

A44801-MS-PR (5/17) Med Supp

Enrollment Kit Booklet effective: May 2017

Blue Shield of California rates effective: April 1, 2016

Need help? Contact your authorized Blue Shield broker.

Part Number: MS-PR-PTS-0517

### Included in this booklet:

- Why Choose Blue Shield
- SilverSneakers
- Rate Schedule
- Summary of Benefits
- Guaranteed acceptance guide
- Application form
- Replacement of coverage form
- Dental and dental + vision plans

# Thank you

for considering Blue Shield of California for your Medicare Supplement plan needs.

We understand how important it is for you to be able to access the high-quality care you've earned as a Medicare beneficiary.

Blue Shield's Medicare Supplement plans offer the freedom to choose any doctor, specialist, hospital or other provider that accepts Medicare.

**In other words, access the care you've earned with no network limits!**

As a part of our commitment to affordable care for all, please check out our competitive rates included in this booklet. You may also be eligible for savings programs. See the "Additional Savings" section of this booklet for more details about these savings\* programs:

- Our **\$25 Welcome to Medicare Rate Savings Program** if you are new to Medicare Part B.
- You can save \$3 each month for the first six months on your dental or dental + vision plan rates if you enroll in a dental or dental + vision plan **at the same time** you enroll in any Blue Shield Medicare Supplement plan.
- The \$3 monthly **Easy\$Pay<sup>SM</sup> program** when you deduct plan dues automatically from your bank account.
- Our **two-party contract savings program**.

See the next page for more great reasons to choose a Blue Shield Medicare Supplement plan.

Applying is easy! Everything you'll need to enroll in a Blue Shield Medicare Supplement plan is included in this packet. Simply go to the enrollment form section of this booklet and follow the instructions to enroll.

Again, thank you for considering Blue Shield. We look forward to serving you.

\* Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed on to the subscriber. The Welcome to Medicare Rate Savings is available only for Plans A, C, D and F. They are not available for High Deductible Plan F, Plan K and Plan N. Two-party rates do not apply to Plan K or High Deductible Plan F, and do not apply to tobacco users.





# Why choose a Blue Shield Medicare Supplement plan?

|                    |   |
|--------------------|---|
| <b>Choice</b>      | You've earned the right to go to any doctor or specialist who accepts Medicare anywhere in the United States – <b>you're not limited to a provider network, and no referrals are necessary.</b> |
| <b>Coverage</b>    | Medicare Supplement plans (or Medigap plans) help pay some of the healthcare costs that Original Medicare doesn't cover, such as copayments, coinsurance and deductibles.                       |
| <b>Ease</b>        | No medical claim forms to file.   |
| <b>Flexibility</b> | Many different supplemental plans designed to fit various needs and budgets.  |

## Why choose Blue Shield?

|  |  |
|--|--|
| <b>We serve California, not shareholders</b> | As a nonprofit company, Blue Shield doesn't answer to shareholders. Instead, we reinvest profits to benefit our members and our communities.                                     |
| <b>SilverSneakers</b>                        | We offer basic gym access through SilverSneakers® Fitness at no additional cost to Medicare Supplement plan subscribers.   |
| <b>Dependability</b>                         | We have over 75 years of experience providing Californians with affordable, quality health coverage.   |
| <b>Affordability</b>                         | Along with affordable rates, there are several opportunities to save on your monthly plan. Please check out our competitive rates and savings programs included in this booklet. |

|  |  |
|--|--|
| <b>Convenience</b>                     | <p>In addition to your Blue Shield Medicare Supplement plan, we offer other plans you can apply for and purchase:</p> <ul style="list-style-type: none"> <li>  Medicare Part D prescription drug coverage. </li> <li>  Affordable dental or dental + vision coverage. We've included information about dental and dental + vision PPO plans offered exclusively to our Medicare Supplement plan members in this booklet. </li> </ul> <p>Blue Shield also offers standalone dental plans for all ages, including a dental HMO plan with immediate plan benefits for many comprehensive procedures, dental PPO and dental PPO plus vision plans. Ask us or your broker for more information.</p> |
| <b>NurseHelp<br/>24/7<sup>SM</sup></b> | <p>Blue Shield provides round-the-clock access to registered nurses who can help direct you to a healthy solution anytime, day or night.</p>   |
| <b>ID protection</b>                   | <p>Identity protection such as credit monitoring, identity repair assistance and identity theft insurance offered to eligible members at no charge.</p>  |

Blue Shield of California is a PDP plan with a Medicare contract. Enrollment in Blue Shield depends on contract renewal.

