the date canals are explored to the apex;
 - d. For periodontal surgery: on the date the surgery is actually performed;
 - e. For all other services: on the date the service is performed.
12. Crowns, bridges or dentures started in one office (while under Blue Shield 65 Plus coverage) are considered “in progress” until delivered. Additional benefits will not be provided for such treatment in progress.
13. Care provided by a prosthodontic specialist is not covered.
14. Replacement of lost or stolen fixed and removable dental prosthetics (crowns, bridges, full or partial dentures) regardless of payer is excluded from coverage.
15. The “ADA description of services” chart above is the definitive statement of coverage and supersedes all other materials. Any dental service that is not specifically listed as a covered benefit is excluded from coverage, regardless of any other written material presented or implied.
16. Crown lengthening procedures are not covered.
17. Replacement of long-standing missing teeth in an otherwise stable dentition is excluded from coverage. (For example: teeth missing two years or longer, not currently replaced, and where adjacent and opposing teeth are in occlusion.)
18. Treatment for individuals with medical or other barriers to receiving dental care in a network dental provider’s office or who have mental or behavioral limitations that affect the provider’s ability to render appropriate dental care in a network dental provider’s office is excluded from coverage.
19. Benefits do not include splinting, hemisection, implants, overdentures, grafting (unless otherwise stated), guided tissue regeneration, all ceramic-cast restorations, precision attachments, duplicate dentures, and appliances for the treatment of bruxism.
20. Pathology reports are excluded from coverage.
21. Dental treatment for crowns, bridges and/or dentures to restore tooth structure lost as a result of accidental injury are not covered. Accidental dental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from external forces to the mouth. Treatment for all accident-related services payable by another liability carrier other than a dental plan are not covered.

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

Section 2.2	Extra “optional supplemental” benefits you can buy
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Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package. These extra benefits are called “**Optional Supplemental Benefits.**” If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

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

- The HMO plan has a lower monthly Premium of \$12.50 and offers defined Member out-of-pocket costs; while,
- The PPO plan lets you choose from in- and out-of-network dentists, but you will pay a higher monthly Premium of \$42.30.

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 65 Plus optional supplemental Dental HMO and PPO plans

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

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

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

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

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

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

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

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

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

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

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

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

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

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

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

Re-enrolling

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

Refund of Premium

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

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

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

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

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

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, please refer to our “Alternate Benefit Provision” for more information.

Some dental services are not covered by the optional supplemental dental HMO or PPO plans under any conditions (also known as Exclusions), and some dental services are only covered under specific conditions (also known as Limitations). Please refer to the “General limitations” and “General exclusions” listed after this benefits chart for more information.

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

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

Conditions characterized by acute pain or infection include the following:

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

Emergent restorative conditions include the following:

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

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

Chapter 4 Medical Benefits Chart (what is covered and what you pay)**Summary of Benefits Chart**

	Dental HMO	Dental PPO	
Network Access	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists
Calendar year Deductible per Member (not applicable to Diagnostic and Preventive services provided by in-network and out-of-network dentists)	None	\$50	
Calendar year maximum per Member	\$1,000 for covered endodontic, periodontic and oral surgery services when performed by an in-network dental specialist. You pay any amount above the \$1,000 calendar year benefit maximum.	\$1,500 for covered preventive and comprehensive dental services combined, no matter if the services are performed by an in-network general dentist or a dental specialist. Up to \$1,000 of this maximum amount may be used for covered preventive and comprehensive dental services performed by out-of-network dentists in a calendar year. You pay any amount above the \$1,500 calendar year benefit maximum.	

There are no waiting periods for any covered services in either the Optional Supplemental dental HMO or PPO plan.

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

		What you must pay		
		Dental HMO	Dental PPO	
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists
Diagnostic Services				
D0120	Periodic oral evaluation - established patient	\$0	0%	20%
D0140	Limited oral evaluation - problem focused	\$0	0%	20%
D0150	Comprehensive oral evaluation - new or established patient	\$5	0%	20%
D0160	Detailed and extensive oral evaluation - problem focused, by report	\$0	0%	20%
D0170	Re-evaluation - limited, problem focused (not post-operative visit)	\$0	0%	20%
D0180	Comprehensive periodontal evaluation – new or established patient	\$5	0%	20%
D0210	Intraoral X-ray - complete series (including bitewings)	\$0	0%	20%
D0220	Intraoral X-ray – periapical, first film	\$0	0%	20%
D0230	Intraoral X-ray – periapical, each additional film	\$0	0%	20%
D0240	Intraoral X-ray - occlusal film	\$0	0%	20%
D0250	Extraoral X-ray - first film	\$0	0%	20%
D0270	Bitewing - single film	\$0	0%	20%
D0272	Bitewings - two films	\$0	0%	20%
D0273	Bitewings - three films	\$0	0%	20%
D0274	Bitewings - four films	\$0	0%	20%
D0277	Vertical bitewings - 7 to 8 films	\$0	0%	20%
D0330	Panoramic film	\$0	0%	20%
D0460	Pulp vitality tests	\$0	0%	20%
D0470	Diagnostic casts	\$10	0%	20%
D0701	Panoramic radiographic - image capture only	\$0	0%	20%
D0702	2-D cephalometric radiographic image - image capture only	\$0	0%	20%
D0706	Intraoral - occlusal radiographic image - image capture only	\$0	0%	20%
D0707	Intraoral - periapical radiographic image - image capture only	\$0	0%	20%
D0708	Intraoral - bitewing radiographic image - image capture only. Image axis may be horizontal or vertical.	\$0	0%	20%

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

		What you must pay		
		Dental HMO	Dental PPO	
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists
D0709	Intraoral - complete series of radiographic images - image capture only	\$0	0%	20%
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	\$0	20%	30%
D9995	Teledentistry – synchronous; real-time encounter	\$0	0%	20%
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	\$0	0%	20%
Preventive Services				
D1110	Prophylaxis - adult	\$5	0%	20%
D1206	Topical fluoride varnish	\$0	0%	20%
D1310	Nutritional counseling for control of dental disease	\$0	0%	20%
D1330	Oral hygiene instruction	\$0	0%	20%
D1351	Sealant - per tooth	\$5	0%	20%
Minor Restorative Services				
D2140	Amalgam - one surface, primary or permanent	\$8	20%	30%
D2150	Amalgam - two surfaces, primary or permanent	\$10	20%	30%
D2160	Amalgam - three surfaces, primary or permanent	\$15	20%	30%
D2161	Amalgam - four or more surfaces, primary or permanent	\$18	20%	30%
D2330	Resin-based composite - one surface, anterior	\$11	20%	30%
D2331	Resin-based composite - two surfaces, anterior	\$17	20%	30%
D2332	Resin-based composite - three surfaces, anterior	\$19	20%	30%
D2335	Resin-based composite - four or more surfaces or involving incisal angle, anterior	\$19	20%	30%
D2391	Resin-based composite – one surface, posterior	\$50	Not Covered	Not Covered
D2392	Resin-based composite – two surfaces, posterior	\$60	Not Covered	Not Covered

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

		What you must pay		
		Dental HMO	Dental PPO	
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists
D2393	Resin-based composite – three surfaces, posterior	\$70	Not Covered	Not Covered
D2394	Resin-based composite – four or more surfaces, posterior	\$80	Not Covered	Not Covered
Major Restorative Services				
D2510	Inlay - metallic - one surface	\$50	50%	50%
D2520	Inlay - metallic - two surfaces	\$70	50%	50%
D2530	Inlay - metallic - three or more surfaces	\$90	50%	50%
D2543	Onlay - metallic - three surfaces	\$110	50%	50%
D2544	Onlay - metallic - four or more surfaces	\$115	50%	50%
D2710	Crown - resin-based composite (indirect)	\$95	50%	50%
D2712	Crown - 3/4 resin-based composite (indirect)	\$95	50%	50%
D2720	Crown - resin with high noble metal	\$122	50%	50%
D2721	Crown - resin with predominantly base metal	\$122	50%	50%
D2722	Crown - resin with noble metal	\$122	50%	50%
D2740	Crown - porcelain/ceramic	\$275	50%	50%
D2750	Crown - porcelain fused to high noble metal	\$275	50%	50%
D2751	Crown - porcelain fused to predominantly base metal	\$275	50%	50%
D2752	Crown - porcelain fused to noble metal	\$275	50%	50%
D2753	Crown – porcelain fused to titanium and titanium alloys	\$275	50%	50%
D2780	Crown - 3/4 cast high noble metal	\$275	50%	50%
D2781	Crown - 3/4 cast predominantly base metal	\$275	50%	50%
D2782	Crown - 3/4 cast noble metal	\$275	50%	50%
D2790	Crown - full cast high noble metal	\$275	50%	50%
D2791	Crown - full cast predominantly base metal	\$275	50%	50%
D2792	Crown - full cast noble metal	\$275	50%	50%
D2910	Recement inlay, onlay or partial coverage restoration	\$10	50%	50%
D2915	Recement cast or prefabricated post and core	\$10	50%	50%
D2920	Recement crown	\$10	50%	50%
D2940	Protective restoration	\$0	50%	50%

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

		What you must pay		
		Dental HMO	Dental PPO	
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists
D2950	Core buildup, including any pins	\$30	50%	50%
D2951	Pin retention - per tooth - in addition to restoration	\$5	50%	50%
D2952	Post and core in addition to crown, indirectly fabricated	\$60	50%	50%
D2953	Each additional indirectly fabricated post, same tooth	\$60	50%	50%
D2954	Prefabricated post and core in addition to crown	\$35	50%	50%
D2960	Labial veneer (resin laminate) (direct)	\$73	50%	50%
D2961	Labial veneer (resin laminate) (indirect)	\$122	50%	50%
D2962	Labial veneer (porcelain laminate) (indirect)	\$295	50%	50%
Endodontic Services				
D3110	Pulp cap (direct) excluding final restoration	\$5	50%	50%
D3120	Pulp cap (indirect) excluding final restoration	\$5	50%	50%
D3310	Endodontic therapy - anterior tooth (excluding final restoration)	\$195/\$268	50%	50%
D3320	Endodontic therapy - premolar tooth (excluding final restoration)	\$250/\$332	50%	50%
D3330	Endodontic therapy - molar tooth (excluding final restoration)	\$335/\$425	50%	50%
D3346	Retreatment of previous root canal - anterior	\$195/\$268	50%	50%
D3347	Retreatment of previous root canal - bicuspid	\$250/\$332	50%	50%
D3348	Retreatment of previous root canal - molar	\$335/\$425	50%	50%
D3410	Apicoectomy/periradicular surgery - anterior	\$100	50%	50%
D3421	Apicoectomy/premolar (first root)	\$195	50%	50%
D3425	Apicoectomy/periradicular surgery - molar, first root	\$295	50%	50%
D3426	Apicoectomy/periradicular surgery - molar, each additional root	\$120	50%	50%
D3430	Retrograde filling - per root	\$120	50%	50%

