

# MEDICARE ADVANTAGE

Take the first steps on your journey  
to a healthier, happier lifestyle.

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Blue Shield Balance (HMO)  
Los Angeles County  
2023 Enrollment Kit

Blue Shield of California is an independent member of the Blue Shield Association  
BS-WEB-BAL-2023.pdf

**ENROLLMENT KIT**

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## WHAT'S INSIDE

This kit contains important information for you to review before enrolling, including:

- Why Blue - Blue Shield of California
- Benefits and services beyond original Medicare
- Blue Shield's Medicare Star Ratings
- Summary of Benefits

## HOW TO ENROLL

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## WHAT OUR PLAN OFFERS



Dental



Transportation



Vision



Healthy Grocery



Over-the-counter items benefit (OTC)



Insulin Savings Program

# WHY BLUE – BLUE SHIELD OF CALIFORNIA

Blue Shield of California’s mission is to provide affordable access to health care that is worthy of our family and friends – and that includes you.

**Here are two important considerations when choosing your Medicare plan:**



## HOW MUCH DOES MY PLAN COST?

Use the Summary of Benefits – located in this kit – to compare what you will pay with our plan versus other plans.



## ARE MY PRESCRIPTIONS COVERED?

If you currently take medication, you can confirm if it is covered on our drug list.



## MORE REASONS TO CHOOSE BLUE SHIELD

### One of the largest networks in the state.

Our large network means that chances are good you can keep seeing your current doctor and specialists. If you want to switch doctors, you can search [blueshieldca.com/find-a-doctor](https://blueshieldca.com/find-a-doctor) any time.



### Here when you need us.

From our California-based Customer Care team to our money-saving network mail service pharmacy, we’re here for you.

### Here for caregivers, too!

We also provide support for caregivers who help with everyday activities. From community and health resources to plan materials and more, we want to help caregivers to be as informed as possible about choices and benefits. Learn more on our site at [blueshieldca.com/caregiverresource](https://blueshieldca.com/caregiverresource).

# BENEFITS AND SERVICES BEYOND ORIGINAL MEDICARE



## Dental benefits

Blue Shield of California Medicare Advantage Plans offer coverage for many common dental procedures such as checkups, cleaning, gum care, and more. Simply choose a network dentist who will provide and coordinate all your dental care needs.

Your dental coverage features comprehensive benefits with diagnostic, restorative, and preventive services; low copays; and access to a network of general dentists. Additionally, you are covered for emergency dental needs.

**For more comprehensive dental coverage**, Blue Shield of California offers Optional Supplemental dental plans. These plans offer a wide range of dental benefits, including many diagnostic and preventive services at no charge to you.

### Optional Supplemental Dental plans:

- **Dental HMO** – The Optional Supplemental Dental HMO plan has a low monthly premium and offers defined member out-of-pocket costs.
- **Dental PPO** – The Optional Supplemental Dental PPO plan lets you choose from a more extensive list of participating dentists, but you will pay a higher monthly premium.

Please see the Summary of Benefits included in this kit for more information on the Optional Supplemental Dental plans and the cost for the extra plan premiums. Use our Dental Directory online to locate a network provider anytime at [blueshieldca.com/find-a-doctor](https://blueshieldca.com/find-a-doctor).



## Vision Benefits

Vision benefits for this plan include everything Medicare covers, and more. Please see the Summary of Benefits included in this kit for more information. Use our Vision Directory online to locate a Vision Service Plan (VSP) network provider near you at [blueshieldca.com/find-a-doctor](https://blueshieldca.com/find-a-doctor).





## Over-the-counter (OTC) items benefit

Blue Shield Balance (HMO) offers a \$45 allowance each month to cover OTC health and wellness products, including first-aid supplies, pain relievers, cough and cold medicines, and more.

These products can be purchased in-store, online, through the mobile app or by phone. For more information, visit [blueshieldca.com/balanceOTC](https://blueshieldca.com/balanceOTC).



## Transportation services

Blue Shield of California provides transportation for plan members to plan-approved health related locations. Transportation is provided on an as-needed basis to facilitate non-emergent access to healthcare, e.g., physician office visits. Once a member you can call directly by using the number behind your ID card to arrange transportation. Arrangements for transportation must be made at least 24 hours in advance.

For additional benefit details or information on how to schedule transportation services, please refer to the *Evidence of Coverage* or visit [blueshieldca.com/medtransport](https://blueshieldca.com/medtransport).





## Healthy Grocery

As a member, you get a \$25 allowance each month to purchase healthy grocery items at participating retailers. From fresh fruit and vegetables to soups and salad kits, you can save on your meals at home. For more information, visit [blueshieldca.com/healthygrocery](https://blueshieldca.com/healthygrocery).



The benefit mentioned is part of special supplemental benefit which requires eligibility. Not all plan members will qualify. Refer to the *Evidence of Coverage* for details and eligibility requirements.