NurseHelp 24/7 is a service mark of Blue Shield of California. Blue Shield and the Shield symbol are registered trademarks of the BlueCross BlueShield Association, an association of independent Blue Cross and Blue Shield plans.

Tivity Health and SilverSneakers are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries. © 2017 Tivity Health, Inc. All rights reserved.

Blue Shield of California complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Blue Shield of California cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Blue Shield of California 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

# 10 reasons to enroll in a Blue Shield of California Medicare Supplement plan today and get SilverSneakers

-  Use 13,000+ fitness locations nationwide at no extra cost.
-  Enroll at multiple locations at any time.
-  Strive to reach and maintain a healthy body weight.
-  Expand your circle of friends and enjoy social activities.
-  Potentially increase muscle strength and bone density.
-  Work to prevent, delay or treat certain medical conditions.<sup>1</sup>
-  Take fitness classes at convenient community venues.
-  Seek to be more flexible and have better balance.
-  Aim to improve your memory and think more clearly.
-  Enjoy access to classes, pools, free weights, treadmills and more.

## Need more reasons?

Go to [go.silversneakers.com/ChangeToday](http://go.silversneakers.com/ChangeToday) to find out how others have changed their lives with SilverSneakers.



**Enroll in** a Blue Shield of California Medicare Supplement plan **now and get SilverSneakers® at no extra cost.**

(888) 713-0000 TTY: 711, 8:30 a.m. to 5:30 p.m., Monday through Friday, excluding holidays.

1. [nihseniorhealth.gov/exerciseformolderadults/healthbenefits/01.html](http://nihseniorhealth.gov/exerciseformolderadults/healthbenefits/01.html)

# Experience better health

in mind, body and spirit through regular participation in SilverSneakers. Millions of people like you already do.



Tivity Health and SilverSneakers are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries. © 2017 Tivity Health, Inc. All rights reserved.

Blue Shield and the Shield symbol are registered trademarks of the BlueCross BlueShield Association, an association of independent Blue Cross and Blue Shield plans.

BSCA2507SLSMS0317\_T



# Blue Shield Medicare Supplement plan rate schedule

Blue Shield of California rates effective: April 1, 2016

# Blue Shield of California Medicare Supplement plans

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

|  |   |
|--|---|
| Opportunities for additional savings .....             | 3 |
| Welcome to Medicare rate savings .....                 | 3 |
| New member dental or dental + vision plan savings..... | 3 |
| Easy\$Pay .....  | 3 |
| Locate your rate .....                                 | 4 |
| Rate schedule – Region 1 to 9.....                     | 5 |

## OPPORTUNITIES FOR ADDITIONAL SAVINGS

### Welcome to Medicare Rate Savings

New to Medicare? Then we want to welcome you! Effective August 1, 2017, you can save \$25 each month for the first 12 months on your Medicare Supplement plan rates if you're new to Medicare Part B.<sup>1</sup>

To qualify, you must be age 65 or older, and Blue Shield must receive your application within six months of the date you first enrolled for benefits under Medicare Part B.

The savings will be in effect for the first 12 months of your plan dues.

The Welcome to Medicare Rate Savings is available only for Plans A, C, D, and F. They are not available for Plans High Deductible Plan F, Plan K, and Plan N.

### New member dental or dental + vision plan savings

Effective August 1, 2017, you can save \$3 each month for the first 6 months on your dental or dental + vision plan rates if you enroll in a dental or dental + vision plan **at the same time** you enroll in any Blue Shield Medicare Supplement plan.<sup>1</sup>

### Easy\$Pay

Easy\$Pay is a simple, convenient way to pay your dues. Simply authorize Blue Shield to withdraw the monthly dues from your personal checking or savings account. By choosing this method, you will save \$3 per month on your plan dues.<sup>1</sup>

### Two-party enrollment

If you and your spouse or domestic partner are age 65 or older, apply together, and are accepted in the *same benefit plan type*, you may be able to save on your combined monthly dues if coverage is issued under one agreement.<sup>1</sup> Two-party rates are based on the age of the older party. For more information, please ask your Blue Shield representative for eligibility and details about our two-party enrollment feature.

**Please note:** If you are currently enrolled in a Medicare Supplement plan, you may transfer to a plan of equal or lesser value during an annual open enrollment period, which begins every year on your birthday and lasts for 30 days. However, if you currently have a two-party agreement and change to a benefit plan that is different from your spouse or domestic partner's, you will no longer be eligible for the two-party rate if your spouse does not change to the same plan.

## LOCATE YOUR RATE

Several factors determine your rate, including where you live, the Medicare Supplemental plan you chose and your age at the start of your coverage effective date.