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

		What you must pay		
		Dental HMO	Dental PPO	
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists
D3471	Surgical repair of root resorption – anterior	\$100	50%	50%
D3472	Surgical repair of root resorption – premolar. For surgery on root of premolar teeth. Does not include placement of restoration.	\$100	50%	50%
D3473	Surgical repair of root resorption – molar. For surgery on root of molar tooth. Does not include placement of restoration.	\$100	50%	50%
D3911	Intraoffice barrier	\$50	Not Covered	Not Covered
Periodontic Services				
D4210	Gingivectomy/gingivoplasty - four or more contiguous teeth or tooth bounded spaces - per quadrant	\$100	50%	50%
D4211	Gingivectomy/gingivoplasty - one to three contiguous teeth or tooth bounded spaces - per quadrant	\$20	50%	50%
D4240	Gingival flap procedure including root planing - four or more teeth - per quadrant	\$168	50%	50%
D4241	Gingival flap procedure including root planing - one to three teeth - per quadrant	\$112	50%	50%
D4260	Osseous surgery (including flap entry and closures) - four or more contiguous teeth or tooth bounded spaces - per quadrant	\$293	50%	50%
D4261	Osseous surgery (including flap entry and closures) - one to three contiguous teeth or tooth bounded spaces - per quadrant	\$195	50%	50%
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	\$168	50%	50%
D4341	Periodontal scaling and root planing - four or more teeth - per quadrant	\$45	50%	50%

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

		What you must pay		
		Dental HMO	Dental PPO	
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists
D4342	Periodontal scaling and root planing - one to three teeth - per quadrant	\$45	50%	50%
D4346	Scaling in presence of generalized moderate or severe gingival inflammation	\$20	Not Covered	Not Covered
D4355	Full mouth debridement to enable comprehensive oral evaluation and diagnosis on a subsequent visit	\$40	Not Covered	Not Covered
D4910	Periodontal maintenance	\$20	50%	50%
Removable Prosthetic Services				
D5110	Complete denture - maxillary	\$285	50%	50%
D5120	Complete denture - mandibular	\$285	50%	50%
D5130	Immediate denture - maxillary	\$285	50%	50%
D5140	Immediate denture - mandibular	\$285	50%	50%
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	\$149	50%	50%
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	\$149	50%	50%
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$310	50%	50%
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$185	50%	50%
D5221	Immediate maxillary partial denture – resin base	\$300	Not Covered	Not Covered
D5222	Immediate mandibular partial denture – resin base	\$300	Not Covered	Not Covered
D5282	Removable unilateral partial denture – one-piece cast metal (including retentive/clasping materials, rests and teeth), maxillary	\$185	50%	50%

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

ADA Code	ADA description of services covered for you	What you must pay		
		Dental HMO	Dental PPO	
		In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists
D5283	Removable unilateral partial denture – one-piece cast metal (including retentive/clasping materials, rests and teeth), mandibular	\$185	50%	50%
D5284	Removable unilateral partial denture – one-piece flexible base (including retentive/clasping materials, rests and teeth) – per quadrant	\$185	Not Covered	Not Covered
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests and teeth) – per quadrant	\$185	Not Covered	Not Covered
D5410	Adjust complete denture - maxillary	\$10	50%	50%
D5411	Adjust complete denture - mandibular	\$10	50%	50%
D5421	Adjust partial denture - maxillary	\$10	50%	50%
D5422	Adjust partial denture - mandibular	\$10	50%	50%
D5511	Repair broken complete denture base, mandibular	\$21	50%	50%
D5512	Repair broken complete denture base, maxillary	\$21	50%	50%
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$21	50%	50%
D5621	Repair cast partial framework, mandibular	\$22	50%	50%
D5622	Repair cast partial framework, maxillary	\$21	50%	50%
D5630	Repair or replace broken retentive/clasping materials – per tooth	\$25	50%	50%
D5640	Replace broken teeth - per tooth	\$27	50%	50%
D5650	Add tooth to existing partial denture	\$25	50%	50%
D5660	Add clasp to existing partial denture	\$33	50%	50%
D5670	Replace all teeth and acrylic on cast framework - maxillary	\$134	50%	50%
D5671	Replace all teeth and acrylic on cast framework - mandibular	\$134	50%	50%
D5710	Rebase complete maxillary denture	\$75	50%	50%
D5711	Rebase complete mandibular denture	\$75	50%	50%
D5720	Rebase maxillary partial denture	\$67	50%	50%
D5721	Rebase mandibular partial denture	\$67	50%	50%
D5725	Rebase hybrid prosthesis	\$75	50%	50%

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

		What you must pay		
		Dental HMO	Dental PPO	
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists
D5730	Reline complete maxillary denture (direct)	\$35	50%	50%
D5731	Reline complete mandibular denture (direct)	\$35	50%	50%
D5740	Reline maxillary partial denture (direct)	\$35	50%	50%
D5741	Reline mandibular partial denture (direct)	\$35	50%	50%
D5750	Reline complete maxillary denture (indirect)	\$59	50%	50%
D5751	Reline complete mandibular denture (indirect)	\$59	50%	50%
D5760	Reline maxillary partial denture (indirect)	\$59	50%	50%
D5761	Reline mandibular partial denture (indirect)	\$59	50%	50%
D5765	Soft liner for complete or partial removable denture	\$28	50%	50%
D5810	Interim complete denture - maxillary	\$145	50%	50%
D5811	Interim complete denture - mandibular	\$145	50%	50%
D5850	Tissue conditioning - maxillary	\$28	50%	50%
D5851	Tissue conditioning - mandibular	\$28	50%	50%
Fixed Prosthodontic Services				
D6205	Pontic - indirect resin-based composite	\$150	50%	50%
D6210	Pontic - cast high noble metal	\$210	50%	50%
D6211	Pontic - cast predominantly base metal	\$210	50%	50%
D6212	Pontic - cast noble metal	\$210	50%	50%
D6240	Pontic - porcelain fused to high noble metal	\$210	50%	50%
D6241	Pontic - porcelain fused to predominantly base metal	\$210	50%	50%
D6242	Pontic - porcelain fused to noble metal	\$210	50%	50%
D6243	Pontic – porcelain fused to titanium and titanium alloys	\$210	50%	50%
D6250	Pontic - resin with high noble metal	\$210	50%	50%
D6251	Pontic - resin with predominantly base metal	\$210	50%	50%
D6252	Pontic - resin with noble metal	\$210	50%	50%
D6602	Inlay - cast high noble metal - two surfaces	\$70	50%	50%

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

ADA Code	ADA description of services covered for you	What you must pay		
		Dental HMO	Dental PPO	
		In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists
D6603	Inlay - cast high noble metal - three or more surfaces	\$90	50%	50%
D6604	Inlay - cast predominantly base metal - two surfaces	\$70	50%	50%
D6605	Inlay - cast predominantly base metal - three or more surfaces	\$90	50%	50%
D6606	Inlay - cast noble metal- two surfaces	\$70	50%	50%
D6607	Inlay - cast noble metal - three or more surfaces	\$90	50%	50%
D6610	Onlay - cast high noble metal - two surfaces	\$275	50%	50%
D6611	Onlay - cast high noble metal - three or more surfaces	\$275	50%	50%
D6612	Onlay - cast predominantly base metal - two surfaces	\$275	50%	50%
D6613	Onlay - cast predominantly base metal - three or more surfaces	\$275	50%	50%
D6614	Onlay - cast noble metal- two surfaces	\$275	50%	50%
D6615	Onlay - cast noble metal - three or more surfaces	\$275	50%	50%
D6710	Crown - indirect resin-based composite	\$275	50%	50%
D6720	Crown - resin with high noble metal	\$275	50%	50%
D6721	Crown - resin with predominantly base metal	\$275	50%	50%
D6722	Crown - resin with noble metal	\$275	50%	50%
D6750	Crown - porcelain fused to high noble metal	\$275	50%	50%
D6751	Crown - porcelain fused to predominantly base metal	\$275	50%	50%
D6752	Crown - porcelain fused to noble metal	\$275	50%	50%
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	\$275	50%	50%
D6780	Crown - 3/4 cast high noble metal	\$275	50%	50%
D6781	Crown - 3/4 cast predominantly base metal	\$275	50%	50%
D6782	Crown - 3/4 cast noble metal	\$275	50%	50%
D6784	Retainer crown 3/4 – porcelain fused to titanium and titanium alloys	\$275	50%	50%
D6790	Crown - full cast high noble metal	\$275	50%	50%

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

		What you must pay		
		Dental HMO	Dental PPO	
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists
D6791	Crown - full cast predominantly base metal	\$275	50%	50%
D6792	Crown - full cast noble metal	\$275	50%	50%
D6930	Recement fixed partial denture	\$12	50%	50%
Oral Surgery Services				
D7111	Extraction, coronal remnants – primary tooth	\$10	50%	50%
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$15	50%	50%
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$30	50%	50%
D7220	Removal of impacted tooth – soft tissue	\$40	50%	50%
D7230	Removal of impacted tooth – partial bony	\$50	50%	50%
D7240	Removal of impacted tooth – complete bony	\$80	50%	50%
D7250	Surgical removal of residual tooth roots	\$60	50%	50%
D7285	Biopsy of oral tissue – hard (bone, tooth)	\$30	50%	50%
D7286	Biopsy of oral tissue – soft	\$70	50%	50%
D7287	Exfoliative cytological sample collection	\$15	50%	50%
D7288	Brush biopsy transepithelial sample collection	\$30	50%	50%
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces - per quadrant	\$75	50%	50%
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces - per quadrant	\$75	50%	50%
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces - per quadrant	\$70	50%	50%
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces - per quadrant	\$70	50%	50%
D7471	Removal of lateral exostosis (maxilla or mandible)	\$94	50%	50%