## Insulin Savings Program

To help keep your healthcare costs low, Select Insulins are no more than \$30 for a one-month (30-day) supply at our in-network pharmacy with preferred cost sharing and \$35 for a one-month (30-day) supply at our in-network pharmacy with standard cost sharing or our out-of-network pharmacy. This applies during the Initial Coverage and Coverage Gap phases of your benefits. For more information, see the *Evidence of Coverage* and the most recent drug list at [blueshieldca.com/medformulary2023](https://blueshieldca.com/medformulary2023).



Note: This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs (such as Extra Help).

## HEALTHCARE RESOURCES

We want to help you stay healthy, so we offer tools and information that can assist you in making healthy lifestyle choices and healthcare decisions, including:



### Senior Wellness Assessment

Regular wellness assessments are a great way to know where you stand and help identify issues that may be important to discuss with your healthcare team.

Once you take it, share your results with your physician so that you can work toward your health and longevity goals. To get started, visit [blueshieldca.com/hra](https://blueshieldca.com/hra).



### Medicare Diabetes Prevention Program

Medicare Diabetes Prevention Program services will be covered for eligible Medicare beneficiaries under all Medicare health plans.

The Medicare Diabetes Prevention Program can help you learn how to be more active, eat healthier and lose weight by making small changes to your daily routine. These changes can help you prevent type 2 diabetes.



### Teladoc

Teladoc provides physician consultations 24/7 by phone or video. Teladoc physicians can diagnose and treat many non-emergency medical conditions outside of an emergency room, urgent care clinic, or doctor's office. Teladoc physicians can also prescribe certain medications.

To learn more about this benefit, visit [blueshieldca.com/Teladoc](https://blueshieldca.com/Teladoc).



### NurseHelp 24/7

Connect with a registered nurse who will listen and offer you immediate, reliable information about treating minor illnesses and injuries, or help you choose the most appropriate treatment. Chat online at [blueshieldca.com/nursehelp](https://blueshieldca.com/nursehelp) or call **(877) 304-0504** (TTY: 711), 24 hours a day, seven days a week.



# 2023 Summary of Benefits

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## Blue Shield Balance (HMO)

**Medicare Advantage Prescription Drug Plan**

Los Angeles County



# Summary of benefits

Blue Shield Balance (HMO)  
Los Angeles County

Effective January 1, 2023 - December 31, 2023

Premiums and benefits	You pay	What you should know
<b>Monthly plan premium</b>	\$0	You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.
<b>Deductible</b>	\$0	
<b>Annual out-of-pocket maximum amount</b>	\$1,200	Does not include Part D prescription drugs. This is the most you would pay for the year for in-network covered Medicare Part A and Part B services.
<b>Inpatient hospital care</b>	\$0 copay per admission	Our plan covers an unlimited number of days for a Medicare-covered inpatient hospital stay in a network hospital.
<b>Outpatient hospital services</b> <ul style="list-style-type: none"> <li>Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery</li> </ul>	\$150 copay for each visit to an outpatient hospital facility \$0 copay for observation services \$125 copay for each visit to an emergency room (this copay is waived if you are admitted to the hospital within one day for the same condition)	Our plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.
<b>Outpatient surgery</b>	\$0 copay for each visit to an ambulatory surgical center \$150 copay for each visit to an outpatient hospital facility	
<b>Doctor visits</b> <ul style="list-style-type: none"> <li>Primary care physician</li> <li>Specialists</li> </ul>	\$0 copay per visit \$0 copay per visit	<b>A referral from your doctor may be required for Specialist visits.</b>
<b>Preventive care</b>	\$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.

# Summary of benefits (cont'd)

Blue Shield Balance (HMO)  
Los Angeles County

Effective January 1, 2023 - December 31, 2023

Premiums and benefits	You pay	What you should know
<b>Emergency care</b>	\$125 copay per visit \$50,000 combined annual limit for emergency care and urgently needed services outside the United States and its territories	This copay is waived if you are admitted to the hospital within one day for the same condition. Worldwide coverage.
<b>Urgently needed services</b>	\$0 copay for each visit to a network urgent care center within the plan service area \$0 copay for each visit to an urgent care center outside of the plan service area but within the United States and its territories \$125 copay for each visit to an emergency room outside of the plan service area but within the United States and its territories \$125 copay for each visit to an emergency room or urgent care center that is outside of the United States and its territories \$50,000 combined annual limit for emergency care and urgently needed services outside the United States and its territories	This copay is waived if you are admitted to the hospital within one day for the same condition. Worldwide coverage.

