Important information

About changes to your Medicare drug and health plan

blue california

Blue Shield 65 Plus (HMO) offered by California Physicians' Service (dba Blue Shield of California)

Annual Notice of Changes for 2023

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

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

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

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

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

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

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

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

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

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2022, you will stay in Blue Shield 65 Plus.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with Blue Shield 65 Plus.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Care number at (800) 776-4466 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., seven days a week.
- If you would like to receive your plan materials online, log in to your account at blueshieldca.com/login**,** click *My profile* on the top right under your initials, go to Communication preferences and select "Go paperless" as your delivery preference. If you do not have an account, go to blueshieldca.com/login and click *Create account* and you can select your delivery preference as you create your account.
- This information may be available in a different format, including large print. Please call Customer Care at the number listed above if you need plan information in another format.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Blue Shield 65 Plus

- Blue Shield of California is an HMO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal.
- When this document says "we," "us," or "our", it means California Physicians' Service (dba Blue Shield of California). When it says "plan" or "our plan," it means Blue Shield 65 Plus.

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Annual Notice of Changes for 2023
Table of Contents

Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Blue Shield 65 Plus in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher lower than this amount. See Section 2.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	$3,400	$1,200
Doctor office visits	Primary care visits: $0 copay per visit Specialist visits: $10 copay per visit	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit
Inpatient hospital stays	For each Medicare-covered stay in a network hospital you pay: $120 copay per day for days 1 to 5 $0 copay per day for days 6 and over	For each Medicare-covered stay in a network hospital you pay: $0 copay per admission

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 or $5* copay • Drug Tier 2: $10 or $17* copay • Drug Tier 3: $40 or $47* copay • Drug Tier 4: $95 or $100* copay • Drug Tier 5: 33% coinsurance * The first copay listed is the amount you will pay if you use a network pharmacy with preferred cost-sharing. The second copay listed is the amount you will pay if you use a network pharmacy with standard cost-sharing. See Section 2.5 below for more information.	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 or $5* copay • Drug Tier 2: $5 or $12* copay • Drug Tier 3: $38 or $47* copay • Drug Tier 4: $95 or $100* copay • Drug Tier 5: 33% coinsurance * The first copay listed is the amount you will pay if you use a network pharmacy with preferred cost-sharing. The second copay listed is the amount you will pay if you use a network pharmacy with standard cost-sharing. See Section 2.5 below for more information

SECTION 1 We Are Changing the Plan's Name

On January 1, 2023, our plan name will change from Blue Shield Vital to Blue Shield 65 Plus.

In December, we will send you a new ID card in the mail with the new plan name. Start using your new ID card as of January 1, 2023. Any communications you receive from us in 2023 will have our new plan name, Blue Shield 65 Plus. If you have any questions, please contact Customer Care.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
Monthly premium for the optional supplemental Dental HMO plan	$12.40	$12.50
Monthly premium for the optional supplemental Dental PPO plan	$41.90	$42.30
Part B premium reduction	$49.00	Part B premium reduction is not available.

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

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

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400	$1,200 Once you have paid $1,200 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 2.3 – Changes to the Provider and Pharmacy Networks

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

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

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

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

Section 2.4 – Changes to Benefits and Costs for Medical Services

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

Cost	2022 (this year)	2023 (next year)
Ambulance services	You pay a $100 copay per trip (each way).	You pay a $200 copay per trip (each way) for Medicare-covered ground ambulance services. You pay 20% of the total cost per trip (each way) for Medicare-covered air ambulance services.
Cardiac rehabilitation services	You pay a $0 copay per visit.	You pay a $20 copay per visit.
Chiropractic services (Medicare covered)	You pay a $10 copay per visit for all Medicare-covered services.	You pay a $0 copay per visit for all Medicare-covered services.
Emergency care	You pay a $120 copay per visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition). Worldwide emergency coverage: You have a $10,000 combined annual limit for covered emergency care or urgently needed services outside the United States and its territories. Services outside the United States and its territories do not apply to the plan's maximum out-of-pocket limit.	You pay a $125 copay per visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition). Worldwide emergency coverage: You have no 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.

Cost	2022 (this year)	2023 (next year)
Health and wellness education programs		
SilverSneakers Fitness	SilverSneakers is not covered.	You pay a $0 copay.
Personal Emergency Response System (PERs) - a medical alert monitoring system that provides access to help 24/7, at the push of a button.	PERS is not covered.	You pay a $0 copay.
Hearing services		
Diagnostic hearing and balance evaluations and Routine (non-Medicare covered) hearing exams	You pay a $0 copay per visit if performed at your PCP's office and a $10 copay per visit if performed at a specialist's office.	You pay a $0 copay per visit.
Hearing aids	Hearing aids are not covered.	You pay a $0 copay for one routine hearing exam per year. You pay a $449 copay for each Silver technology level hearing aid. You pay a $699 copay for each Gold technology level hearing aid.
Inpatient hospital care	For each Medicare-covered stay in a network hospital you pay a: • $120 copay per day for days 1 to 5 • $0 copay per day for days 6 and over	For each Medicare-covered stay in a network hospital you pay a: • $0 copay per admission