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

		What you must pay		
		Dental HMO	Dental PPO	
ADA Code	ADA description of services covered for you	In-Network Dentists only	In-Network Dentists	Out-of-Network Dentists
D7510	Incision & drainage of abscess – intraoral soft tissue	\$19	50%	50%
D7511	Incision & drainage of abscess – intraoral soft tissue – complicated	\$19	50%	50%
D7520	Incision & drainage of abscess – extraoral soft tissue	\$19	50%	50%
D7521	Incision & drainage of abscess – extraoral soft tissue – complicated	\$19	50%	50%
D7963	Frenuloplasty	Not Covered	50%	50%
D7970	Excision of hyperplastic tissue – per arch	\$71	50%	50%
Adjunctive General Services				
D9110	Palliative (emergency) treatment of dental pain – minor procedure	\$8	20%	30%
D9120	Fixed partial denture sectioning	\$24	20%	30%
D9215	Local anesthesia in conjunction with outpatient surgical procedures	\$0	20%	30%
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	\$0	Not Covered	Not Covered
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	\$3	20%	30%
D9440	Office visit – after regularly scheduled hours	\$25	20%	30%
D9450	Case presentation	\$0	20%	30%
D9951	Occlusal adjustment - limited	Not Covered	20%	30%

General notes for the optional supplemental HMO dental plan:

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

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

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

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

Getting routine dental care**Before Obtaining Dental Services**

If you purchased the optional supplemental dental HMO plan, you are responsible for assuring that the dentist you choose is an in-network dentist. For the optional supplemental PPO plan, you are able to choose from in- and out-of-network dentists. However, if you choose to go to an in-network dentist to lower your costs, you are responsible for assuring that the dentist you choose is an in-network dentist.

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

Visiting your dentist**Optional Supplemental Dental HMO Plan:**

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

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

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Optional Supplemental Dental PPO Plan:

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

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

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

Member Cost-Sharing

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

Optional Supplemental Dental HMO Plan:

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

Optional Supplemental Dental PPO Plan:

The Deductible is due and payable at time of service or inception of care. You may be billed at a later date by your dental provider for your 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. It is therefore to your advantage to obtain dental services from in network dentists.

Chapter 4 Medical Benefits Chart (what is covered and what you pay)**OPTIONAL SUPPLEMENTAL DENTAL PPO PLAN MEMBER COST-SHARING EXAMPLE:**

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

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

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

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

Deductible: \$50

Amount paid to date toward Deductible: \$50

In-Network Dentist Coinsurance: 50%

Out-of-Network Dentist Coinsurance: 50%

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

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

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

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

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

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

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

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 dental services from in-network dentists.

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

Optional dental treatment

Optional dental treatment is any procedure that is:

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

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

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

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

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

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Non-Medicare covered emergency dental care

Non-Medicare covered emergency dental care is any dental service (provided inside or outside the Blue Shield 65 Plus plan Service Area) required for treatment of severe pain, swelling, or bleeding, or the diagnosis and treatment of unforeseen dental conditions which, if not given immediate attention, may lead to disability, dysfunction, or permanent damage to your health.

In-area non-Medicare covered emergency dental care

If you feel you need non-Medicare covered emergency dental care and you are in the Blue Shield 65 Plus plan Service Area, immediately call your dentist. The dental office personnel will advise you what to do. Network dentists are available in an emergency 24 hours a day, 7 days a week.

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

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

Optional Supplemental Dental HMO reimbursement:

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

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

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

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

Optional Supplemental Dental PPO reimbursement:

You will be reimbursed at the payment percentage listed under the Out-of-Network dentist's portion of the *Summary of Benefits Chart*. You will be responsible for the remainder of your dentist's billed charges. Whenever possible, you should ask your dentist to send the bill directly to Blue Shield at the address listed above. Our DPA will review the non-Medicare covered emergency dental service you received and notify you within 30 days from receipt of the claim if you qualify for reimbursement. 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. The notification will include the specific reason for the denial and will inform you that you may request a reconsideration of the denial.

To request reconsideration of the denial or partial denial, submit a written notice to Blue Shield 65 Plus within 60 calendar days from the date on the written denial notice.

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

Obtaining a second opinion for dental care

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

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

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

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

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

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

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Transferring to another dentist

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

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

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

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

Since the DPA cannot compel or require a contracted dentist to treat any Member for any reason, the DPA will notify Blue Shield 65 Plus when a breakdown of a workable dentist-patient relationship occurs or cannot be established.

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

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

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

If your selected in-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 canceled the contract, the DPA will notify you at least 30 days prior to the dentist's effective termination date so you may select another dentist.

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

If you have another dental plan

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

Resolving disagreements

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

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

General limitations for the optional supplemental Dental HMO and PPO plans

1. Crowns, bridges, and dentures (including immediate dentures) may be replaced no earlier than 5 years after initial placement regardless of payer. Adjustments to crowns, bridges and dentures are included in the coverage for the appliance for the first 6 months after initial placement.
2. Partial dentures (including interim partial dentures, resin-based partial dentures and metal-framework partial dentures) can only be replaced 5 years after initial placement, unless replacement is due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

3. Denture relines are limited to one per denture (including immediate dentures) every 12 months.
4. Periodic oral exam is limited to two (2) visits in a twelve (12) month period.
5. Cosmetic crowns (such as resin-based, noble metals, and porcelain) and pontics are not a covered benefit for molar teeth. Crowns on molar teeth are limited to base metal materials.

General limitations for the optional supplemental Dental HMO plan only

1. The maximum amount the plan will pay for specialty care is \$1,000 per calendar year. Once the plan has paid \$1,000, the Member is responsible for all costs for specialty care.
2. Referral to a dental specialist is limited to only those procedures that cannot be performed by a contracted general dentist as determined by the Dental Director prior to service.
3. Prophylaxis is limited to one treatment every 6 months (includes periodontal maintenance following active therapy).
4. Replacement will be provided for an existing denture, partial denture or bridge once every five (5) years only if it is unsatisfactory and cannot be made satisfactory by reline or repair.
5. Non-surgical periodontal treatments (including but not limited to root planing/subgingival curettage) are limited to four quadrants during any 12 consecutive months. Surgical procedures are limited to one treatment per quadrant or area during any 36 consecutive months.
6. Full mouth debridement (gross scale) is limited to one treatment in any 24 consecutive month period.
7. Bitewing x-rays are limited to one series in any six-month period.
8. Full mouth x-rays and/or panoramic type films are limited to one set every 24 consecutive months. A full mouth x-ray series is defined as a minimum of 6 periapical films plus bitewing x-rays.
9. Single-unit cast metal and/or ceramic restorations and crowns are covered only when the Member is 17 years of age or older, and the tooth cannot be adequately restored with other restorative materials. Crown build-ups, including pins, are only allowable as a separate procedure when extensive tooth structure is lost and the need for a substructure can be demonstrated by written report and x-rays.
10. Cosmetic dental care is limited to composite restorations on posterior teeth when a network dentist determines the treatment is appropriate dental care. Composite restorations will be covered on premolar facial surfaces. Crowns on molar teeth are limited to metal materials.

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11. The plan benefits include cast restorations using predominantly base metal. If the Member requests noble or high noble metal be used (for example: gold, semi-precious metals, etc.), the Member may be charged a surcharge based on the increase in laboratory charges for such metals.
12. Dental services such as crowns, bridges or dentures started in one office (while the Member is covered by the Blue Shield 65 Plus optional supplemental dental HMO plan) are considered “in progress” until delivered. Additional benefits will not be provided for such treatment in progress.
13. Members who are temporarily outside the Blue Shield 65 Plus plan Service Area and require non-Medicare covered emergency dental care may obtain treatment from any licensed dentist. Services received from an out-of-area dentist are covered up to \$100 (minus any applicable Member Copayments) as long as transfer to a network dentist is a risk to the Member’s health.
14. Sealants are limited to the first and second molars and bicuspid up to age 14.

General limitations for the optional supplemental Dental PPO plan only

The following services will be subject to limitations as set forth below:

1. One (1) in a six (6) month period:
 - a. Routine prophylaxis;
 - b. Recementations if the crown or inlay was provided by other than the original dentist; not eligible if the dentist is doing the recementation of a service he/she provided within twelve (12) months.
2. One (1) in a twelve (12) month period:
 - a. Oral cancer screening;
 - b. Bitewing x-rays (maximum four (4) per year).
3. Two (2) visits in a twelve (12) month period:
 - a. Periodic oral exam;
 - b. Topical fluoride/fluoride varnish application.
4. One in a twenty-four (24) month period:
 - a. Gingival flap surgery per quad;
 - b. Scaling and root planning per area (limited to 2 quadrants per visit);
 - c. Occlusal guards;
 - d. Diagnostic casts;
 - e. Sealants.
5. Two quadrants in a twenty-four (24) month period:
 - a. Non-surgical periodontal treatments (including but not limited to root planing/subgingival curettage);
 - b. General Anesthesia/IV sedation.
6. One in a thirty-six (36) month period:
 - a. Mucogingival surgery per area;

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- b. Osseous surgery per quad;
 - c. Full mouth debridement;
 - d. Gingivectomy per quad;
 - e. Gingivectomy per tooth;
 - f. Bone replacement grafts for periodontal purposes;
 - g. Guided tissue regeneration for periodontal purposes;
 - h. Full mouth series and panoramic x-rays.
7. One (1) in a five (5) year period:
- a. Single crowns and onlays;
 - b. Single post and core buildups;
 - c. Crown buildup including pins;
 - d. Prefabricated post and core;
 - e. Cast post and core in addition to crown;
 - f. Fixed partial denture (bridge) pontics;
 - g. Fixed partial denture (bridge) abutments;
 - h. Abutment post and core buildups.
8. Oral surgery services are limited to removal of teeth, bony protuberances and frenectomy.
9. An Alternate Benefit Provision (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.
10. General or IV Sedation is covered for:
- a. 3 or more surgical extractions;
 - b. Any number of dentally necessary impactions;
 - c. Full mouth or arch alveoloplasty;
 - d. Surgical root recovery from sinus;
 - e. Medical problem contraindicates the use of local anesthesia.
- NOTE:** General or IV Sedation is not a covered benefit for dental phobic reasons.
11. Restorations, crowns, inlays and onlays - covered only if necessary to treat diseased or accidentally fractured teeth.
12. Root canal treatment – one per tooth per lifetime.
13. Root canal retreatment – one per tooth per lifetime.