# Summary of benefits (cont'd)

Blue Shield Balance (HMO)  
Los Angeles County

Effective January 1, 2023 - December 31, 2023

Premiums and benefits	You pay	What you should know
<p><b>Diagnostic services, labs, and imaging</b></p> <ul style="list-style-type: none"> <li>• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)</li> <li>• Lab services</li> <li>• Diagnostic tests and procedures</li> <li>• Outpatient X-rays</li> <li>• Therapeutic radiology services (such as radiation treatment for cancer)</li> </ul>	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>20% coinsurance for each therapeutic radiology service</p>	<p><b>A referral from your doctor may be required for diagnostic services, labs and imaging services.</b></p> <p>Covered according to Medicare guidelines.</p> <p>While you pay 20% coinsurance for therapeutic radiology services, you will never pay more than your \$1,200 total out-of-pocket maximum for the year.</p>
<p><b>Hearing services</b></p> <ul style="list-style-type: none"> <li>• Hearing exam (Medicare covered)</li> <li>• Routine (non-Medicare covered) hearing exam</li> </ul>	<p>\$0 copay</p> <p>\$0 copay</p>	<p><b>A referral from your doctor may be required for hearing services.</b></p> <p>Routine hearing exams are unlimited if provided by your doctor but are limited to one exam every 12 months with network hearing aid provider.</p>
<p><b>Dental services (non-Medicare covered)</b></p> <ul style="list-style-type: none"> <li>• Prophylaxis (cleaning)</li> <li>• Dental X-rays</li> <li>• Fluoride</li> <li>• Oral exam</li> </ul>	<p>\$0 copay</p> <p>\$0 - \$10 copay, depending on the service/type</p> <p>\$5 copay</p> <p>\$5 - \$16 copay, depending on the service</p>	<p>One cleaning every 6 months.</p> <p>One series of bitewing X-rays every 6 months.</p> <p>One series of full mouth X-rays every 24 months.</p> <p>Two visits every 12 months for fluoride.</p> <p>One exam every 6 months.</p> <p>See optional supplemental dental HMO and PPO plans for more information about dental services for an extra plan premium.</p>

# Summary of benefits (cont'd)

Blue Shield Balance (HMO)  
Los Angeles County

Effective January 1, 2023 - December 31, 2023

Premiums and benefits	You pay	What you should know
<b>Vision services</b> <ul style="list-style-type: none"> <li>Exam to diagnose and treat diseases and conditions of the eye</li> <li>Routine (non-Medicare covered) eye exam and refraction</li> <li>Eyeglass frames</li> <li>Eyeglass lenses or contact lenses</li> </ul>	<p>\$0 copay for each Medicare-covered visit</p> <p>\$0 copay per visit</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p><b>A referral from your doctor may be required for an exam to diagnose and treat diseases and conditions of the eye.</b></p> <p>One visit every 12 months with network provider. Some coverage at non-network providers included; see the plan EOC for details.</p> <p>Our plan pays up to \$125 for one pair of eyeglass frames every 24 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.</p> <p>Our plan pays for either one pair of prescription eyeglass lenses or up to \$125 for contact lenses every 12 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.</p>
<b>Mental health services</b> <ul style="list-style-type: none"> <li>Inpatient mental health care</li> <li>Outpatient group therapy visit</li> <li>Outpatient individual therapy visit</li> </ul>	<p>\$900 copay per Medicare-covered stay for 1 - 150</p> <p>\$30 copay per visit</p> <p>\$30 copay per visit</p>	<p><b>A referral from your doctor may be required for mental health services.</b></p> <p>If you go over the 150-day limit, you will be responsible for all costs. See EOC for more information.</p>
<b>Skilled nursing facility (SNF) care</b>	<p>\$0 copay per day for days 1 - 20</p> <p>\$75 copay per day for days 21 - 100</p>	<p><b>A referral from your doctor may be required for skilled nursing facility care.</b></p> <p>If you go over the 100-day limit, you will be responsible for all costs; no prior hospitalization required with network provider.</p>

# Summary of benefits (cont'd)

Blue Shield Balance (HMO)  
Los Angeles County

Effective January 1, 2023 - December 31, 2023

Premiums and benefits	You pay	What you should know
<b>Rehabilitation Services</b> <ul style="list-style-type: none"> <li>Occupational therapy</li> <li>Physical therapy and speech and language therapy</li> </ul>	\$0 copay per visit \$0 copay per visit	<b>A referral from your doctor may be required for rehabilitation services.</b>
<b>Ambulance</b>	Medicare-covered ground ambulance services: \$200 copay per trip (each way) Medicare-covered air ambulance services: 20% coinsurance per trip (each way)	
<b>Transportation</b>	\$0 copay	Limited to 6 one-way trips to plan-approved health-related locations every year.
<b>Medicare Part B Drugs</b>	20% coinsurance	Some Part B drugs may require a prior authorization from your provider.

