blue CALIFORNIA

Important information

About changes to your Medicare drug and health plan

Blue Shield of California is an independent member of the Blue Shield Association A54666MAD_0825
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Blue Shield 65 Plus (HMO) offered by California Physicians' Service (dba Blue Shield of California)

Annual Notice of Change for 2026

You're enrolled as a member of Blue Shield 65 Plus.

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in Blue Shield 65 Plus.
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at blueshieldca.com/MAPDdocuments2026 or call Customer Service at (800) 776-4466 (TTY users call 711) to get a copy by mail.

More Resources

- This material is available for free in Spanish.
- Call Customer Service at (800) 776-4466 (TTY users call 711) for more information. Hours are 8 a.m. to 8 p.m. PT, seven days a week. This call is free.
- This information may be available in a different format, including Braille, large print, audio cd, and data cd. Please call Customer Service at the number listed above if you need plan information in another format.
- If you would like to receive your plan materials digitally, log in to your account at blueshieldca.com/login, click the *My profile* button in the header, scroll to the Communication preferences section, and select "Electronic Delivery" as your delivery preference. You can also log into the Blue Shield of California mobile app and navigate to Communication preferences via the *More* tab. If you do not have an account, go to blueshieldca.com/login and click *Get started* to register. You can set up your delivery preference as you register.

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.
- Blue Shield of California's pharmacy network includes limited lower-cost, pharmacies

with preferred cost sharing in certain counties within California. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost pharmacies with preferred cost sharing in your area, please call Customer Service at (800) 776-4466, (TTY: 711), 8 a.m. to 8 p.m. PT, seven days a week, or consult the online pharmacy directory at blueshieldca.com/medpharmacy2026.

- When this material 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.
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in Blue Shield 65 Plus.** Starting January 1, 2026, you'll get your medical and drug coverage through Blue Shield 65 Plus. Go to Section 3 for more information about how to change plans and deadlines for making a change.

Table of Contents

Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 1.1 for details.	$0	**$0**
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	$1,800	**$1,750**
Primary care office visits	$0 copayment per visit	**$0 copayment per visit**
Specialist office visits	$5 copayment per visit	**$0 copayment per visit**
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	For each Medicare-covered stay in a network hospital you pay: $150 copayment per day for days 1 to 7 $0 copayment per day for days 8 and over	**For each Medicare-covered stay in a network hospital you pay: $150 copayment per day for days 1 to 7 $0 copayment per day for days 8 and over**
Part D drug coverage deductible (Go to Section 1.7 for details.)	$0	**$250, except for Tier 1: Preferred Generic Drugs and Tier 2: Generic Drugs, covered insulin products and most adult Part D vaccines**

	2025 (this year)	2026 (next year)
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: $0 or $5* Drug Tier 2: $3 or $10* Drug Tier 3: $35 or $47* You pay $35 per month supply of each covered insulin product on this tier. Drug Tier 4: $95 or $100* You pay $35 per month supply of each covered insulin product on this tier. Drug Tier 5: 33% of the total cost * The first amount listed is what you will pay if you use a network pharmacy with preferred cost sharing. The second amount listed is what you will pay if you use a network pharmacy with standard cost sharing. See Section 1 below for more information.	**Copayment/Coinsurance during the Initial Coverage Stage:** **Drug Tier 1: $0 or $5*** **Drug Tier 2: $0 or $10*** **Drug Tier 3: 20% of the total cost** **You pay the lesser of $35 or 20% of the total cost per month supply of each covered insulin product on this tier.** **Drug Tier 4: 25% of the total cost** **You pay the lesser of $35 or 25% of the total cost per month supply of each covered insulin product on this tier.** **Drug Tier 5: 30% of the total cost** *** The first amount listed is what you will pay if you use a network pharmacy with preferred cost sharing.** **The second amount listed is what you will pay if you use a network pharmacy with standard cost sharing. See Section 1 below for more information.**

	2025 (this year)	2026 (next year)
Part D drug coverage (cont'd)	Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.	**Catastrophic Coverage Stage:** **During this payment stage, you pay nothing for your covered Part D drugs.**

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	$0	**$0**
Additional premium for optional supplemental Dental HMO plan benefits **If you've enrolled in an optional supplemental benefit package, you'll pay this premium in addition to the monthly plan premium above.** (You must also continue to pay your Medicare Part B premium.)	$16	**$16**
Additional premium for optional supplemental Dental PPO plan benefits If you've enrolled in an optional supplemental benefit package, you'll pay this premium in addition to the monthly plan premium above. (You must also continue to pay your Medicare Part B premium.)	$47	**$49**

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.

- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.

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

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

	2025 (this year)	**2026 (next year)**
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments) **count** toward your maximum out-of-pocket amount. Your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	$1,800	**$1,750** **Once you've paid $1,750 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services for the rest of the calendar year.**

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* at blueshieldca.com/medicare/providerdirectory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at blueshieldca.com/medicare/providerdirectory.
- Call Customer Service at (800) 776-4466 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Customer Service at (800) 776-4466 (TTY users call 711) for help. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Our network of pharmacies has changed for next year. Review the 2026 *Pharmacy Directory* at blueshieldca.com/medpharmacy2026 to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at blueshieldca.com/medpharmacy2026.
- Call Customer Service at (800) 776-4466 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Customer Service at (800) 776-4466 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
Chiropractic services (Medicare-covered)	$5 copayment per visit for all Medicare-covered services.	**$0 copayment per visit for all Medicare-covered services.**

	2025 (this year)	2026 (next year)
Durable medical equipment (DME) and related supplies	Continuous glucose monitors: $0 copayment. We do not have a preferred manufacturer.	**Continuous glucose monitors: Dexcom and Freestyle Libre are our preferred manufacturers. $0 copayment for Dexcom and Freestyle Libre continuous glucose monitors and 20% of the total cost for continuous glucose monitors from all other manufacturers.**
Emergency care	$140 copayment per visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition). Worldwide coverage: $140 copayment for each 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).	**$150 copayment per visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition).** **Worldwide coverage: $150 copayment for each 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).**

	2025 (this year)	2026 (next year)
Hearing aids	Platinum technology level hearing aids are not covered. All technology levels include up to two follow-up visits for hearing aid fitting, consultation, device check, and adjustment for no additional fee within 12 months of purchase.	**$999 copayment for each Platinum technology level hearing aid.** **All technology levels include up to three follow-up visits for hearing aid fitting, consultation, device check, and adjustment for no additional fee within 12 months of purchase.**
Home meal delivery	$0 copayment per covered home meal delivery. Upon discharge from an inpatient hospital or skilled nursing facility, we cover: 22 meals and 10 snacks per discharge Meals and snacks will be divided into up to three separate deliveries as needed. Coverage is limited to two discharges per year	**$0 copayment per covered home meal delivery.** **Upon discharge from an inpatient hospital or skilled nursing facility, we cover:** **22 meals and 10 snacks per discharge** **Meals and snacks will be divided into up to two separate deliveries as needed.** **Coverage is limited to two discharges per year**

	2025 (this year)	2026 (next year)
Inpatient stay: Covered services received in a SNF during a non-covered skilled nursing facility (SNF) stay **Physician services**	$5 copayment per specialist visit.	**$0 copayment per specialist visit.**
Opioid treatment program services	$0 copayment per visit.	**$20 copayment per visit.**
Optional supplemental Dental PPO plan	In- and Out-of-network You pay 50% of the total cost for ADA code D6095. In- and Out-of-network ADA code D6180 is not covered. In- and Out-of-network ADA code D6193 is not covered. This plan is available for an extra monthly premium of $47. Please refer to Chapter 4, Section 2.2 of the *Evidence of Coverage* for additional information/details.	**In- and Out-of-network** **ADA code D6095 is not covered.** **In- and Out-of-network** **You pay 50% of the total cost for ADA code D6180.** **In- and Out-of-network** **You pay 50% of the total cost for ADA code D6193.** **This plan is available for an extra monthly premium of $49. Please refer to Chapter 4, Section 2.1 of the *Evidence of Coverage* for additional information/details.**