General exclusions for the optional supplemental Dental HMO and PPO plans

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

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2. Services for which it is the professional opinion of Blue Shield's attending dentist or the Dental Director that a satisfactory result cannot be obtained, or the prognosis is poor or guarded, i.e., without a minimum service expectancy of 3 years, are excluded from coverage.
3. Removal of asymptomatic teeth, non-pathological teeth, extractions for orthodontic purposes, surgical orthognathic procedures, and crown exposure are excluded from coverage. Third-molar ("wisdom teeth") extraction is limited to only those instances where the teeth cannot be treated in a minimally invasive manner.
4. 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.
5. 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.
6. 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.).
7. Treatment/removal of malignancies, cysts, tumors, or neoplasms are not covered.
8. 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.
9. Treatment of fractures and dislocations of the jaws are not covered.
10. 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.
11. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage, and dental expenses incurred for treatment in progress prior to Member's eligibility with Blue Shield 65 Plus optional supplemental dental PPO coverage (for example: teeth prepared for crowns, root canals in progress, fixed and removable prosthetics) are not covered. For the purpose of this exclusion, the date on which a procedure shall be considered to have started is defined as follows:
 - a. For full dentures or partial dentures: on the date the final impression is taken;
 - b. For fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared;
 - c. For root canal therapy: on the later of the date the pulp chamber is opened or the date canals are explored to the apex;
 - d. For periodontal surgery: on the date the surgery is actually performed;
 - e. For all other services: on the date the service is performed.

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12. Crowns, bridges or dentures started in one office (while under Blue Shield 65 Plus optional supplemental dental HMO and PPO coverage) are considered “in progress” until delivered. Additional benefits will not be provided for such treatment in progress.
13. Care provided by a prosthodontic specialist is not covered.

General exclusions for the optional supplemental Dental HMO plan only

1. General anesthesia and the services of a special anesthesiologist, intravenous and inhalation sedation, and prescription drugs for dental procedures are excluded from coverage.
2. Replacement of lost or stolen fixed and removable dental prosthetics (crowns, bridges, full or partial dentures) regardless of payer is excluded from coverage.
3. The “ADA description of services” chart above is the definitive statement of coverage and supersedes all other materials. Any dental service that is not specifically listed as a covered benefit is excluded from coverage, regardless of any other written material presented or implied.
4. Crown lengthening procedures are not covered.
5. Replacement of long-standing missing teeth in an otherwise stable dentition is excluded from coverage. (For example: teeth missing two years or longer, not currently replaced, and where adjacent and opposing teeth are in occlusion.)
6. Treatment for individuals with medical or other barriers to receiving dental care in a network dental provider’s office or who have mental or behavioral limitations that affect the provider’s ability to render appropriate dental care in a network dental provider’s office is excluded from coverage.
7. Benefits do not include splinting, hemisection, implants, overdentures, grafting (unless otherwise stated), guided tissue regeneration, all ceramic-cast restorations, precision attachments, duplicate dentures, and appliances for the treatment of bruxism.
8. Pathology reports are excluded from coverage.
9. Dental treatment for crowns, bridges and/or dentures to restore tooth structure lost as a result of accidental injury are not covered. Accidental dental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from external forces to the mouth. Treatment for all accident-related services payable by another liability carrier other than a dental plan are not covered.
10. Dental services received from any dentist other than a network dentist, unless expressly authorized in writing by Blue Shield 65 Plus prior to treatment, are excluded from coverage.

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

General exclusions for the optional supplemental Dental PPO plan only

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

1. Charges for vestibuloplasty (i.e., surgical modification of the jaw, gums and adjacent tissues), and for any procedure, service, or supply including office visits, examination, and diagnosis provided directly or indirectly to treat a muscular, neural, or skeletal disorder, diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint syndrome (TMJ) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint.
2. Charges for services performed by a close relative or by a person who ordinarily resides in the Member's home.
3. Services, procedures, or supplies which are not reasonably necessary for the care of the Member's dental condition according to broadly accepted standards of professional care or which are experimental or investigational in nature or which do not have uniform professional endorsement.
4. The replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, inlay or onlay, etc.) within five (5) years of its installation.
5. Myofunctional therapy; biofeedback procedures; athletic mouthguards; precision or semi-precision attachments; denture duplication; oral hygiene instruction; treatment of jaw fractures.
6. Alloplastic bone grafting materials.
7. Bone grafting done for socket preservation after tooth extraction or in preparation for implants.
8. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable.
9. Extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues).
10. Services for which the Member is not legally obligated to pay, or for services for which no charge is made.
11. Treatment for which payment is made by any governmental agency, including any foreign government.
12. Charges for prosthetic appliances, fixed or removable, which are related to periodontal treatment.
13. Charges for onlays or crowns installed as multiple abutments.
14. Charges for any inlay restoration.

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

15. Charges for dental appointments which are not kept.
16. Charges for services incident to any intentionally self-inflicted injury.
17. Removal of 3rd 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 pericoronitis alone is not dental necessity.
18. 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.
19. 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.
20. Procedures which are principally cosmetic in nature such as bleaching, veneers, use of porcelain on molar teeth, personalization and characterization of dentures.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do <i>not</i> cover (exclusions)
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This section tells you what services are “excluded” from Medicare coverage and therefore, are not covered by this plan.

The chart below lists services and items that either are not 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 receive the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them. The only exception is if the service is appealed and decided: upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this document.)

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		Available for people with chronic low back pain under certain circumstances. Additional coverage as described in the Medical Benefits Chart earlier in this chapter.
Cosmetic surgery or procedures		<ul style="list-style-type: none"> Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care. Custodial care is personal care that does not 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.	✓	
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. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Home-delivered meals		Coverage as described in the Medical Benefits Chart earlier in this chapter.
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Naturopath services (uses natural or alternative treatments).	✓	
Non-routine dental care		Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet		Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with, diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Private room in a hospital.		Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Routine chiropractic care		Manual manipulation of the spine to correct a subluxation is covered. Additional coverage as described in the Medical Benefits Chart earlier in this chapter.
Routine dental care, such as cleanings, fillings, or dentures.		Coverage as described in the Medical Benefits Chart, the Routine Dental Benefits Procedure Chart and the optional supplemental dental Summary of Benefits Chart earlier in this chapter.

Chapter 4 Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		<p>Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.</p> <p>Additional coverage as described in the Medical Benefits Chart earlier in this chapter.</p>
Routine foot care		Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Routine hearing exams, hearing aids, or exams to fit hearing aids.		<p>Coverage as described in the Medical Benefits Chart earlier in this chapter.</p> <p>Additional coverage as described in the Medical Benefits Chart earlier in this chapter.</p>
Services considered not reasonable and necessary, according to Original Medicare standards		Covered only if listed by our plan as covered services.

CHAPTER 5:

*Using the plan's coverage
for Part D prescription drugs*

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**. Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

Section 1.1 Basic rules for the plan's Part D drug coverage

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail service pharmacy*).
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List"*).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail service pharmacy

Section 2.1 Use a network pharmacy
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In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

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

Section 2.2 Network pharmacies
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How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (blueshieldca.com/medpharmacy2023), and/or call Customer Care.

Chapter 5 Using the plan's coverage for Part D prescription drugs

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

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. Or if the pharmacy you have been using stays within the network but is no longer offering preferred cost sharing, you may want to switch to a different network or preferred pharmacy, if available. To find another pharmacy in your area, you can get help from Customer Care or use the *Pharmacy Directory*. You can also find information on our website at blueshieldca.com/medpharmacy2023.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Care.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (**Note:** This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Customer Care.

Section 2.3	Using the plan's mail service pharmacy
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For certain kinds of drugs, you can use the plan's network mail service pharmacy. Generally, the drugs provided through mail service are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs that are *not* available through the plan's mail service pharmacy are marked with the symbol **NDS** in our Drug List.

Our plan's mail service pharmacy allows you to order **up to a 100-day supply for Tier 1: Preferred Generic Drugs and a 90-day supply for Tier 2: Generic Drugs, Tier 3: Preferred Brand Drugs and Tier 4: Non-Preferred Drugs.**

Chapter 5 Using the plan's coverage for Part D prescription drugs

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

Usually, a mail service pharmacy order will get to you in no more than 14 days. However, sometimes your mail service prescription may be delayed. If you receive notification that there may be a delay in the shipment of your prescription, at no fault of your own, by the mail service pharmacy, please contact Customer Care at the number on the back cover of this document. A Blue Shield representative will assist you in obtaining a sufficient supply of medication from a local retail network pharmacy, so you are not without medication until your mail service medication arrives. This may require contacting your physician to have him/her phone or fax a new prescription to the retail network pharmacy for the necessary quantity of medication needed until you receive your mail service medication.

If the delay is greater than 14 days from the date the prescription was ordered from the mail service pharmacy and the delay is due to a loss of medication in the mail system, Customer Care can coordinate a replacement order with the mail service pharmacy.

New prescriptions the pharmacy receives directly from your doctor's office.

After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

Refills on mail service prescriptions. For refills, please contact your pharmacy 14 days before your current prescription will run out to make sure your next order is shipped to you in time.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

Section 2.4	How can you get a long-term supply of drugs?
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When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network (which offer preferred cost sharing) allow you to get a long-term supply of maintenance drugs at the mail service cost-sharing amount. Other retail pharmacies may not agree to the mail service cost-sharing amounts. In this case you will be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Care for more information.

Chapter 5 Using the plan's coverage for Part D prescription drugs

2. You may also receive maintenance drugs through our mail service pharmacy. Please see Section 2.3 for more information.