# Summary of benefits (cont'd)

Blue Shield Balance (HMO)  
Los Angeles County

Effective January 1, 2023 - December 31, 2023

## Additional benefits included in your plan

Premiums and benefits	You pay	What you should know
<b>Annual Physical Exam</b>	\$0 copay	One every 12 months.
<b>Special Supplemental Benefits for the Chronically Ill: Healthy Grocery</b>	You have a \$25 per month allowance to spend on covered items	This is a Special Supplemental Benefit for the Chronically Ill (SSBCI) which requires eligibility determination. You must meet one or more qualifying chronic conditions to receive this Benefit. Please see the plan EOC for additional details.
<b>Opioid Treatment Program Services</b>	\$0 copay	
<b>Additional telehealth services</b>	\$0 copay	Teladoc Physicians can diagnose and treat basic medical conditions and can also prescribe certain medication.
<b>Foot care (podiatry services)</b> <ul style="list-style-type: none"> <li>• Foot exams and treatment</li> <li>• Routine (non-Medicare covered) foot care</li> </ul>	\$0 copay for each Medicare-covered visit  You will be reimbursed up to \$1,000 every year for routine foot care	<b>A referral from your doctor may be required for foot care services.</b>  You may obtain routine foot care at the provider of your choice.
<b>Diabetic Supplies &amp; Services</b> <ul style="list-style-type: none"> <li>• Blood glucose monitors</li> <li>• Diabetes self- management training, diabetic services and supplies</li> </ul>	\$0 copay for ACCU-CHEK blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers  \$0 copay for all training, services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	<b>A referral from your doctor may be required for diabetic supplies &amp; services.</b>  Prior authorization from the plan may be required for durable medical equipment, blood glucose monitors and test strips.  See the plan EOC for more information.

# Summary of benefits (cont'd)

Blue Shield Balance (HMO)  
Los Angeles County

Effective January 1, 2023 - December 31, 2023

Premiums and benefits	You pay	What you should know
<b>Durable Medical Equipment (DME) and Related Supplies</b> <ul style="list-style-type: none"> <li>Durable medical equipment (e.g., wheelchairs, oxygen)</li> </ul>	20% coinsurance	<b>A referral from your doctor may be required for DME and related supplies.</b>  Prior authorization from the plan may be required for DME. See the plan EOC for more information.
<b>Prosthetics/Medical Supplies</b> <ul style="list-style-type: none"> <li>Prosthetics (e.g., braces, artificial limbs)</li> <li>Medical supplies (e.g., splints, casts)</li> </ul>	20% coinsurance  20% coinsurance	<b>A referral from your doctor may be required for prosthetics/medical supplies.</b>
<b>Health and Wellness programs</b> <ul style="list-style-type: none"> <li>NurseHelp 24/7<sup>SM</sup> (telephone and online support)</li> </ul>	\$0 copay	
<b>Over-the-Counter (OTC) Items (Solutran)</b>	You have a \$45 allowance per month to spend on covered items	You cannot roll over your unused allowance into the next month. Some limitations may apply. Refer to the OTC items catalog for more information.

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

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



# Prescription drug coverage

Blue Shield Balance (HMO)  
Los Angeles County

Effective January 1, 2023 - December 31, 2023

## You pay the following:

Part D prescription drug benefit						
<b>Stage 1: Annual Deductible Stage</b>	This stage does not apply because there is no deductible.					
<b>Stage 2: Initial Coverage Stage</b>	<b>Preferred retail cost-sharing (in-network)</b>			<b>Standard retail cost-sharing (in-network)<sup>^</sup></b>		
	<b>30-day supply</b>	<b>90-day supply<sup>*NDS</sup></b>	<b>100-day supply<sup>NDS</sup></b>	<b>30-day supply</b>	<b>90-day supply<sup>NDS</sup></b>	<b>100-day supply<sup>NDS</sup></b>
<b>Tier 1: Preferred Generic Drugs</b>	\$0 copay	See 100-day supply	\$0 copay	\$5 copay	See 100-day supply	\$5 copay
<b>Tier 2: Generic Drugs</b>	\$3 copay	\$4.50 copay	Not Covered	\$10 copay	\$30 copay	Not Covered
<b>Tier 3: Preferred Brand Drugs</b>	\$35 copay	\$87.50 copay	Not Covered	\$47 copay	\$141 copay	Not Covered
<b>Tier 3: Select Insulins<sup>**</sup></b>	\$25 copay	\$75 copay	Not Covered	\$35 copay	\$105 copay	Not Covered
<b>Tier 4: Non-Preferred Drugs</b>	\$95 copay	\$237.50 copay	Not Covered	\$100 copay	\$300 copay	Not Covered
<b>Tier 5: Specialty Tier Drugs</b>	33% coinsurance	Not Covered	Not Covered	33% coinsurance	Not Covered	Not Covered

<sup>\*\*</sup>Select Insulins are marked with the symbol SS on the drug list. This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help").

<sup>^</sup>If you reside in a long-term care facility, you pay the same as at an in-network standard retail cost-sharing pharmacy. There are limited situations where you may be able to get drugs from an out-of-network pharmacy at the same cost as an in-network standard retail cost-sharing pharmacy.