	2025 (this year)	2026 (next year)
Outpatient hospital services **Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery**	$140 copayment per visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition).	**$150 copayment per visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition).**
Over-the-Counter (OTC) Items	You have a $90 allowance per quarter for covered items. You can place two orders per quarter and cannot roll over your unused allowance into the next quarter. Some limitations may apply. Refer to the OTC Items catalog for more information.	**You have a $100 allowance per quarter for covered items. You can place two orders per quarter and cannot roll over your unused allowance into the next quarter. Some limitations may apply. Refer to the OTC Items catalog for more information.**
Physician/Practitioner services, including doctor's office visits	$5 copayment per visit if performed by a specialist.	**$0 copayment per visit if performed by a specialist.**
Podiatry services	$5 copayment for each Medicare-covered visit. $5 copayment for each routine (non-Medicare covered) visit.	**$0 copayment for each Medicare-covered visit.** **$0 copayment for each routine (non-Medicare covered) visit.**
Pulmonary rehabilitation services	$20 copayment per visit.	**$30 copayment per visit.**

	2025 (this year)	2026 (next year)
Transportation Services (non-Medicare covered)	$0 copayment for each one-way trip to plan-approved health-related locations (limited to 18 one-way trips per year).	**$0 copayment for each one-way trip to plan-approved health-related locations (limited to 18 one-way trips per year and each trip may not exceed 70 miles).**
Urgently needed services	$140 copayment for each 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 coverage: $140 copayment for each 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).	**$150 copayment for each 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 coverage: $150 copayment for each 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).**
Vision care, Medicare-covered	$5 copayment per visit.	**$0 copayment per visit.**

	2025 (this year)	2026 (next year)
Vision care, non-Medicare covered (obtained from a network provider): **Eyeglass frames** **Eyeglass lenses or contact lenses. If you choose eyeglass lenses, you may elect single, lined bifocal, lined trifocal, or lenticular lenses. If you opt for other lens types not listed or add-on treatments, you will be responsible for paying the additional costs, even if the total costs remain within the allowance.**	$0 copayment for eyeglass frames (priced up to a maximum plan benefit coverage amount of $280) every 24 months when you use a network provider. If you choose eyeglass frames priced above $280, you are responsible for the difference. $0 copayment for either one pair of prescription eyeglass lenses (regardless of size or power) OR for contact lenses (priced up to $280 for contact lens services and materials) every 12 months when you use a network provider. If the services and materials price above $280, you are responsible for the difference.	**$0 copayment for eyeglass frames (priced up to a maximum plan benefit coverage amount of $300) every 2 years when you use a network provider. If you choose eyeglass frames priced above $300, you are responsible for the difference.** **$0 copayment for either one pair of prescription eyeglass lenses (regardless of size or power) OR for contact lenses (priced up to $300 for contact lens services and materials) every year when you use a network provider. If the services and materials price above $300, you are responsible for the difference.**

Section 1.6 Changes to Part D 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, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year**

and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Customer Service at (800) 776-4466 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you**. We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and you don't get this material by September 30, 2025, call Customer Service at (800) 776-4466 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***

  You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 3: Preferred Brand Drugs, Tier 4: Non-Preferred Drugs and Tier 5: Specialty Tier Drugs until you've reached the yearly deductible.

- ***Stage 2: Initial Coverage***

  Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach $2,100.

- ***Stage 3: Catastrophic Coverage***

  This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2025 (this year)	**2026 (next year)**
Yearly Deductible	Because we have no deductible, this payment stage doesn't apply to you.	**$250** **During this stage, you pay $5 (standard cost-sharing) or $0 (preferred cost-sharing) for drugs on Tier 1: Preferred Generic Drugs, $10 (standard cost-sharing) or $0 (preferred cost-sharing) for drugs on Tier 2: Generic Drugs, and the full cost of drugs on Tier 3: Preferred Brand Drugs, Tier 4: Non-Preferred Drugs and Tier 5: Specialty Tier Drugs until you've reached the yearly deductible.**

Drug Costs in Stage 2: Initial Coverage

For drugs on Tier 3: Preferred Brand Drugs and Tier 4: Non-Preferred Drugs, your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Go to the following table for the changes from 2025 to 2026.