Section 2.5	When can you use a pharmacy that is not in the plan's network?
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Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Customer Care** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail service pharmacy (these drugs include orphan drugs, high-cost and unique drugs or other specialty pharmaceuticals).
- Some vaccines administered in your physician's office that are not covered under Medicare Part B and cannot reasonably be obtained at a network pharmacy may be covered under our out-of-network access.
- Prescriptions filled at out-of-network pharmacies are limited to a 30-day supply of covered medications.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

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

Section 3.1 The "Drug List" tells which Part D drugs are covered
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The plan has a "*List of Covered Drugs (Formulary)*." In this *Evidence of Coverage*, we call it the **"Drug List"** for short.

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The drugs on the Drug List are only those covered under Medicare Part D.

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

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.
- -- *or* -- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the drug list, when we refer to "drugs," this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or biological product and usually cost less. There are generic drug substitutes or biosimilar alternatives available for many brand name drugs and some biological products.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List. In some cases, you may be able to obtain a drug that is not on the drug list. For more information, please see Chapter 9.

Section 3.2 There are five “cost-sharing tiers” for drugs on the Drug List

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

- Cost-Sharing Tier 1: Preferred Generic Drugs (lowest cost-sharing tier)
Includes preferred generic drugs.
- Cost-Sharing Tier 2: Generic Drugs
Includes generic drugs.
- Cost-Sharing Tier 3: Preferred Brand Drugs
Includes preferred brand name.
- Cost-Sharing Tier 4: Non-Preferred Drugs
Includes non-preferred brand name and some generic drugs.
- Cost-Sharing Tier 5: Specialty Tier Drugs (highest cost-sharing tier)
Includes very high-cost brand name and generic drugs which may require special handling and/or close monitoring.

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

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Check the most recent Drug List we provided electronically.
2. Visit the plan's website ([blueshieldca.com/medformulary2023](https://www.blueshieldca.com/medformulary2023)). The Drug List on the website is always the most current.
3. Call Customer Care to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. If a safe, lower-cost drug will work just as well medically

Chapter 5 Using the plan's coverage for Part D prescription drugs

as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

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

Section 4.2	What kinds of restrictions?
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The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Customer Care to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9)

Restricting brand name drugs when a generic version is available

Generally, a “generic” drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version instead of the brand name drug.** However, if your provider has told us the medical reason that the generic drug will not work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called “**prior authorization**.” This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called “**step therapy**.”

Quantity limits

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

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered
--

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- The drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?
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If your drug is not on the Drug List or is restricted, here are options:

- You may be able to get a temporary supply of the drug
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

Chapter 5 Using the plan's coverage for Part D prescription drugs

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

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

For questions about a temporary supply, call Customer Care.

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

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

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

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

Section 5.3	What can you do if your drug is in a cost-sharing tier you think is too high?
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If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

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

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

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

SECTION 6	What if your coverage changes for one of your drugs?
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Section 6.1	The Drug List can change during the year
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Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.**
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic drug.**

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

Section 6.2	What happens if coverage changes for a drug you are taking?
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Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan year

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
 - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
 - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
 - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9.
- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
 - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you right away.
 - Your prescriber will also know about this change and can work with you to find another drug for your condition.
- **Other changes to drugs on the Drug List**
 - We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the Drug List or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

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- For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.
- After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
- You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9.

Changes to the Drug List that do not affect you during this plan year

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

In general, changes that will not affect you during the current plan year are:

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

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restrictions to your use of the drug.

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

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover
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This section tells you what kinds of prescription drugs are “excluded.” This means Medicare does not pay for these drugs.

Chapter 5 Using the plan's coverage for Part D prescription drugs

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

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
- Coverage for "off-label use" is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

In addition, if you are **receiving "Extra Help"** to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will

Chapter 5 Using the plan's coverage for Part D prescription drugs

automatically bill the plan for *our* share of your drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2	What if you don't have your membership information with you?
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If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then ask us to reimburse you for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9	Part D drug coverage in special situations
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Section 9.1	What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?
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If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

Section 9.2	What if you're a resident in a long-term care (LTC) facility?
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Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy or uses a pharmacy that supplies drugs for all of its residents. If you are a resident of a LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Customer Care. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Drug List or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3	What if you're also getting drug coverage from an employer or retiree group plan?
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If you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator**. He or she can help you determine how your current prescription drug coverage will work with our plan.

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

Special note about 'creditable coverage':

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

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

Keep this notice about creditable coverage because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4	What if you're in Medicare-certified hospice?
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Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication or antianxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

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

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

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

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

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

- Requiring you to get all your prescriptions for opioid medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid medications from a certain doctor(s)
- Limiting the amount of opioid medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will explain the limitations we think should apply to you. You will have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to

respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3	Medication Therapy Management (MTM) program to help members manage their medications
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We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

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

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

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Customer Care.

CHAPTER 6:

*What you pay for your
Part D prescription drugs*

Chapter 6 What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Customer Care, and ask for the “LIS Rider.”

SECTION 1 Introduction

Section 1.1	Use this chapter together with other materials that explain your drug coverage
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This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use “drug” in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules.

Section 1.2	Types of out-of-pocket costs you may pay for covered drugs
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There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called “cost sharing” and there are three ways you may be asked to pay.

- The “**deductible**” is the amount you pay for drugs before our plan begins to pay its share.
- “**Copayment**” is a fixed amount you pay each time you fill a prescription.
- “**Coinsurance**” is a percentage of the total cost you pay each time you fill a prescription.

Section 1.3	How Medicare calculates your out-of-pocket costs
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Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

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

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

- The amount you pay for drugs when you are in any of the following drug payment stages:
 - The Initial Coverage Stage
 - The Coverage Gap Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$7,400 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

Your out-of-pocket costs **do not include** any of these types of payments:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.

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- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Customer Care.

How can you keep track of your out-of-pocket total?

- **We will help you.** The Part D EOB report you receive includes the current amount of your out-of-pocket costs. When this amount reaches \$7,400, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.]

SECTION 2 What you pay for a drug depends on which “drug payment stage” you are in when you get the drug

Section 2.1	What are the drug payment stages for Blue Shield 65 Plus members?
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There are four “drug payment stages” for your prescription drug coverage under Blue Shield 65 Plus. How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage**Stage 2: Initial Coverage Stage****Stage 3: Coverage Gap Stage****Stage 4: Catastrophic Coverage Stage**

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.

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1	We send you a monthly summary called the <i>Part D Explanation of Benefits</i> (the “Part D EOB”)
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Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your “**out-of-pocket**” cost.
- We keep track of your “**total drug costs**.” This is the amount you pay out-of-pocket, or others pay on your behalf plus the amount paid by the plan.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a *Part D Explanation of Benefits* (“Part D EOB”). The Part D EOB includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called “year-to-date” information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim.

Section 3.2	Help us keep our information about your drug payments up to date
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To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. Here are examples of when you should give us copies of your drug receipts:
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan’s benefit.

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- When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive the Part D EOB look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Customer Care. Be sure to keep these reports.

SECTION 4 There is no deductible for Blue Shield 65 Plus

There is no deductible for Blue Shield 65 Plus. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs, and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription
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During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has five cost-sharing tiers

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

- **Cost-Sharing Tier 1: Preferred Generic Drugs (lowest cost-sharing tier)**
Includes preferred generic drugs.
- **Cost-Sharing Tier 2: Generic Drugs**
Includes generic drugs.

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- Cost-Sharing Tier 3: Preferred Brand Drugs
Includes preferred brand.
- Cost-Sharing Tier 4: Non-Preferred Drugs
Includes non-preferred brand name and some generic drugs.
- Cost-Sharing Tier 5: Specialty Tier Drugs (highest cost-sharing tier)
Includes very high-cost brand name and generic drugs which may require special handling and/or close monitoring.

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

Your pharmacy choices

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

- A network retail pharmacy that offers standard cost sharing. Costs may be less at pharmacies that offer preferred cost sharing.
- A network retail pharmacy that offers preferred cost sharing
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail service pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and the plan's *Pharmacy Directory*.

Section 5.2	A table that shows your costs for a <i>one-month</i> supply of a drug
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During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on the cost-sharing tier.

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

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Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	Standard retail cost sharing (in-network) (up to a 30-day supply)	Preferred retail cost sharing (in-network) (up to a 30-day supply)	Mail-order cost sharing (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generic Drugs)	\$5 copay	\$0 copay	Mail service is not available for drugs in Tier 1.	\$5 copay	\$5 copay
Cost-Sharing Tier 2 (Generic Drugs)	\$18 copay	\$10 copay	Mail service is not available for drugs in Tier 2.	\$18 copay	\$18 copay
Cost-Sharing Tier 3 (Preferred Brand Drugs)	\$47 copay	\$40 copay	Mail service is not available for drugs in Tier 3.	\$47 copay	\$47 copay
Cost-Sharing Tier 4 (Non-Preferred Drugs)	\$100 copay	\$95 copay	Mail service is not available for drugs in Tier 4.	\$100 copay	\$100 copay
Cost-Sharing Tier 5 (Specialty Tier Drugs)	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance

Section 5.3	If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply
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Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

- If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.
- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.

If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.

Section 5.4	A table that shows your costs for a <i>long-term</i> (up to a 90- or 100-day) supply of a drug
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For some drugs, you can get a long-term supply (also called an "extended supply"). A long-term supply is up to a 90- or 100-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

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

Chapter 6 What you pay for your Part D prescription drugs

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Tier	Standard retail cost sharing (in-network)	Preferred retail cost sharing (in-network)	Mail service cost sharing
Cost-Sharing Tier 1 Preferred Generic Drugs (up to a 100-day supply)	\$5 copay	\$0 copay	\$0 copay
Cost-Sharing Tier 2 Generic Drugs (up to a 90-day supply)	\$54 copay	\$15 copay	\$15 copay
Cost-Sharing Tier 3 Preferred Brand Drugs (up to a 90-day supply)	\$141 copay	\$100 copay	\$100 copay
Cost-Sharing Tier 4 Non-Preferred Drugs (up to a 90-day supply)	\$300 copay	\$237.50 copay	\$237.50 copay
Cost-Sharing Tier 5 Specialty Tier Drugs (up to a 90-day supply)	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

Section 5.5	You stay in the Initial Coverage Stage until your total drug costs for the year reach \$4,660
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You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **\$4,660 limit for the Initial Coverage Stage**.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf during the year. Many people do not reach the \$4,660 limit in a year.