For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please refer to the plan EOC.

<sup>\*</sup>90- and 100-day supply cost-sharing also applies to Blue Shield's mail service pharmacy.

**NDS** A long-term (up to a 90- or 100-day) supply is not available for select drugs. The drugs that are not available for a long-term supply are marked with the symbol NDS in our Drug List.

# Prescription drug coverage (cont'd)

Blue Shield Balance (HMO)  
Los Angeles County

Effective January 1, 2023 - December 31, 2023

Part D prescription drug benefit		
<b>Stage 3: Coverage Gap Stage</b>	Coverage for outpatient prescription drugs after the total yearly drug costs paid by both you and Blue Shield reach \$4,660, until your yearly out-of-pocket drug costs reach \$7,400.	Tier 1: Preferred Generic Drugs, Tier 2: Generic Drugs, and Tier 3: Select Insulins only are covered at the copays described above. For all other tiers, you pay 25% of the price for brand-name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs until your year-to-date out-of-pocket drug costs total \$7,400, which is the end of the coverage gap stage. Whether a drug is considered generic or brand can be determined using the plan formulary. During this stage, your out-of-pocket costs for Tier 3: Select Insulins will be \$25 for a one-month (30-day) supply and \$75 for a long-term (90-day) supply.
<b>Stage 4: Catastrophic Coverage</b>	After your yearly out-of-pocket drug costs (including drugs you bought through your retail pharmacy and through mail service) reach \$7,400, you pay the greater of: <ul style="list-style-type: none"> <li>• 5% of the cost, or</li> <li>• \$4.15 copay for a generic drug (including brand-name drugs treated as generic) and a \$10.35 copay for all other drugs</li> </ul> (This stage <b>protects</b> you from any additional costs once you have paid your yearly out-of-pocket drug costs.)	

## Mail Service Pharmacy

CVS Caremark is our network mail service pharmacy where you may obtain a 90- or 100-day supply of maintenance drugs at a lower cost. They will be delivered to your home or office with no charge for shipping or delivery. Sign up at [caremark.com](http://caremark.com) or call (866) 346-7200 [TTY: 711].

Tier 5 drugs are limited to a 30-day supply by mail service.

## Network pharmacies that offer preferred cost-sharing

You may pay less when you visit one of our network pharmacies that offer preferred cost-sharing. Here's just a few:

- CVS/pharmacy<sup>‡</sup> (888) 607-4287 [TTY: 711]  
(including CVS pharmacy at Target)
- Safeway and Vons pharmacies<sup>‡</sup> (877) 723-3929 [TTY: 711]
- Albertsons/Sav-on/Osco pharmacies<sup>‡</sup> (877) 932-7948 [TTY: 711]
- Costco<sup>‡</sup> (800) 955-2292 [TTY: 711]
- Ralphs<sup>‡</sup>, Walmart<sup>‡</sup> and many more.



You do not have to be a Costco member to use Costco Pharmacies. Other pharmacies are available in our network.

<sup>‡</sup>Accepts e-prescribing

# Optional supplemental dental HMO and PPO plans

Blue Shield Balance (HMO)  
Los Angeles County

Effective January 1, 2023 - December 31, 2023

## You pay the following:

	Optional supplemental dental HMO	Optional supplemental dental PPO	
	Participating dentists only	Participating dentists	Non-participating dentists
<b>Monthly optional supplemental dental plan premium</b>	\$12.50	\$42.30	
<b>Calendar year deductible per member (not applicable to diagnostic and preventive services)</b>	\$0	You pay \$50 before major services begin.	
<b>Calendar year benefit maximum per member*</b>	\$1,000 for covered endodontic, periodontic, and oral surgery services when performed by a network dental specialist.	<p>\$1,500 for covered preventive and comprehensive dental services combined, no matter if the services are performed by a participating general dentist or a dental specialist.</p> <p>Up to \$1,000 of this maximum amount may be used for covered preventive and comprehensive dental services performed by non-participating dentists in a calendar year.</p> <p>You pay any amount above the \$1,500 calendar year benefit maximum.</p>	
<b>Waiting Period</b>	No waiting period	No waiting period	

\*All services must be performed, prescribed or authorized by your network dentist. If you need to see a specialist, you must get a referral from your primary dentist to receive covered specialist services. Plan pays a maximum of \$1,000 per calendar year for covered specialist services. You are responsible for amounts above \$1,000. If you are enrolled in the optional supplemental dental PPO plan and you need to see a specialist, you may go directly to the specialist.