Cost	2022 (this year)	2023 (next year)
Inpatient mental health care	For each Medicare-covered stay in a network hospital, you pay a $250 copay per stay plus a: • $120 copay per day for days 1 to 10. • $0 copay per day for days 11 to 150. • 100% of the cost of the hospital stay for days 151 and over unless a new benefit period begins. You are covered for 150 days each benefit period, up to the 190-day lifetime limit. A benefit period begins the day you go into a hospital or skilled nursing facility (SNF) and ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row.	For each Medicare-covered stay in a network hospital, you pay a: • $900 copay per stay for days 1 to 150. • 100% of the cost of the hospital stay for days 151 and over. You are covered for 150 days per admission, up to the 190-day lifetime limit.
Inpatient stay: Covered services received in a skilled nursing facility (SNF) during a non-covered SNF stay		
Physician services	You pay a $0 copay for each PCP visit and a $10 copay for each specialist visit.	You pay a $0 copay for each visit.

Cost	2022 (this year)	2023 (next year)
Outpatient diagnostic tests & therapeutic services and supplies	You pay a $5 copay for each diagnostic radiology service. Diagnostic radiology services include, but are not limited to, ultrasound, MRI scans, PET scans, nuclear medicine studies, CT scans, cardiac stress tests, SPECT, myelogram, cystogram, and angiogram. The copay is applicable to the global, technical and professional components of the diagnostic radiology services only. Office visit copays may apply.	You pay a $20 copay for each diagnostic radiology service. Diagnostic radiology services include, but are not limited to, ultrasound, MRI scans, PET scans, nuclear medicine studies, CT scans, cardiac stress tests, SPECT, myelogram, cystogram, and angiogram. The copay is applicable to the global, technical and professional components of the diagnostic radiology services only.
Outpatient hospital services		
Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	You pay a $120 copay for each visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition).	You pay a $125 copay for each visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition).
Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it	You pay a $55 copay per visit for partial-hospitalization and a $20 copay for each individual or group therapy visit.	You pay a $30 copay per visit.
Outpatient mental health care	You pay a $20 copay for each individual or group therapy visit.	You pay a $30 copay for each individual or group therapy visit.
Outpatient substance abuse services	You pay a $20 copay for each individual or group therapy visit.	You pay a $30 copay for each individual or group therapy visit.

Cost	2022 (this year)	2023 (next year)
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	You pay a $50 copay for each visit to an ambulatory surgical center.	You pay a $0 copay for each visit to an ambulatory surgical center.
Partial Hospitalization Services (Mental health)	You pay a $55 copay per visit.	You pay a $30 copay per visit.
Physician/Practitioner services, including doctor's office visits	You pay a $0 copay per visit if performed by your PCP and a $10 copay per visit if performed by a specialist.	You pay a $0 copay per visit if performed by your PCP or a specialist.
Podiatry services (Medicare-covered)	You pay a $10 copay per visit.	You pay a $0 copay per visit.
Pulmonary rehabilitation services	You pay a $0 copay per visit.	You pay a $20 copay per visit.
Services to treat kidney disease 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.	You pay a $0 copay per visit if performed at your PCP's office and a $10 copay per visit if performed at a specialist's office.	You pay a $0 copay per visit.

Cost	2022 (this year)	2023 (next year)
Skilled nursing facility (SNF) care	For each stay in a Medicare-certified skilled nursing facility, you pay a: • $20 copay per day for days 1 to 20. • $75 copay per day for days 21 to 100. There is a limit of 100 days for each benefit period if your condition requires additional rehabilitation services, other types of daily skilled nursing, or other skilled care. If you go over the 100-day limit, you will be responsible for all costs. A benefit period begins the day you go into a hospital or skilled nursing facility (SNF) and ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row.	For each stay in a Medicare-certified skilled nursing facility, you pay a: • $0 copay per day for days 1 to 20. • $75 copay per day for days 21 to 100. There is a limit of 100 days per admission if your condition requires additional rehabilitation services, other types of daily skilled nursing, or other skilled care. If you go over the 100-day limit, you will be responsible for all costs.
Supervised Exercise Therapy (SET)	You pay a $0 copay per visit.	You pay a $20 copay per visit.