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We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 Costs in the Coverage Gap Stage

For Cost-Sharing Tier 1 (Preferred Generic Drugs) and Cost-Sharing Tier 2 (Generic Drugs): You pay the copayment listed in the tables shown above in Sections 5.2 and 5.4. For Cost-Sharing Tier 1 (Preferred Generic Drugs) and Cost-Sharing Tier 2 (Generic Drugs), the amount paid by the plan does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

For Cost-Sharing Tier 3 (Preferred Brand Drugs), Cost-Sharing Tier 4 (Non-Preferred Drugs) and Cost-Sharing Tier 5 (Specialty Tier Drugs): When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay, and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 25% of the cost for generic drugs and the plan pays the rest. Only the amount you pay counts and moves you through the coverage gap.

You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount \$7,400, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.

Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs (Chapter 4, Section 1.3).

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$7,400 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs. You will pay:

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
 - *either* – coinsurance of 5% of the cost of the drug
 - *or* – \$4.15 for a generic drug or a drug that is treated like a generic and \$10.35 for all other drugs.

SECTION 8 Part D Vaccines. What you pay for depends on how and where you get them

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

There are two parts to our coverage of Part D vaccinations:

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

Your costs for a Part D vaccination depend on three things:

- 1. The type of vaccine** (what you are being vaccinated for).
 - Some vaccines are considered medical benefits. (See the *Medical Benefits Chart (what is covered and what you pay)* in Chapter 4).
 - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s *List of Covered Drugs (Formulary)*.
- 2. Where you get the vaccine.**
 - The vaccine itself may be dispensed by a pharmacy or provided by the doctor’s office.
- 3. Who gives you the vaccine.**
 - A pharmacist may give the vaccine in the pharmacy, or another provider may give it in the doctor’s office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what Drug Stage you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit.

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

- Situation 1:* You get your vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give vaccines.)
- You will pay the pharmacy your coinsurance or copayment for the vaccine itself which includes the cost of giving you the vaccine.

Chapter 6 What you pay for your Part D prescription drugs

- Our plan will pay the remainder of the costs.

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

- When you get the vaccine, you will pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7.
- You will be reimbursed the amount you paid less your normal coinsurance or copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

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

- You will have to pay the pharmacy your coinsurance *OR* copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

CHAPTER 7:

*Asking us to pay our share of a bill
you have received for covered
medical services or drugs*

Chapter 7 Asking us to pay our share of a bill you have received for covered medical services or drugs

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In these cases, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see 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 have received or possibly for more than your share of cost sharing as discussed in the document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will 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.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you’ve received emergency or urgently needed medical care from a provider who is not in our plan’s network

You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

- You are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you accidentally pay the entire amount yourself at the time you receive 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 have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

Chapter 7 Asking us to pay our share of a bill you have received for covered medical services or drugs

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the 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 do not 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 is a dispute and we don’t pay certain provider charges.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

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

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

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out of network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

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

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

Chapter 7 Asking us to pay our share of a bill you have received for covered medical services or drugs

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

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this document has information about how to make an appeal.

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

You may request 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 received the service, item, or drug.

To make sure you are 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 will help us process the information faster.
- Either download a copy of the form from our website ([blueshieldca.com](https://www.blueshieldca.com)) or call Customer Care and ask for the form.

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

Medical claims:

Blue Shield 65 Plus
Medicare Customer Care
P.O. Box 927, Woodland Hills, CA 91365

Prescription drug claims:

Blue Shield of California
P.O. Box 52066
Phoenix, AZ 85072-2066

Chapter 7 Asking us to pay our share of a bill you have received for covered medical services or drugs

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

Section 3.1	We check to see whether we should cover the service or drug and how much we owe
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When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

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

Section 3.2	If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal
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If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9 of this document

CHAPTER 8:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan

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, in braille, in large print, or other alternate formats, etc.)
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Your 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 a plan may meet these accessibility requirements include, but are not 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 are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Care.

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, seeing a women's health specialists or finding a network specialist, please 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 may 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.

Sección 1.1	Debemos proporcionar información de una manera que a usted le sea útil y se ajuste a sus sensibilidades culturales (en otros idiomas que no sean el inglés, en braille, en letra grande, en formatos alternativos, etc.)
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Su plan debe asegurarse de que todos los servicios, tanto clínicos como no clínicos, se brinden de una manera culturalmente competente y de que todas las personas inscritas puedan obtener acceso a estos servicios, incluidas aquellas que tienen un dominio limitado del inglés, habilidades de lectura limitadas o problemas de audición, o aquellas de distinto origen cultural y étnico. Entre los ejemplos de cómo un plan puede cumplir con estos requisitos de accesibilidad se incluyen, entre otros, los servicios de traducción e interpretación y la conexión por teletipo, o teléfono de teletipo o de texto (TTY, por sus siglas en inglés).

Nuestro plan cuenta con servicios gratis de interpretación para responder las preguntas de los miembros que no hablen inglés. Además, podemos brindarle la información en braille, en letra grande o en algún otro formato alternativo sin costo, si es necesario. Tenemos la obligación de brindarle información acerca de los beneficios del plan en un formato que sea apropiado y accesible para usted. Para que le brindemos información de una manera que a usted le sea útil, comuníquese con Servicio para Miembros.

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

Si en la red del plan no hay proveedores disponibles para una determinada especialidad, el plan tendrá la responsabilidad de encontrar proveedores especializados fuera de la red para que brinden la atención necesaria. En este caso, usted solo pagará el costo compartido dentro de la red. Si se encuentra en una situación en la que no hay especialistas en la red del plan que cubran un servicio que usted necesita, llame al plan y pida información sobre dónde debe dirigirse para obtener este servicio al nivel de costo compartido dentro de la red.

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

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

Chapter 8 Your rights and responsibilities

También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles (Office for Civil Rights) al 1-800-368-1019 (TTY 1-800-537-7697).

Section 1.2	We must ensure that you get timely access to your covered services and drugs
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You have the right to choose a primary care physician (PCP) in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

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

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

Section 1.3	We must protect the privacy of your protected health information
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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 are required to get written permission from you or someone you have given legal power to make decisions for you first*.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - We are required to release health information to government agencies that are checking on quality of care.

Chapter 8 Your rights and responsibilities

- Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

You have the right to look at your medical records held by the plan, and to get a copy of your records. We are 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 will work with your healthcare 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 are not routine.

If you have questions or concerns about the privacy of your protected health information, please call Customer Care.

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 Care 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., Monday through Friday. TTY users call 711.
4. Email us at: privacy@blueshieldca.com.

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

As a member of Blue Shield 65 Plus, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Care:

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.

Chapter 8 Your rights and responsibilities

- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5	We must support your right to make decisions about your care
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You have the right to know your treatment options and participate in decisions about your health 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 of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what is to be done if you are not able to 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 are in this situation. This means that, *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.

The legal documents that you can use to give your directions in advance of these situations are called “**advance directives**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Care to ask for the forms.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should 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 are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with Livanta. See Chapter 2, Section 4 for contact information.

Section 1.6	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

Section 1.7	What can you do if you believe you are being treated unfairly or your rights are not being respected?
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If it is about discrimination, call the Office for Civil Rights

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

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and it's not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Care**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8	How to get more information about your rights
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There are several places where you can get more information about your rights:

- You can **call Customer Care**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 2	You have some responsibilities as a member of the plan
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Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Care.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services.
 - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **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 that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all 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 are responsible for these payments:
 - You must continue to pay a premium for your Medicare Part B to remain a member of the plan.
 - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.
 - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
 - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our 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 cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 9:

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

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 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 of these 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 guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the 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,” or “coverage determination” or “at-risk 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 assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

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 are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- 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.
- You can also visit the Medicare website (www.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 the parts of this chapter that apply to your situation. The guide that follows will help.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care or prescription drugs are covered or not, the way they are covered, and problems related to payment for medical care or prescription drugs.

Yes.

Go on to the next section of this chapter, **Section 4, “A guide to the basics of coverage decisions and appeals.”**

No.

Skip ahead to **Section 10** at the end of this chapter: **“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 the basics of coverage decisions and appeals

Section 4.1	Asking for coverage decisions and making appeals: the big picture
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Coverage decisions and appeals deal with problems related to your benefits and coverage for medical services and prescription drugs, including payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving services

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. 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

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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 will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service or drug 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 a service is received, and you are not satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request 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 were properly following the rules. When we have completed 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 will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (Appeals for medical services and Part B drugs will be automatically sent to the independent review organization for a Level 2 appeal – you do not need to do anything. For Part D drug appeals, if we say no to all or part of your appeal you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 6 of this chapter). If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2	How to get help when you are asking for a coverage decision or making an appeal
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Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You can call us at **Customer Care**.
- You can get **free help** from your State Health Insurance Assistance Program.

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- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Customer Care and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at the *Forms* page in the *Member Center* section of blueshieldca.com.)
 - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
 - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or other person to be your representative, call Customer Care and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at the *Forms* page in the *Member Center* section of blueshieldca.com.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
 - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will 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 may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3	Which section of this chapter gives the details for your situation?
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There are four different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 6** of this chapter: “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”

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- **Section 7** of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 8** of this chapter: “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 section you should be using, please call Customer Care. You can also get help or information from government organizations such as your SHIP.

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 5.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care
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This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” which includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not 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 will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 5.2.**
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3.**
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**

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5. You are being told that coverage for certain medical care you have 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, you need to read Sections 7 and 8 of this Chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms

When a coverage decision involves your medical care, it 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 14 days 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. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical care *you have not yet received*.
- 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 function*.
- **If your doctor tells us that your health requires a “fast coverage decision,” we will 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 will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
 - Explains that we will use the standard deadlines.
 - Explains if your doctor asks for the fast coverage decision, we will 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 requested.

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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 will give you an answer within 14 calendar days after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive 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 days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint." We will 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. See Section 10 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe

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

- **However**, if you ask for more time, or if we need more that may benefit you, **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint." (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**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 are going on to Level 1 of the appeals process.