# Optional supplemental dental HMO and PPO plans (cont'd)

Blue Shield Balance (HMO)  
Los Angeles County

Effective January 1, 2023 - December 31, 2023

	Optional supplemental dental HMO	Optional supplemental dental PPO	
	Participating dentists only	Participating dentists	Non-participating dentists
<b>Summary list of services covered (ADA code)<sup>†</sup></b>			
	You pay	You pay	You pay
<b>Diagnostic services</b>			
<b>Comprehensive oral exam (D0150)</b>	\$5 copay (2 visits in 12 months)	0% (2 visits in 12 months)	20% (2 visits in 12 months)
<b>Complete X-rays (D0210)</b>	\$0 copay (1 series every 24 months)	0% (1 series every 36 months)	20% (1 series every 36 months)
<b>Preventive care</b>			
<b>Prophylaxis – adult (D1110)</b>	\$5 copay (1 cleaning every 6 months)	0% (1 cleaning every 6 months)	20% (1 cleaning every 6 months)
<b>Restorative services</b>			
<b>One surface composite resin restoration – anterior (D2330)</b>	\$11 copay	20%	30%
<b>Crown (porcelain fused to noble metal) (D2750)</b>	\$275 copay <sup>‡</sup>	50%	50%
<b>Periodontics</b>	<b>For the optional supplemental dental HMO plan, your copayment will be higher if these services are performed by a specialist.</b>		
<b>Periodontal scaling &amp; root planing/four or more teeth per quadrant (D4341)</b>	\$45 copay	50%	50%
<b>Endodontics</b>	<b>For the optional supplemental dental HMO plan, your copayment will be higher if these services are performed by a specialist.</b>		
<b>Anterior root canal therapy (D3310)</b>	\$195 copay	50%	50%
<b>Molar tooth therapy (D3330)</b>	\$335 copay	50%	50%

<sup>†</sup>ADA codes are procedure codes established by the American Dental Association for efficient processing and reporting of dental claims.

<sup>‡</sup>You pay the copayment plus the cost of precious or semi-precious metals. Porcelain on molar crowns is not a covered benefit.



## 2023 Individual Enrollment Request Form

**Blue Shield Medicare Advantage Plans: Blue Shield 65 Plus (HMO), Blue Shield 65 Plus Plan 2 (HMO), Blue Shield 65 Plus Choice Plan (HMO), Blue Shield Inspire (HMO), Blue Shield Balance (HMO), Blue Shield Enhanced (HMO), Blue Shield AdvantageOptimum Plan (HMO), Blue Shield AdvantageOptimum Plan 1 (HMO), Blue Shield TotalDual Plan (HMO D-SNP), Blue Shield Inspire (HMO D-SNP)**

### Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

### To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

**Important:** To join a Medicare Advantage Plan, you must also have either, or both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

### When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit [Medicare.gov](https://www.Medicare.gov) to learn more about when you can sign up for a plan.

### What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

**Note:** You must complete all items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

### Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.

- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

### What happens next?

Email, Mail, or Fax your completed and signed form to:

**Email:** [WHMembership@blueshieldca.com](mailto:WHMembership@blueshieldca.com)

**Mail:** Blue Shield of California  
PO Box 948  
Woodland Hills, CA 91365-9856

**Fax:** (877) 251-3660

Once they process your request to join, they'll contact you.

### How do I get help with this form?

Call your Authorized Agent or your Blue Shield Representative at **(888) 534-4263**. TTY users can call **711**. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a su Agente Autorizado o a su Representante de Blue Shield al **(888) 534-4263**. Los usuarios del sistema TTY pueden llamar al **711** o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

### Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

### IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

**Section 1 – All fields in this section are required (unless marked optional)**

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**Select the plan you want to join:**

- Blue Shield 65 Plus (HMO) Los Angeles/Orange Counties (\$0 per month)
  - Blue Shield 65 Plus (HMO) Kern County (\$0 per month)
  - Blue Shield 65 Plus (HMO) Riverside County (\$0 per month)
  - Blue Shield 65 Plus (HMO) San Bernardino County (\$0 per month)
  - Blue Shield 65 Plus (HMO) San Diego County (\$0 per month)
  - Blue Shield 65 Plus (HMO) San Luis Obispo/Santa Barbara Counties (\$39 per month)
  - Blue Shield 65 Plus (HMO) Ventura County (\$0 per month)
  - Blue Shield 65 Plus Plan 2 (HMO) Los Angeles/Orange Counties (\$0 per month)
  - Blue Shield 65 Plus Choice Plan (HMO) San Bernardino/Riverside Counties (\$0 per month)
  - Blue Shield Enhanced (HMO) Los Angeles/Orange Counties (\$39 per month)
  - Blue Shield AdvantageOptimum Plan (HMO) Los Angeles/Orange Counties (\$0 per month)
  - Blue Shield AdvantageOptimum Plan 1 (HMO) San Diego County (\$0 per month)
  - Blue Shield Balance (HMO) Los Angeles County (\$0 per month)
  - Blue Shield Inspire (HMO) Alameda/San Mateo Counties (\$0 per month)
  - Blue Shield Inspire (HMO) Los Angeles/Orange Counties (\$0 per month)
  - Blue Shield Inspire (HMO) Sacramento County (\$53 per month)
  - Blue Shield Inspire (HMO) San Joaquin/Stanislaus/Merced/Fresno/Madera/Santa Clara Counties (\$0 per month)
  - Blue Shield Inspire (HMO D-SNP) Merced/San Joaquin/Stanislaus Counties (\$38.90 per month)
  - Blue Shield TotalDual Plan (HMO D-SNP) Los Angeles/San Diego Counties (\$0 per month)
- 