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

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. Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply; or for home delivery prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid $2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	**2026** **(next year)**
Tier 1 Preferred Generic Drugs:	*Standard cost sharing:* You pay $5 *Preferred cost sharing:* You pay $0	***Standard cost sharing:*** **You pay $5** ***Preferred cost sharing:*** **You pay $0**
Tier 2 Generic Drugs:	*Standard cost sharing:* You pay $10 *Preferred cost sharing:* You pay $3	***Standard cost sharing:*** **You pay $10** ***Preferred cost sharing:*** **You pay $0**
Tier 3 Preferred Brand Drugs:	*Standard cost sharing:* You pay $47 You pay $35 per month supply of each covered insulin product on this tier.	***Standard cost sharing:*** **You pay 20% of the total cost** **You pay the lesser of $35 or 20% of the total cost per month supply of each covered insulin product on this tier.**

	2025 (this year)	2026 (next year)
Tier 3 Preferred Brand Drugs (cont'd):	*Preferred cost sharing:* You pay $35	***Preferred cost sharing:*** **You pay 20% of the total cost**
	You pay $35 per month supply of each covered insulin product on this tier.	**You pay the lesser of $35 or 25% of the total cost per month supply of each covered insulin product on this tier**
Tier 4 Non-Preferred Drugs:	*Standard cost sharing:* You pay $100	***Standard cost sharing:*** **You pay 25% of the total cost**
	You pay $35 per month supply of each covered insulin product on this tier.	**You pay the lesser of $35 or 25% of the total cost per month supply of each covered insulin product on this tier.**
	Preferred cost sharing: You pay $95	***Preferred cost sharing:*** **You pay 25% of the total cost**
	You pay $35 per month supply of each covered insulin product on this tier.	**You pay the lesser of $35 or 25% of the total cost per month supply of each covered insulin product on this tier.**
Tier 5 Specialty Tier Drugs:	*Standard cost sharing:* You pay 33% of the total cost	***Standard cost sharing:*** **You pay 29% of the total cost**
	Preferred cost sharing: You pay 33% of the total cost	***Preferred cost sharing:*** **You pay 29% of the total cost**

Changes to the Catastrophic Coverage Stage

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

	2025 (this year)	2026 (next year)
Additional telehealth services: Change to vendor name and URL	Teladoc blueshieldca.com/Teladoc	**Teladoc Health** **blueshieldca.com/teladochealth**
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	**If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** **To learn more about this payment option, call us at (833) 696-2087 (TTY users call 711) or visit www.Medicare.gov.**

SECTION 3 How to Change Plans

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

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from Blue Shield 65 Plus.

- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from Blue Shield 65 Plus.
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Customer Service at (800) 776-4466 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227).

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into, or currently live in, 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 (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **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 drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
    - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call 1-800-325-0778.
    - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you 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 drugs that are also covered by ADAP qualify for prescription cost-sharing help through the ADAP in California. For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call the California ADAP Call Center at (844) 421-7050, 8 a.m. to 5 p.m., Monday through Friday (excluding holidays), or visit their website at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_eligibility.aspx. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  Extra Help from Medicare and help from your ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan

payment option. To learn more about this payment option, call us at (800) 776-4466 (TTY users call 711) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from Blue Shield 65 Plus

- **Call Customer Service at (800) 776-4466. (TTY users call 711.)**

  We're available for phone calls 8 a.m. to 8 p.m. PT, seven days a week. Calls to these numbers are free.

- **Read your 2026 *Evidence of Coverage***

  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for Blue Shield 65 Plus. The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at blueshieldca.com/MAPDdocuments2026 or call Customer Service at (800) 776-4466 (TTY users call 711) to ask us to mail you a copy.

- **Visit blueshieldca.com/medicare**

  Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

Get 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).

Call HICAP to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call HICAP at (800) 434-0222. Learn more about HICAP by visiting http://www.cahealthadvocates.org/hicap/.

Get Help 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 can call 1-877-486-2048.

- **Chat live with www.Medicare.gov**

  You can chat live at www.Medicare.gov/talk-to-someone.

- **Write to Medicare**

  You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit www.Medicare.gov**

  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2026***

  The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

blueshieldca.com/medicare

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