Section 5.3 Step-by-step: How to make a Level 1 appeal**Legal Terms**

An appeal to the 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 days. A “fast appeal” is generally made within 72 hours.

- If you are appealing a decision, we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.” If your doctor tells us that your health requires a “fast appeal,” we will 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 are asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you are 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 60 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 requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We are allowed to charge a fee for copying and sending this information to you.

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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 of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a “fast appeal”

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health 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 will tell you in writing. We can’t take extra time if your request is for a Medicare Part B prescription drug.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will 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 receives your appeal.

Deadlines for a “standard” appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will 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 will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a “fast complaint.” When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 10 of this chapter for information on complaints.)
 - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested**, 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 Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal**, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 Step-by-step: How a Level 2 appeal is done

Legal Term
The formal name for the “independent review organization” is the “ Independent Review Entity .” It is sometimes called the “ IRE .”

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

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

If you had a “fast” appeal at Level 1, you will also have a “fast” appeal at Level 2

- For the “fast appeal” the review organization must give you an answer to your Level 2 appeal within 72 hours of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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If you had a “standard” appeal at Level 1, you will also have a “standard” appeal at Level 2

- For the “standard appeal” if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can’t take extra time to make a decision if your request is for a Medicare Part B prescription 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 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 receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we receive the decision from the 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 should not 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:
 - Explaining its decision.
 - Notifying you of the 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.
 - Telling you how to file a Level 3 appeal.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes.

Section 5.5	What if you are asking us to pay you for our share of a bill you have received for medical care?
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Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you have received 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 are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all 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 all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the services, we will 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 will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why.

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are 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 that we describe in Section 5.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not 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 requested to you or to the provider within 60 calendar days.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time. We also use the term “drug list” instead of “List of Covered Drugs” or “Formulary.”

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term
An initial coverage decision about your Part D drugs is called a “coverage determination.”

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan’s *List of Covered Drugs*. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get) **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Section 6.2 What is an exception?****Legal Terms**

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **“formulary exception.”**

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **“formulary exception.”**

Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **“tiering exception.”**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4: Non-Preferred Drugs. You cannot ask for an exception to the cost sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.
 - If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
 - If the drug you’re taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
 - If the drug you’re taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.

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- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 1: Preferred Generic Drugs and Tier 5: Specialty Tier Drugs.
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions**Your doctor must tell us the medical reasons**

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception**Legal Term**

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

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

“Standard coverage decisions” are made within **72 hours** after we receive your doctor’s statement. “Fast coverage decisions” are made within **24 hours** after we receive your doctor’s statement.

If your health requires it, ask us to give you a “fast coverage decision.” To get a fast coverage decision, you must meet two requirements:

- You must be asking for a *drug you have not yet received*. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber’s support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
 - Explains that we will use the standard deadlines.
 - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
 - Tells you how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a “standard coverage decision” or a “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 can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Chapter 2 has contact information. For the details, go to Chapter 2, Section 1 and look for the section called *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. You may also submit an appeal through our website; visit blueshieldca.com/medappeals. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the “supporting statement,”** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the

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statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.***Deadlines for a “fast coverage decision”***

- We must generally give you our answer **within 24 hours** after we receive your request.
 - For exceptions, we will give you our answer within 24 hours after we receive your doctor’s supporting statement. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a “standard” coverage decision about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request.
 - For exceptions, we will give you our answer within 72 hours after we receive your doctor’s supporting statement. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a “standard” coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

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

Section 6.5 Step-by-step: How to make a Level 1 appeal

Legal Terms

An appeal to the plan about a Part D drug coverage decision is called a plan **“redetermination.”**

A “fast appeal” is also called an **“expedited redetermination.”**

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

A “standard appeal” is usually made within 7 days. A “fast appeal” is generally made within 72 hours. If your health requires it, ask for a “fast appeal”

- If you are appealing a decision, we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.4 of this chapter.

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a “fast appeal.”

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at (800) 776-4466 (TTY: 711) 8 a.m. to 8 p.m., seven days a week.** Chapter 2 has contact information.
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 60 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.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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 requesting an appeal.

- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

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

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a “fast appeal”

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a “standard” appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
 - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a “standard appeal” about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If we do not meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within **30 calendar days** after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 6.6	Step-by-step: How to make a Level 2 appeal
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Legal Term
The formal name for the “independent review organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding “at-risk” determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for “fast” appeal

- If your health requires it, ask the independent review organization for a “fast appeal.”
- If the organization agrees to give you a “fast appeal,” the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for “standard” appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.***For “fast appeals”:***

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For “standard appeals”:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says **no to part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called “upholding the decision.” It is also called “turning down your appeal.”). In this case, the independent review organization will send you a letter:

- Explaining its decision.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

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

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will 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 are being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

Section 7.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights
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Within two days of being admitted to the hospital, you will 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 do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Customer Care or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

1. Read this notice carefully and ask questions if you don't understand it. It tells you:

- Your right to receive 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 are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2. You will be asked to sign the written notice to show that you received 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 have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.

3. Keep your copy of the notice handy so you will 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 two days before your discharge date, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Customer Care or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Section 7.2**Step-by-step: How to make a Level 1 appeal to change your hospital discharge date**

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will 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 at any time, please call Customer Care. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not 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 received (*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 may 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 do *not* meet this deadline**, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Customer Care or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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 may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.***What happens if the answer is yes?***

- If the review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will 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 review organization says *no*, they are 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 review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive 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 has said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to Level 2 of the appeals process.

Section 7.3	Step-by-step: How to make a Level 2 appeal to change your hospital discharge date
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During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their 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 that 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 of 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 review organization says yes:

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

If the 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 wish to continue with the review process.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 7.4 What if you miss the deadline for making your Level 1 appeal?

Legal Term

A “fast review” (or “fast appeal”) is also called an “**expedited appeal**.”

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge date. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

Step 1: Contact us and ask for a “fast review.”

- **Ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines. Chapter 2 has contact information.

Step 2: We do a “fast” review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a “fast review.”

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

If we say no to your appeal, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.

- If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Step 4: If we say *no* to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

Step-by-Step: Level 2 *Alternate* appeal Process

Legal Term
The formal name for the “independent review organization” is the “ Independent Review Entity .” It is sometimes called the “ IRE .”

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

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the Independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- If this organization says yes to your appeal**, then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan’s coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- If this organization says *no* to your appeal**, it means they agree that your planned hospital discharge date was medically appropriate.
 - The written notice you get from the independent review organization will tell how to start a Level 3 appeal with the review process, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 *This section is only about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services*

When you are getting **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your covered 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 is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

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

Section 8.2 We will tell you in advance when your coverage will be ending

Legal Term

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

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
 - The date when we will stop covering the care for you.
 - How to request a “fast track appeal” to request 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 received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan’s decision to stop care.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 8.3	Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time
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If you want to ask us to cover your care for a longer period of time, you will 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 at any time, please call Customer Care. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not 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 received (*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.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Your deadline for contacting this organization.

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

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

Legal Term
“Detailed Explanation of Non-Coverage.” Notice that provides 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 may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will 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 is medically necessary.**
- You will 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 have 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, then **you will have to pay the full cost** of this care yourself.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

Section 8.4	Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time
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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 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 that 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 of the information related to your appeal.

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

What happens if the review organization says yes?

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

What happens if the 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 wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

- There are three additional levels of appeal after Level 2, for a total of five 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.

Section 8.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* appeal

Legal Term
A “fast review” (or “fast appeal”) is also called an “ expedited appeal. ”

Step 1: Contact us and ask for a “fast review.”

- **Ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines. Chapter 2 has contact information.

Step 2: We do a “fast” review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a “fast review.”

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If you continued to get 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, then **you will have to pay the full cost** of this care.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

Legal Term
The formal name for the “independent review organization” is the “ Independent Review Entity .” It is sometimes called the “ IRE .”

Step-by-Step: Level 2 Alternate Appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your “fast appeal.” This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal**, then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says no to your appeal**, it means they agree with the decision our plan made to your first appeal and will not change it.
- The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five 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.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

If the dollar value of the item or medical service you have 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 cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is 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 is 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 service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we will 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 service 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 this decision that turns down your appeal, the appeals process is over.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If you do not 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 will 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 service within 60 calendar days after receiving the Council's decision.
 - If we decide to appeal the decision, we will 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 do not 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 on 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 of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Level 3 appeal An Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals)** or **make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, 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 do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals)** or **make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, 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 do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of 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.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)
MAKING COMPLAINTS
SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns
Section 10.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> Has someone been rude or disrespectful to you? Are you unhappy with our Customer Care? Do you feel you are being encouraged to leave the plan?
Waiting times	<ul style="list-style-type: none"> 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 Care or other staff at the plan? Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	<ul style="list-style-type: none"> Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> Did we fail to give you a required notice? Is our written information hard to understand?

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Complaint	Example
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	<p>If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> You asked us for a “fast coverage decision” or a “fast appeal,” and we have said no; you can make a complaint. You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. You believe we are not meeting deadlines for covering or reimbursing you for certain medical services or drugs that were approved; you can make a complaint. You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 How to make a complaint

Legal Terms
<ul style="list-style-type: none"> A “Complaint” is also called a “grievance.” “Making a complaint” is also called “filing a grievance.” “Using the process for complaints” is also called “using the process for filing a grievance.” A “fast complaint” is also called an “expedited grievance.”

Section 10.3 Step-by-step: Making a complaint

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

- Usually, calling Customer Care is the first step. If there is anything else you need to do, Customer Care will let you know.
- If you do not wish 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 will respond to your complaint in writing.
- Here’s how it works:

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- Step 1: File a Grievance

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

Blue Shield 65 Plus
Appeals & Grievances Department
P.O. Box 927, Woodland Hills CA 91365-9856
FAX: (916) 350-6510

If contacting us by fax or by mail, please call us to request a **Blue Shield 65 Plus Appeals & Grievance Form**.

We will send you a letter letting you know that we received the notice of your concern within 5 calendar days and give you the name of the person who is working on it. We will normally resolve it within 30 calendar days.

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.”

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.