Blue Shield Inspire (HMO) in the counties of Alameda, Fresno, Madera, Merced, Sacramento, San Joaquin, San Mateo, Santa Clara, and Stanislaus; Blue Shield Inspire (HMO D-SNP) in San Joaquin, Merced and Stanislaus; and Blue Shield Balance (HMO) in the county of Los Angeles includes one or more Special Supplemental Benefits for the Chronically Ill (SSBCI). SSBCI are part of special supplemental benefits available in select plans. Not all plan members will qualify. Refer to the Evidence of Coverage for details and eligibility requirements. To be eligible for each SSBCI benefit, you must have at least one of the required qualifying chronic conditions which can vary by plan. Please refer to the "Attestation for Special Supplemental Benefit for the Chronically Ill (SSBCI)" form included in the enrollment kit, online or contact Customer Care **(800) 776-4466 (TTY: 711)** for a copy. For members enrolled in D-SNP plans, please contact D-SNP Customer Care **(800) 452-4413 (TTY: 711)**.

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**Please indicate if you would like to enroll in the Optional Supplemental Dental HMO or PPO plan**

- Optional Supplemental Dental HMO plan**, (\$12.50 per month)  
(not available in all plans/service areas; refer to the plan summary of benefits for additional information.)
- 

Name of Dentist:

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Provider ID#:

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If you do not select a dentist, you will be assigned a dentist at the time of enrollment.

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- Optional Supplemental Dental PPO plan**, (\$42.30 per month)  
(not available in all plans/service areas; refer to the plan summary of benefits for additional information.)

No dentist selection necessary for the PPO plan.

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First Name:		(optional): Middle Initial:
Last Name:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Birth Date (MM/DD/YYYY):	Phone Number:	(optional): <input type="checkbox"/> Landline <input type="checkbox"/> Cell
	Alternate Phone Number (optional):	(optional): <input type="checkbox"/> Landline <input type="checkbox"/> Cell

Optional: I agree that Blue Shield and its affiliated entities and agents may communicate with me about my account and various health and wellness programs available to me, and other promotional information that may benefit me and my dependents, including by phone or text to the numbers I have listed on this form, using an auto-dialer or artificial or prerecorded voice; standard data rates apply.  Yes  No

Participation is voluntary and you can opt-out at any time, for more information visit [blueshieldca.com/terms](http://blueshieldca.com/terms).

Go paperless! Please watch for an email with a link which will allow you to register your account, customize your communication preferences, and access your digital ID card and benefit information.

**Email address** (Optional, but required for electronic communications)

I would like to receive both required and non-required plan materials via email (i.e., enrollment notifications, Annual Notice of Change, benefit promotions, and plan newsletters) in place of mailed printed copies.

Not checking the box above means you will receive printed plan materials via mail. You may choose to go back to printed materials at any time by calling Customer Care at the number on your plan ID card.

**Preferred communication channel:**  Email  SMS (Text)  Standard Mail  Call

It's our goal to communicate with you in your preferred method. However, in some situations, we may need to adjust how we are providing you with information.

**Permanent Residence street address:**  
Street Address:

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City: State: ZIP code:

**Mailing address, if different from your permanent address (P.O. Box allowed):**  
Street Address:

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City: State: ZIP code:

**Your Medicare information:**  
Medicare Number:

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**Answer these important questions:**

Will you have other prescription drug coverage (like VA, TRICARE) in addition to a Blue Shield Medicare Advantage Plan?

Yes  No

---

**Prescription drug coverage:**

Name of other coverage:

---

ID # for this coverage:

---

Group #:

---

**Medical coverage:**

Name of other coverage:

---

ID # for this coverage:

---

Group #:

---

Are you enrolled in your State Medicaid (Medi-Cal) program?  Yes  No  
If yes, please provide your Medicaid (Medi-Cal) number

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**IMPORTANT: Read and sign below:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in a Blue Shield Medicare Advantage Plan.
- By joining this Medicare Advantage Plan, I acknowledge that my Blue Shield Medicare Advantage Plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA or Part D plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Blue Shield Medicare Advantage Plan coverage begins, I must get all of my medical and prescription drug benefits from that Blue Shield Medicare Advantage Plan. Benefits and services provided by my Blue Shield Medicare Advantage Plan and contained in my Blue Shield Medicare Advantage Plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor my Blue Shield Medicare Advantage Plan will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  - 1) This person is authorized under State law to complete this enrollment, and
  - 2) Documentation of this authority is available upon request by Medicare.