Cost	2022 (this year)	2023 (next year)
Urgently needed services	You pay a $10 copay per visit to a network urgent care center within the plan service area (waived if you are admitted to the hospital within one day for the same condition). You pay a $10 copay per visit to an urgent care center outside of the plan service area but within the United States and its territories (waived if you are admitted to the hospital within one day for the same condition). You pay a $120 copay per visit to an emergency room outside of the 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). Worldwide urgent coverage: You pay a $120 copay per visit to an emergency room or urgent care center that is outside the United States and its territories (waived if you are admitted to the hospital within one day for the same condition).	You pay a $5 per visit to a network urgent care center within plan service area (waived if you are admitted to the hospital within one day for the same condition). You pay a $5 copay per visit to an urgent care center outside of the plan service area but within the United States and its territories (waived if you are admitted to the hospital within one day for the same condition). You pay a $125 copay per visit to an emergency room outside of the 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). Worldwide urgent coverage: You pay a $125 copay per visit to an emergency room or urgent care center that is outside the United States and its territories (waived if you are admitted to the hospital within one day for the same condition).

Cost	2022 (this year)	2023 (next year)
Urgently needed services (continued)	There is a $10,000 combined annual limit for covered emergency care or urgently needed services outside the United States and its territories. Services outside the United States and its territories do not apply to the plan's maximum out-of-pocket limit.	There is no 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.
Vision care (Medicare covered) Outpatient physician services for 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.	You pay a $10 copay per visit.	You pay a $0 copay per visit.

Cost	2022 (this year)	2023 (next year)
Vision care, non-Medicare covered (obtained from a network provider)		
Routine eye exam, including refraction and prescription for eyeglass lenses.	You pay a $10 copay for one exam every 12 months when you use a network provider.	You pay a $0 copay for one exam every 12 months when you use a network provider.
Eyeglass frames and eyeglass lenses (including single, lined bifocal, lined trifocal, and lenticular lenses) or contact lenses	You pay a $20 copay for one pair of eyeglass frames (up to a maximum plan benefit coverage amount of $75) every 24 months when you use a network provider. If you choose eyeglass frames priced above $75, you are responsible for the difference. You pay a $20 copay for one pair of prescription eyeglass lenses (regardless of size or power) every 12 months when you use a network provider. Contact lenses are not covered.	You pay a $0 copay for one pair of eyeglass frames (up to a maximum plan benefit coverage amount of $140) every 24 months when you use a network provider. If you choose eyeglass frames priced above $140, you are responsible for the difference. You pay a $0 copay for either one pair of prescription eyeglass lenses (regardless of size or power) OR for contact lenses (priced up to $140 for contact lens services and materials) every 12 months when you use a network provider. If you choose contact lens services and materials priced above $140, you are responsible for the difference.

Section 2.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

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

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

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

Changes to Prescription Drug Costs

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

There are four "drug payment stages."

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

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail service prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply at a network pharmacy: **Tier 1 Preferred Generic Drugs:** *Standard cost sharing:* You pay $5 per prescription. *Preferred cost sharing:* You pay $0 per prescription. **Tier 2 Generic Drugs:** *Standard cost sharing:* You pay $17 per prescription. *Preferred cost sharing:* You pay $10 per prescription. **Tier 3 Preferred Brand Drugs:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $40 per prescription. **Tier 4 Non-Preferred Drugs:** *Standard cost sharing:* You pay $100 per prescription. *Preferred cost sharing:* You pay $95 per prescription.	Your cost for a one-month supply at a network pharmacy: **Tier 1 Preferred Generic Drugs:** *Standard cost sharing:* You pay $5 per prescription. *Preferred cost sharing:* You pay $0 per prescription. **Tier 2 Generic Drugs:** *Standard cost sharing:* You pay $12 per prescription. *Preferred cost sharing:* You pay $5 per prescription. **Tier 3 Preferred Brand Drugs:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $38 per prescription. **Tier 4 Non-Preferred Drugs:** *Standard cost sharing:* You pay $100 per prescription. *Preferred cost sharing:* You pay $95 per prescription.

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage (continued)	**Tier 5 Specialty Tier Drugs:** *Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost. Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	**Tier 5 Specialty Tier Drugs:** *Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost. Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

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

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

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Blue Shield 65 Plus

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in Blue Shield 65 Plus.

Section 3.2 – If you want to change plans

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

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023*

handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2). As a reminder, California Physicians' Service (dba Blue Shield of California) offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Blue Shield 65 Plus.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Blue Shield 65 Plus.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Care if you need more information on how to do so.
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

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

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

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

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

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

SECTION 5 Programs That Offer Free Counseling about Medicare

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

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

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the ADAP in California. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the California ADAP Call Center at (844) 421-7050, 8 a.m. to 5 p.m., Monday through Friday, or visit their website at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_eligibility.aspx

SECTION 7 Questions?

Section 7.1 – Getting Help from Blue Shield 65 Plus

Questions? We're here to help. Please call Customer Care at (800) 776-4466. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m., seven days a week. Calls to these numbers are free.

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

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2023. For details, look in the *2023 Evidence of Coverage* for Blue Shield 65 Plus. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at blueshieldca.com/MAPDdocuments2023. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

Visit our Website

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

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read *Medicare & You 2023*

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

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