To see the rate you will pay, locate your age range, and plan selected in the following rate schedule.

## Region 1

Los Angeles County (except for ZIP codes 91711, 91759, 91765, 91766, 91767, 93535, 93544, 93563, and 93591)

### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

#### Single-party rates

| Age range                  | A     | C     | D     | F     | Hi F  | K     | N     |
|----------------------------|-------|-------|-------|-------|-------|-------|-------|
| 65 to 66                   | \$125 | \$171 | \$146 | \$184 | \$61  | \$78  | \$117 |
| 67 to 68                   | \$133 | \$180 | \$153 | \$193 | \$64  | \$81  | \$123 |
| 69 to 70                   | \$145 | \$197 | \$168 | \$213 | \$71  | \$89  | \$136 |
| 71 to 72                   | \$167 | \$227 | \$192 | \$244 | \$81  | \$102 | \$156 |
| 73 to 74                   | \$182 | \$248 | \$210 | \$270 | \$90  | \$117 | \$172 |
| 75 to 76                   | \$210 | \$281 | \$240 | \$308 | \$102 | \$129 | \$196 |
| 77 to 78                   | \$226 | \$299 | \$255 | \$334 | \$111 | \$140 | \$213 |
| 79 to 80                   | \$233 | \$320 | \$274 | \$342 | \$114 | \$150 | \$218 |
| 81 to 82                   | \$248 | \$336 | \$286 | \$363 | \$120 | \$159 | \$231 |
| 83 to 84                   | \$260 | \$354 | \$300 | \$380 | \$126 | \$167 | \$242 |
| 85 plus                    | \$272 | \$370 | \$316 | \$400 | \$133 | \$175 | \$254 |
| 64 or younger <sup>2</sup> | \$643 | \$876 | \$735 | \$945 | \$314 | \$393 | \$602 |

#### Two-party rates<sup>1</sup>

| Age range                  | A     | C     | D     | F     | Hi F | K   | N     |
|----------------------------|-------|-------|-------|-------|------|-----|-------|
| 65 to 66                   | \$244 | \$336 | \$286 | \$362 | N/A  | N/A | \$228 |
| 67 to 68                   | \$241 | \$335 | \$281 | \$361 | N/A  | N/A | \$221 |
| 69 to 70                   | \$265 | \$369 | \$311 | \$401 | N/A  | N/A | \$247 |
| 71 to 72                   | \$309 | \$429 | \$359 | \$463 | N/A  | N/A | \$287 |
| 73 to 74                   | \$339 | \$471 | \$395 | \$515 | N/A  | N/A | \$319 |
| 75 to 76                   | \$395 | \$537 | \$455 | \$591 | N/A  | N/A | \$367 |
| 77 to 78                   | \$427 | \$573 | \$485 | \$643 | N/A  | N/A | \$401 |
| 79 to 80                   | \$441 | \$615 | \$523 | \$659 | N/A  | N/A | \$411 |
| 81 to 82                   | \$471 | \$647 | \$547 | \$701 | N/A  | N/A | \$437 |
| 83 to 84                   | \$495 | \$683 | \$575 | \$735 | N/A  | N/A | \$459 |
| 85 plus                    | \$519 | \$715 | \$607 | \$775 | N/A  | N/A | \$483 |
| 64 or younger <sup>2</sup> | N/A   | N/A   | N/A   | N/A   | N/A  | N/A | N/A   |

**Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance.**

#### Single-party rates

| Age range                  | A     | C       | D     | F       | Hi F  | K     | N     |
|----------------------------|-------|---------|-------|---------|-------|-------|-------|
| 65 to 66                   | \$149 | \$204   | \$174 | \$220   | \$73  | \$93  | \$140 |
| 67 to 68                   | \$159 | \$215   | \$183 | \$230   | \$76  | \$97  | \$147 |
| 69 to 70                   | \$173 | \$235   | \$200 | \$254   | \$85  | \$106 | \$162 |
| 71 to 72                   | \$199 | \$271   | \$229 | \$291   | \$97  | \$122 | \$186 |
| 73 to 74                   | \$217 | \$296   | \$251 | \$322   | \$107 | \$140 | \$205 |
| 75 to 76                   | \$251 | \$335   | \$286 | \$367   | \$122 | \$154 | \$234 |
| 77 to 78                   | \$270 | \$357   | \$304 | \$398   | \$132 | \$167 | \$254 |
| 79 to 80                   | \$278 | \$382   | \$327 | \$408   | \$136 | \$179 | \$260 |
| 81 to 82                   | \$296 | \$401   | \$341 | \$433   | \$143 | \$190 | \$276 |
| 83 to 84                   | \$310 | \$422   | \$358 | \$453   | \$150 | \$199 | \$289 |
| 85 plus                    | \$324 | \$441   | \$377 | \$477   | \$159 | \$209 | \$303 |
| 64 or younger <sup>2</sup> | \$767 | \$1,045 | \$877 | \$1,127 | \$375 | \$469 | \$718 |