<b>Signature</b>	<b>Today's Date</b>
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If you're the authorized representative, sign above and fill out these fields.

Name

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Street Address:

---

City:

State: ZIP code:

---

Phone Number:

---

Relationship to Enrollee:

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**Section 2 – All fields in this section are optional**

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Do you work?  Yes  No Does your spouse work?  Yes  No

List your Primary Care Physician (PCP) or clinic:

Physician Name or Clinic Name:

Physician ID #:

Physician Group Name:

Current Patient?  Yes  No

Select one if you want us to send you information in a language other than English.

Spanish  Chinese

Select one if you want us to send you information in an accessible format.

Braille  Large Print  Audio CD

Please contact Blue Shield Customer Care at **(800) 776-4466 (TTY: 711)** if you need information in an accessible format or language other than what is listed above. For members enrolled in D-SNP plans, please contact D-SNP Customer Care **(800) 452-4413 (TTY: 711)**. Our office hours are 8 a.m. to 8 p.m., seven days a week.

**Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.**

- No, not of Hispanic, Latino/a, or Spanish origin.
- Yes, Puerto Rican.  Yes, Cuban.  Yes, another Hispanic, Latino, or Spanish origin.
- Yes, Mexican, Mexican American, Chicano/a  I choose not to answer.

**What's your race? Select all that apply.**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Japanese              | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Korean                | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Native Hawaiian       | <input type="checkbox"/> White                  |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Other Asian           | <input type="checkbox"/> I choose not to answer |

## Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty you currently have or may owe) by mail each month. If your plan has a premium due, you will receive a monthly bill including the amount and the date of when your next payment is due, or you may choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

To learn more about your payment options, visit us at [blueshieldca.com/medicarewaystopay](http://blueshieldca.com/medicarewaystopay) or call Customer Care at **(800) 776-4466 (TTY: 711)**. For members enrolled in D-SNP plans, please contact D-SNP Customer Care **(800) 452-4413 (TTY: 711)**.

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from:  Social Security  RRB

(The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

**If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium.** The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Blue Shield of California the Part D-IRMAA.

**Producer information: Producer name and ID or NPN is required.**

Agency name: \_\_\_\_\_  
(please print appointed agency name)

Agency ID #: \_\_\_\_\_  
(please print agency tax ID)

Producer (writing agent) name (required): John Conner  
(please print writing agent name)

Producer ID #: \_\_\_\_\_  
(please print agent tax ID number)

Producer (writing agent) NPN or TIN (one required): 2547843  
(please print NPN or TIN number)

Producer phone number: 916-682-1117

Producer email address: john@johnconner.com

Date application received by producer: \_\_\_\_\_

Producer signature: \_\_\_\_\_

With my signature, I hereby certify that I have read and understand the CMS Medicare Communications and Marketing Guidelines and Enrollment rules and confirm that the enrollee has received a complete enrollment kit. I agree that this enrollment of a Medicare beneficiary, on behalf of Blue Shield of California, has complied with these rules.

Blue Shield of California is an HMO and an HMO D-SNP plan with a Medicare contract and a contract with the California State Medicaid Program. Enrollment in Blue Shield of California depends on contract renewal.

## **Privacy Act Statement**

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The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

**Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year.** There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- I recently moved outside of the service area for my current plan, or I recently moved, and this plan is a new option for me. I moved on (insert date).  
\_\_\_\_\_
- I recently was released from incarceration. I was released on (insert date).  
\_\_\_\_\_
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date).  
\_\_\_\_\_
- I recently obtained lawful presence status in the United States. I got this status on (insert date).  
\_\_\_\_\_
- I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date).  
\_\_\_\_\_
- I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date).  
\_\_\_\_\_
- I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date).  
\_\_\_\_\_
- I recently left a PACE program on (insert date).  
\_\_\_\_\_
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date).  
\_\_\_\_\_

- I am leaving employer or union coverage on (insert date).  
\_\_\_\_\_
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date).  
\_\_\_\_\_
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualifications required to be in the plan. I was disenrolled from the SNP on (insert date).  
\_\_\_\_\_
- I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster).
- I'm in a plan that was recently taken over by the state or territorial regulatory authority because of financial issues. I want to Switch to another plan.
- I'm in a plan that had a star-rating less than 3 stars for the last 3 years. I want to join a plan with a star rating 3 stars or higher.
- I am new to Medicare AND Medicare entitlement was made retroactively so I was notified about getting Medicare after my Part A and/or B effective date.

If none of these statements applies to you or you're not sure, please contact Blue Shield of California at **(888) 534-4263 (TTY: 711)** or Authorized Agent, to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday, from April 1 to September 30.