# Blue Shield Medicare Supplement plans

Summary of benefits and provisions

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

Effective January 1, 2025

blueshieldca.com/medicaresupplement

blue california

# Blue Shield of California Medicare Supplement plans

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

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

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

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

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

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

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

## Basic benefits

### Hospitalization

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

### Blood

- First three pints of blood each year.

### Medical expenses

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

### Hospice

- Part A coinsurance.

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

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

# DISCLOSURES

Use this outline to compare benefits and charges among policies.

## INFORMATION ABOUT PREPAID OR PERIODIC CHARGES

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

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

## READ YOUR POLICY VERY CAREFULLY

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

## RIGHT TO RETURN POLICY

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

## POLICY REPLACEMENT

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

## NOTICE

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

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

## COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

# PLAN A

## MEDICARE (PART A)
## HOSPITAL SERVICES – PER BENEFIT PERIOD

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

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

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

# PLAN A

## MEDICARE (PART B)
## MEDICAL SERVICES – PER CALENDAR YEAR

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

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

# PLAN A

## PARTS A & B

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

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

## OTHER BENEFITS – NOT COVERED BY MEDICARE

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

# PLAN F EXTRA

## MEDICARE (PART A)
## HOSPITAL SERVICES – PER BENEFIT PERIOD

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

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

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

# PLAN F EXTRA

## MEDICARE (PART B)
## MEDICAL SERVICES – PER CALENDAR YEAR

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

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

# PLAN F EXTRA

## PARTS A & B

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

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

## OTHER BENEFITS – NOT COVERED BY MEDICARE

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

# PLAN F EXTRA

## Other benefits – not covered by Medicare (continued)

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

# PLAN F EXTRA

## Other benefits – not covered by Medicare (continued)

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

# PLAN F EXTRA

## Other benefits – not covered by Medicare (continued)

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

# PLAN F EXTRA

## Other benefits – not covered by Medicare (continued)

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

# PLAN G

## MEDICARE (PART A)
## HOSPITAL SERVICES – PER BENEFIT PERIOD

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

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

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

# PLAN G

## MEDICARE (PART B)
## MEDICAL SERVICES – PER CALENDAR YEAR

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

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

# PLAN G

## PARTS A & B

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

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

## OTHER BENEFITS – NOT COVERED BY MEDICARE

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

# PLAN G EXTRA

## MEDICARE (PART A)
## HOSPITAL SERVICES – PER BENEFIT PERIOD

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

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

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

# PLAN G EXTRA

## MEDICARE (PART B)
## MEDICAL SERVICES – PER CALENDAR YEAR

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

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

# PLAN G EXTRA

## PARTS A & B

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

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

## OTHER BENEFITS – NOT COVERED BY MEDICARE

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

# PLAN G EXTRA

## Other benefits – not covered by Medicare (continued)

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

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

# PLAN G EXTRA

## Other benefits – not covered by Medicare (continued)

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

# PLAN G EXTRA

## Other benefits – not covered by Medicare (continued)

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

# PLAN G EXTRA

## Other benefits – not covered by Medicare (continued)

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

# PLAN N

## MEDICARE (PART A)
## HOSPITAL SERVICES – PER BENEFIT PERIOD

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

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

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

# PLAN N

## MEDICARE (PART B)
## MEDICAL SERVICES – PER CALENDAR YEAR

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

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

# PLAN N

## PARTS A & B

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

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

## OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

# Enrolling in our plans

## Please reference the enrollment form section of this book.

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

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

## Who may apply?

**If you are 65 or older**

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

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

**If you are 64 or younger**

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

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

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

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

## Qualifying for guaranteed acceptance

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

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

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

## Effective date of coverage

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

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

## Switching from another plan to a Blue Shield Medicare Supplement plan

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

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

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

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

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

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

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

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

**Option 1**

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

**Option 2**

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

**Option 3**

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

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

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

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

TTY: **711**

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

Mailing address:

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

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

the date you disenroll from your current Medicare Advantage Plan.

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

**If you have other health coverage**

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

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

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

## Billing options

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

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

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

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

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

# Conditions of coverage

## Termination of benefits

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

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

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

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

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

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

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

## Cancellation

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

## Reinstatement of benefits

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

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

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

**Renewal provision**

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

## Appeal of an underwriting decision

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

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

## Plan interpretation

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

## Confidentiality of personal and health information

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

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

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

**Correspondence address:**

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

**Toll-free telephone:**
**(888) 266-8080**

**Email address:**
**privacy@blueshieldca.com**

# Principal exclusions and limitations on benefits

Please note:

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

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

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

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

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

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



Blue Shield of California is an independent member of the Blue Shield Association MSP14541-PR-DS (12/21)