#### Two-party rates<sup>1</sup> do not apply

## Region 2

### Orange County

#### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

#### Single-party rates

| Age range                  | A     | C     | D     | F     | Hi F  | K     | N     |
|----------------------------|-------|-------|-------|-------|-------|-------|-------|
| 65 to 66                   | \$125 | \$171 | \$146 | \$190 | \$61  | \$78  | \$117 |
| 67 to 68                   | \$133 | \$180 | \$153 | \$198 | \$64  | \$81  | \$123 |
| 69 to 70                   | \$145 | \$203 | \$168 | \$218 | \$71  | \$89  | \$136 |
| 71 to 72                   | \$167 | \$233 | \$197 | \$251 | \$81  | \$102 | \$156 |
| 73 to 74                   | \$182 | \$254 | \$216 | \$277 | \$90  | \$117 | \$172 |
| 75 to 76                   | \$216 | \$288 | \$247 | \$317 | \$102 | \$129 | \$202 |
| 77 to 78                   | \$232 | \$307 | \$262 | \$343 | \$111 | \$140 | \$218 |
| 79 to 80                   | \$240 | \$329 | \$282 | \$351 | \$114 | \$150 | \$224 |
| 81 to 82                   | \$254 | \$345 | \$294 | \$373 | \$120 | \$159 | \$238 |
| 83 to 84                   | \$266 | \$364 | \$308 | \$390 | \$126 | \$167 | \$249 |
| 85 plus                    | \$279 | \$380 | \$324 | \$411 | \$133 | \$175 | \$261 |
| 64 or younger <sup>2</sup> | \$661 | \$899 | \$755 | \$970 | \$322 | \$393 | \$618 |

#### Two-party rates<sup>1</sup>

| Age range                  | A     | C     | D     | F     | Hi F | K   | N     |
|----------------------------|-------|-------|-------|-------|------|-----|-------|
| 65 to 66                   | \$244 | \$336 | \$286 | \$374 | N/A  | N/A | \$228 |
| 67 to 68                   | \$241 | \$335 | \$281 | \$371 | N/A  | N/A | \$221 |
| 69 to 70                   | \$265 | \$381 | \$311 | \$411 | N/A  | N/A | \$247 |
| 71 to 72                   | \$309 | \$441 | \$369 | \$477 | N/A  | N/A | \$287 |
| 73 to 74                   | \$339 | \$483 | \$407 | \$529 | N/A  | N/A | \$319 |
| 75 to 76                   | \$407 | \$551 | \$469 | \$609 | N/A  | N/A | \$379 |
| 77 to 78                   | \$439 | \$589 | \$499 | \$661 | N/A  | N/A | \$411 |
| 79 to 80                   | \$455 | \$633 | \$539 | \$677 | N/A  | N/A | \$423 |
| 81 to 82                   | \$483 | \$665 | \$563 | \$721 | N/A  | N/A | \$451 |
| 83 to 84                   | \$507 | \$703 | \$591 | \$755 | N/A  | N/A | \$473 |
| 85 plus                    | \$533 | \$735 | \$623 | \$797 | N/A  | N/A | \$497 |
| 64 or younger <sup>2</sup> | N/A   | N/A   | N/A   | N/A   | N/A  | N/A | N/A   |

**Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance.**

#### Single-party rates

| Age range                  | A     | C       | D     | F       | Hi F  | K     | N     |
|----------------------------|-------|---------|-------|---------|-------|-------|-------|
| 65 to 66                   | \$149 | \$204   | \$174 | \$227   | \$73  | \$93  | \$140 |
| 67 to 68                   | \$159 | \$215   | \$183 | \$236   | \$76  | \$97  | \$147 |
| 69 to 70                   | \$173 | \$242   | \$200 | \$260   | \$85  | \$106 | \$162 |
| 71 to 72                   | \$199 | \$278   | \$235 | \$299   | \$97  | \$122 | \$186 |
| 73 to 74                   | \$217 | \$303   | \$258 | \$330   | \$107 | \$140 | \$205 |
| 75 to 76                   | \$258 | \$344   | \$295 | \$378   | \$122 | \$154 | \$241 |
| 77 to 78                   | \$277 | \$366   | \$313 | \$409   | \$132 | \$167 | \$260 |
| 79 to 80                   | \$286 | \$392   | \$336 | \$419   | \$136 | \$179 | \$267 |
| 81 to 82                   | \$303 | \$412   | \$351 | \$445   | \$143 | \$190 | \$284 |
| 83 to 84                   | \$317 | \$434   | \$367 | \$465   | \$150 | \$199 | \$297 |
| 85 plus                    | \$333 | \$453   | \$387 | \$490   | \$159 | \$209 | \$311 |
| 64 or younger <sup>2</sup> | \$789 | \$1,073 | \$901 | \$1,157 | \$384 | \$469 | \$737 |