- 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, we will assemble a panel to hear your case. You will be invited to attend the hearing, which includes an uninvolved physician 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,

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

you may contact the Blue Shield 65 Plus Customer Care 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 will 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 will tell you in writing.
- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint.”** If you have a “fast complaint,” it means we will give you **an answer within 24 hours.**
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 10.4	You can also make complaints about quality of care to the Quality Improvement Organization
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When your complaint is about *quality of care*, you also have two extra options:

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

Or

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

Section 10.5	You can also tell Medicare about your complaint
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You can submit a complaint about Blue Shield 65 Plus directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 10:

Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Blue Shield 65 Plus may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

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

Section 2.1	You can end your membership during the Annual Enrollment Period
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You can end your membership in our plan during the **Annual Enrollment Period** (also known as the “Annual Open Enrollment Period”). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Annual Enrollment Period** is from **October 15 to December 7**.
 - **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan, with or without prescription drug coverage.
 - Original Medicare *with* a separate Medicare prescription drug plan.
 - Original Medicare *without* a separate Medicare prescription drug plan.
 - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
- Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.
- **Your membership will end in our plan** when your new plan’s coverage begins on January 1.

Section 2.2	You can end your membership during the Medicare Advantage Open Enrollment Period
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You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
 - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
 - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3	In certain situations, you can end your membership during a Special Enrollment Period
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In certain situations, members of Blue Shield 65 Plus may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have Medi-Cal (Medicaid).
- If you are eligible for “Extra Help” with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

Note: If you’re in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan.
- *or* – Original Medicare *without* a separate Medicare prescription drug plan.

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

Your membership will usually end on the first day of the month after your request to change your plan is received.

If you receive “Extra Help” from Medicare to pay for your prescription drugs: 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 2.4	Where can you get more information about when you can end your membership?
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If you have any questions about ending your membership you can:

- **Call Customer Care.**
- Find the information in the *Medicare & You 2023* handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none">• Another Medicare health plan.	<ul style="list-style-type: none">• Enroll in the new Medicare health plan.• You will automatically be disenrolled from Blue Shield 65 Plus when your new plan’s coverage begins.

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none">• Original Medicare <i>with</i> a separate Medicare prescription drug plan.	<ul style="list-style-type: none">• Enroll in the new Medicare prescription drug plan.• You will automatically be disenrolled from Blue Shield 65 Plus when your new plan's coverage begins.
<ul style="list-style-type: none">• Original Medicare <i>without</i> a separate Medicare prescription drug plan.	<ul style="list-style-type: none">• Send us a written request to disenroll. Contact Customer Care if you need more information on how to do this.• You can also 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.• You will be disenrolled from Blue Shield 65 Plus when your coverage in Original Medicare begins.

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

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical care and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail service to get your prescriptions filled**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Blue Shield 65 Plus must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Blue Shield 65 Plus must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
 - If you move or take a long trip, call Customer Care to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot 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 cannot 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 cannot 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 do not pay the plan premiums for 3 calendar months.
 - We must notify you in writing that you have 3 calendar months to pay the plan premium before we end your membership.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Customer Care.

Section 5.2	We <u>cannot</u> ask you to leave our plan for any health-related reason
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Blue Shield 65 Plus is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

Section 5.3	You have the right to make a complaint if we end your membership in our plan
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If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or 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 are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

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

If you want more information or have concerns about discrimination or unfair treatment, please 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 <https://www.hhs.gov/ocr/index>.

If you have a disability and need help with access to care, please call us at Customer Care. If you have a complaint, such as a problem with wheelchair access, Customer Care can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Blue Shield 65 Plus, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Administration of the Evidence of Coverage

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

SECTION 5 Member cooperation

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

SECTION 6 Assignment

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

SECTION 7 Employer responsibility

For any services that the law requires an employer to provide, we will not pay the employer, and when we cover any such services we may recover the value of the services from the employer.

SECTION 8 Government agency responsibility

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

SECTION 9 U.S. Department of Veterans Affairs

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

SECTION 10 Workers' compensation or employer's liability benefits

You may be eligible for payments or other benefits under workers' compensation or employer's liability law. We will provide covered Part D drugs even if it is unclear whether you are entitled to benefits, but we may recover the value of any Covered Services from the following sources:

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

SECTION 11 Overpayment recovery

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

SECTION 12 When a third party causes your injuries

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

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

You are required to:

1. Notify Blue Shield in writing of any actual or potential claim or legal action which you expect to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and,
3. Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,
4. Provide a lien calculated in accordance with the California Civil Code section 3040. The lien may be filed with the third party, the third party’s agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield, in writing, within ten (10) days after any Recovery has been obtained.

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

SECTION 13 Notice About Health Information Exchange Participation

Blue Shield participates in the **Manifest MedEx** Health Information Exchange (“HIE”) making its Members’ health information available to Manifest MedEx for access by their authorized health care providers. Manifest MedEx is an independent, not-for-profit organization that maintains a statewide database of electronic patient records that includes health information contributed by doctors, health care facilities, health care service plans, and health insurance companies. Authorized health care providers (including doctors, nurses, and hospitals) may securely access their patients’ health information through the Manifest MedEx HIE to support the provision of safe, high-quality care.

Manifest MedEx respects Members’ right to privacy and follows applicable state and federal privacy laws. Manifest MedEx uses advanced security systems and modern data encryption techniques to protect Members’ privacy and the security of their personal information.

Every Blue Shield Member has the right to direct Manifest MedEx not to share their health information with their health care providers. Although opting out of Manifest MedEx may limit your health care provider’s ability to quickly access important health care information about you, a Member’s health insurance or health plan benefit coverage will not be affected by an election to opt-out of Manifest MedEx. No doctor or hospital participating in Manifest MedEx will deny medical care to a patient who chooses not to participate in the Manifest MedEx HIE.

Members who do not wish to have their healthcare information displayed in Manifest MedEx should fill out the online form at <https://www.manifestmedex.org/opt-out> or call Manifest MedEx at (888) 510-7142, 7 a.m. to 7 p.m. PST, Monday through Friday. TTY 711 for the hearing impaired.

SECTION 14 Reporting Fraud, Waste, and Abuse

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

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

Protect yourself and your benefits

Chapter 11 Legal notices

- 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 should call 1-877-486-2048).

CHAPTER 12:

Definitions of important words

Chapter 12 Definitions of important words

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 does not exceed 24 hours.

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of Blue Shield 65 Plus, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$7,400 in covered drugs during the covered year.

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

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

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers.

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 related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or

psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

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

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed “copayment” amount that a plan requires when a specific service or drug is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under your plan, that isn’t a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

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

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Customer Care – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Care.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not 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.

Chapter 12 Definitions of important words

Daily cost-sharing rate – A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month’s supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month’s supply in your plan is 30 days, then your “daily cost-sharing rate” is \$1 per day.

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

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

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist’s time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual’s eligibility.

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 are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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

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

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Chapter 12 Definitions of important words

Extra Help – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a “generic” drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Home Health Aide – A person who provides services that do not 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. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

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

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you’ll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached \$4,660.

Initial Enrollment Period – When you are 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.

List of Covered Drugs (Formulary or “Drug List”) – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See “Extra Help.”

Chapter 12 Definitions of important words

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your Medicare Part A and Part B premiums and prescription drugs do not count toward the maximum out-of-pocket amount.

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

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

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

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

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

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

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term

Chapter 12 Definitions of important words

Medicare-Covered Services does not 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 the 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 Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

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

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits in order 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 like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your

share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not 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 or drugs received 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 care (LTC) services 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 receive both their Medicare and Medicaid benefits through the plan.

Part C – see “Medicare Advantage (MA) Plan.”

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan.

Preferred Cost Sharing – Preferred cost sharing means lower cost sharing for certain covered Part D drugs at certain network pharmacies.

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

Chapter 12 Definitions of important words

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

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

Prior Authorization – Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

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

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

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, 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. The plan must disenroll you if you permanently move out of the 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 are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Standard Cost Sharing – Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

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

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

Blue Shield 65 Plus Customer Care

Method	Customer Care – Contact Information
CALL	(800) 776-4466 Calls to this number are free. 8 a.m. to 8 p.m., seven days a week. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m., seven days a week.
FAX	(877) 251-6671
WRITE	Blue Shield 65 Plus P.O. Box 927, Woodland Hills, CA 91365-9856
WEBSITE	www.blueshieldca.com/medicare

Health Insurance Counseling and Advocacy Program (HICAP) (California's SHIP)

HICAP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	(800) 434-0222
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	California Department of Aging 1300 National Drive, Suite 200, Sacramento, CA 95834
WEBSITE	https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/

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, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



NONDISCRIMINATION NOTICE

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

Blue Shield of California provides:

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

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

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

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

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

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

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

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

MULTI-LANGUAGE INSERT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Navajo D77 ats'77s baa 1hly3 47 doodago azee' bee aa 1hly3 b7na'7d7[kidgo 47 n1 ata' hodoolnih77 h0l=. Ata' halne'4 biniiy4go, koj8' 1-800-776-4466 b44sh bee hod77lnih. Diné k'ehj7 y1[ti'i n7k1 adoolwo]. D77 t'11 j77k'eh bee an1'1wo.

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

Khmer យើងមានសេវាអ្នកបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃដើម្បីឆ្លើយសំណួរនានាដែលអ្នកអាចមានអំពីសុខភាព ឬគម្រោងឱសថរបស់យើង។ ដើម្បីទទួលបានអ្នកបកប្រែផ្ទាល់មាត់ម្នាក់សូមទូរសព្ទមកយើងខ្ញុំតាមលេខ 1-800-776-4466។ អ្នកណាម្នាក់ដែលនិយាយភាសាខ្មែរអាចជួយអ្នកបាន។ សេវានេះមិនគិតថ្លៃនោះទេ។

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

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

Armenian Մենք մոտ հասանելի ենք անվճար թարգմանչական ծառայություններ՝ մեր առողջապահական կազմակերպության հետ կապված Ձեր ցանկացած հարցին անհատական կամ: Թարգմանիչ չենք վճարում և անվճար ապրաքանչյուր զանգահարելը մեզ 1-800-776-4466 հեռախոսահամարով: Ձեզ կօգնի հարցեր են ինքնուրույն թարգմանիչը: Ծառայություններ անվճար է:

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

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