#### Two-party rates<sup>1</sup> do not apply

## Region 3

San Diego, Sonoma, San Bernardino, Kern counties, and Los Angeles  
ZIP codes 91711, 91759, 91765, 91766, 91767, 93535, 93544, 93563, and 93591

### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

#### Single-party rates

| Age range                  | A     | C     | D     | F     | Hi F  | K     | N     |
|----------------------------|-------|-------|-------|-------|-------|-------|-------|
| 65 to 66                   | \$110 | \$148 | \$126 | \$160 | \$48  | \$61  | \$102 |
| 67 to 68                   | \$118 | \$161 | \$137 | \$173 | \$57  | \$67  | \$111 |
| 69 to 70                   | \$132 | \$179 | \$152 | \$194 | \$61  | \$78  | \$124 |
| 71 to 72                   | \$151 | \$205 | \$174 | \$222 | \$70  | \$89  | \$141 |
| 73 to 74                   | \$165 | \$226 | \$193 | \$244 | \$77  | \$102 | \$156 |
| 75 to 76                   | \$192 | \$254 | \$218 | \$282 | \$94  | \$112 | \$179 |
| 77 to 78                   | \$205 | \$272 | \$232 | \$305 | \$101 | \$122 | \$194 |
| 79 to 80                   | \$212 | \$292 | \$249 | \$311 | \$103 | \$130 | \$198 |
| 81 to 82                   | \$225 | \$307 | \$261 | \$330 | \$109 | \$138 | \$209 |
| 83 to 84                   | \$237 | \$322 | \$273 | \$345 | \$115 | \$145 | \$220 |
| 85 plus                    | \$248 | \$338 | \$287 | \$363 | \$121 | \$151 | \$231 |
| 64 or younger <sup>2</sup> | \$584 | \$797 | \$669 | \$859 | \$286 | \$341 | \$547 |

#### Two-party rates<sup>1</sup>

| Age range                  | A     | C     | D     | F     | Hi F | K   | N     |
|----------------------------|-------|-------|-------|-------|------|-----|-------|
| 65 to 66                   | \$214 | \$290 | \$246 | \$314 | N/A  | N/A | \$198 |
| 67 to 68                   | \$211 | \$297 | \$249 | \$321 | N/A  | N/A | \$197 |
| 69 to 70                   | \$239 | \$333 | \$279 | \$363 | N/A  | N/A | \$223 |
| 71 to 72                   | \$277 | \$385 | \$323 | \$419 | N/A  | N/A | \$257 |
| 73 to 74                   | \$305 | \$427 | \$361 | \$463 | N/A  | N/A | \$287 |
| 75 to 76                   | \$359 | \$483 | \$411 | \$539 | N/A  | N/A | \$333 |
| 77 to 78                   | \$385 | \$519 | \$439 | \$585 | N/A  | N/A | \$363 |
| 79 to 80                   | \$399 | \$559 | \$473 | \$597 | N/A  | N/A | \$371 |
| 81 to 82                   | \$425 | \$589 | \$497 | \$635 | N/A  | N/A | \$393 |
| 83 to 84                   | \$449 | \$619 | \$521 | \$665 | N/A  | N/A | \$415 |
| 85 plus                    | \$471 | \$651 | \$549 | \$701 | N/A  | N/A | \$437 |
| 64 or younger <sup>2</sup> | N/A   | N/A   | N/A   | N/A   | N/A  | N/A | N/A   |

**Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance.**

#### Single-party rates

| Age range                  | A     | C     | D     | F       | Hi F  | K     | N     |
|----------------------------|-------|-------|-------|---------|-------|-------|-------|
| 65 to 66                   | \$131 | \$177 | \$150 | \$191   | \$57  | \$73  | \$122 |
| 67 to 68                   | \$141 | \$192 | \$163 | \$206   | \$68  | \$80  | \$132 |
| 69 to 70                   | \$157 | \$214 | \$181 | \$231   | \$73  | \$93  | \$148 |
| 71 to 72                   | \$180 | \$245 | \$208 | \$265   | \$84  | \$106 | \$168 |
| 73 to 74                   | \$197 | \$270 | \$230 | \$291   | \$92  | \$122 | \$186 |
| 75 to 76                   | \$229 | \$303 | \$260 | \$336   | \$112 | \$134 | \$214 |
| 77 to 78                   | \$245 | \$324 | \$277 | \$364   | \$120 | \$146 | \$231 |
| 79 to 80                   | \$253 | \$348 | \$297 | \$371   | \$123 | \$155 | \$236 |
| 81 to 82                   | \$268 | \$366 | \$311 | \$394   | \$130 | \$165 | \$249 |
| 83 to 84                   | \$283 | \$384 | \$326 | \$412   | \$137 | \$173 | \$262 |
| 85 plus                    | \$296 | \$403 | \$342 | \$433   | \$144 | \$180 | \$276 |
| 64 or younger <sup>2</sup> | \$697 | \$951 | \$798 | \$1,025 | \$341 | \$407 | \$653 |

#### Two-party rates<sup>1</sup> do not apply

## Region 4

### Riverside and Ventura counties

#### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

#### Single-party rates

| Age range                  | A     | C     | D     | F     | Hi F  | K     | N     |
|----------------------------|-------|-------|-------|-------|-------|-------|-------|
| 65 to 66                   | \$121 | \$165 | \$141 | \$178 | \$59  | \$68  | \$113 |
| 67 to 68                   | \$130 | \$178 | \$151 | \$192 | \$63  | \$73  | \$123 |
| 69 to 70                   | \$147 | \$198 | \$170 | \$215 | \$68  | \$85  | \$136 |
| 71 to 72                   | \$169 | \$227 | \$193 | \$246 | \$78  | \$98  | \$157 |
| 73 to 74                   | \$183 | \$249 | \$213 | \$271 | \$86  | \$113 | \$173 |
| 75 to 76                   | \$213 | \$283 | \$240 | \$310 | \$103 | \$124 | \$197 |
| 77 to 78                   | \$227 | \$301 | \$259 | \$335 | \$112 | \$135 | \$214 |
| 79 to 80                   | \$236 | \$322 | \$275 | \$345 | \$115 | \$144 | \$219 |
| 81 to 82                   | \$249 | \$339 | \$288 | \$366 | \$121 | \$152 | \$233 |
| 83 to 84                   | \$261 | \$356 | \$302 | \$383 | \$127 | \$160 | \$243 |
| 85 plus                    | \$274 | \$374 | \$317 | \$402 | \$134 | \$168 | \$256 |
| 64 or younger <sup>2</sup> | \$648 | \$881 | \$739 | \$950 | \$316 | \$376 | \$605 |

#### Two-party rates<sup>1</sup>

| Age range                  | A     | C     | D     | F     | Hi F | K   | N     |
|----------------------------|-------|-------|-------|-------|------|-----|-------|
| 65 to 66                   | \$236 | \$324 | \$276 | \$350 | N/A  | N/A | \$220 |
| 67 to 68                   | \$235 | \$331 | \$277 | \$359 | N/A  | N/A | \$221 |
| 69 to 70                   | \$269 | \$371 | \$315 | \$405 | N/A  | N/A | \$247 |
| 71 to 72                   | \$313 | \$429 | \$361 | \$467 | N/A  | N/A | \$289 |
| 73 to 74                   | \$341 | \$473 | \$401 | \$517 | N/A  | N/A | \$321 |
| 75 to 76                   | \$401 | \$541 | \$455 | \$595 | N/A  | N/A | \$369 |
| 77 to 78                   | \$429 | \$577 | \$493 | \$645 | N/A  | N/A | \$403 |
| 79 to 80                   | \$447 | \$619 | \$525 | \$665 | N/A  | N/A | \$413 |
| 81 to 82                   | \$473 | \$653 | \$551 | \$707 | N/A  | N/A | \$441 |
| 83 to 84                   | \$497 | \$687 | \$579 | \$741 | N/A  | N/A | \$461 |
| 85 plus                    | \$523 | \$723 | \$609 | \$779 | N/A  | N/A | \$487 |
| 64 or younger <sup>2</sup> | N/A   | N/A   | N/A   | N/A   | N/A  | N/A | N/A   |

**Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance.**

#### Single-party rates

| Age range                  | A     | C       | D     | F       | Hi F  | K     | N     |
|----------------------------|-------|---------|-------|---------|-------|-------|-------|
| 65 to 66                   | \$144 | \$197   | \$168 | \$212   | \$70  | \$81  | \$135 |
| 67 to 68                   | \$155 | \$212   | \$180 | \$229   | \$75  | \$87  | \$147 |
| 69 to 70                   | \$175 | \$236   | \$203 | \$256   | \$81  | \$101 | \$162 |
| 71 to 72                   | \$202 | \$271   | \$230 | \$293   | \$93  | \$117 | \$187 |
| 73 to 74                   | \$218 | \$297   | \$254 | \$323   | \$103 | \$135 | \$206 |
| 75 to 76                   | \$254 | \$338   | \$286 | \$370   | \$123 | \$148 | \$235 |
| 77 to 78                   | \$271 | \$359   | \$309 | \$400   | \$134 | \$161 | \$255 |
| 79 to 80                   | \$282 | \$384   | \$328 | \$412   | \$137 | \$172 | \$261 |
| 81 to 82                   | \$297 | \$404   | \$344 | \$437   | \$144 | \$181 | \$278 |
| 83 to 84                   | \$311 | \$425   | \$360 | \$457   | \$152 | \$191 | \$290 |
| 85 plus                    | \$327 | \$446   | \$378 | \$480   | \$160 | \$200 | \$305 |
| 64 or younger <sup>2</sup> | \$773 | \$1,051 | \$882 | \$1,133 | \$377 | \$449 | \$722 |

#### Two-party rates<sup>1</sup> do not apply



## Region 5

Santa Barbara, San Joaquin, and Stanislaus counties

### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

#### Single-party rates

| Age range                  | A     | C     | D     | F     | Hi F  | K     | N     |
|----------------------------|-------|-------|-------|-------|-------|-------|-------|
| 65 to 66                   | \$103 | \$138 | \$119 | \$150 | \$50  | \$60  | \$95  |
| 67 to 68                   | \$110 | \$145 | \$126 | \$157 | \$52  | \$64  | \$105 |
| 69 to 70                   | \$118 | \$161 | \$138 | \$174 | \$55  | \$70  | \$111 |
| 71 to 72                   | \$136 | \$184 | \$158 | \$199 | \$63  | \$80  | \$127 |
| 73 to 74                   | \$150 | \$203 | \$173 | \$220 | \$70  | \$92  | \$140 |
| 75 to 76                   | \$172 | \$230 | \$196 | \$252 | \$80  | \$101 | \$160 |
| 77 to 78                   | \$185 | \$244 | \$208 | \$273 | \$86  | \$110 | \$174 |
| 79 to 80                   | \$192 | \$262 | \$224 | \$281 | \$93  | \$117 | \$179 |
| 81 to 82                   | \$203 | \$275 | \$233 | \$296 | \$99  | \$124 | \$189 |
| 83 to 84                   | \$212 | \$289 | \$246 | \$311 | \$103 | \$130 | \$198 |
| 85 plus                    | \$222 | \$304 | \$259 | \$328 | \$108 | \$137 | \$208 |
| 64 or younger <sup>2</sup> | \$527 | \$717 | \$602 | \$773 | \$257 | \$306 | \$492 |

#### Two-party rates<sup>1</sup>

| Age range                  | A     | C     | D     | F     | Hi F | K   | N     |
|----------------------------|-------|-------|-------|-------|------|-----|-------|
| 65 to 66                   | \$200 | \$270 | \$232 | \$294 | N/A  | N/A | \$184 |
| 67 to 68                   | \$195 | \$265 | \$227 | \$289 | N/A  | N/A | \$185 |
| 69 to 70                   | \$211 | \$297 | \$251 | \$323 | N/A  | N/A | \$197 |
| 71 to 72                   | \$247 | \$343 | \$291 | \$373 | N/A  | N/A | \$229 |
| 73 to 74                   | \$275 | \$381 | \$321 | \$415 | N/A  | N/A | \$255 |
| 75 to 76                   | \$319 | \$435 | \$367 | \$479 | N/A  | N/A | \$295 |
| 77 to 78                   | \$345 | \$463 | \$391 | \$521 | N/A  | N/A | \$323 |
| 79 to 80                   | \$359 | \$499 | \$423 | \$537 | N/A  | N/A | \$333 |
| 81 to 82                   | \$381 | \$525 | \$441 | \$567 | N/A  | N/A | \$353 |
| 83 to 84                   | \$399 | \$553 | \$467 | \$597 | N/A  | N/A | \$371 |
| 85 plus                    | \$419 | \$583 | \$493 | \$631 | N/A  | N/A | \$391 |
| 64 or younger <sup>2</sup> | N/A   | N/A   | N/A   | N/A   | N/A  | N/A | N/A   |

**Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance.**

#### Single-party rates

| Age range                  | A     | C     | D     | F     | Hi F  | K     | N     |
|----------------------------|-------|-------|-------|-------|-------|-------|-------|
| 65 to 66                   | \$123 | \$165 | \$142 | \$179 | \$60  | \$72  | \$113 |
| 67 to 68                   | \$131 | \$173 | \$150 | \$187 | \$62  | \$76  | \$125 |
| 69 to 70                   | \$141 | \$192 | \$165 | \$208 | \$66  | \$84  | \$132 |
| 71 to 72                   | \$162 | \$220 | \$188 | \$237 | \$75  | \$95  | \$152 |
| 73 to 74                   | \$179 | \$242 | \$206 | \$262 | \$84  | \$110 | \$167 |
| 75 to 76                   | \$205 | \$274 | \$234 | \$301 | \$95  | \$120 | \$191 |
| 77 to 78                   | \$221 | \$291 | \$248 | \$326 | \$103 | \$131 | \$208 |
| 79 to 80                   | \$229 | \$313 | \$267 | \$335 | \$111 | \$140 | \$214 |
| 81 to 82                   | \$242 | \$328 | \$278 | \$353 | \$118 | \$148 | \$225 |
| 83 to 84                   | \$253 | \$345 | \$293 | \$371 | \$123 | \$155 | \$236 |
| 85 plus                    | \$265 | \$363 | \$309 | \$391 | \$129 | \$163 | \$248 |
| 64 or younger <sup>2</sup> | \$629 | \$855 | \$718 | \$922 | \$307 | \$365 | \$587 |

#### Two-party rates<sup>1</sup> do not apply

## Region 6

Lake, Lassen, Inyo, and Kings counties

### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

#### Single-party rates

| Age range                  | A     | C       | D     | F       | Hi F  | K     | N     |
|----------------------------|-------|---------|-------|---------|-------|-------|-------|
| 65 to 66                   | \$159 | \$216   | \$184 | \$232   | \$77  | \$98  | \$148 |
| 67 to 68                   | \$167 | \$227   | \$193 | \$244   | \$81  | \$102 | \$156 |
| 69 to 70                   | \$183 | \$249   | \$212 | \$269   | \$89  | \$113 | \$171 |
| 71 to 72                   | \$210 | \$286   | \$242 | \$308   | \$102 | \$129 | \$196 |
| 73 to 74                   | \$230 | \$313   | \$266 | \$340   | \$113 | \$148 | \$216 |
| 75 to 76                   | \$266 | \$354   | \$301 | \$390   | \$130 | \$163 | \$249 |
| 77 to 78                   | \$285 | \$377   | \$323 | \$422   | \$140 | \$178 | \$269 |
| 79 to 80                   | \$295 | \$404   | \$346 | \$433   | \$144 | \$190 | \$276 |
| 81 to 82                   | \$312 | \$425   | \$362 | \$458   | \$152 | \$201 | \$292 |
| 83 to 84                   | \$328 | \$447   | \$380 | \$481   | \$160 | \$210 | \$307 |
| 85 plus                    | \$344 | \$469   | \$399 | \$505   | \$168 | \$221 | \$322 |
| 64 or younger <sup>2</sup> | \$813 | \$1,108 | \$929 | \$1,196 | \$397 | \$498 | \$762 |

#### Two-party rates<sup>1</sup>

| Age range                  | A     | C     | D     | F     | Hi F | K   | N     |
|----------------------------|-------|-------|-------|-------|------|-----|-------|
| 65 to 66                   | \$312 | \$426 | \$362 | \$458 | N/A  | N/A | \$290 |
| 67 to 68                   | \$309 | \$429 | \$361 | \$463 | N/A  | N/A | \$287 |
| 69 to 70                   | \$341 | \$473 | \$399 | \$513 | N/A  | N/A | \$317 |
| 71 to 72                   | \$395 | \$547 | \$459 | \$591 | N/A  | N/A | \$367 |
| 73 to 74                   | \$435 | \$601 | \$507 | \$655 | N/A  | N/A | \$407 |
| 75 to 76                   | \$507 | \$683 | \$577 | \$755 | N/A  | N/A | \$473 |
| 77 to 78                   | \$545 | \$729 | \$621 | \$819 | N/A  | N/A | \$513 |
| 79 to 80                   | \$565 | \$783 | \$667 | \$841 | N/A  | N/A | \$527 |
| 81 to 82                   | \$599 | \$825 | \$699 | \$891 | N/A  | N/A | \$559 |
| 83 to 84                   | \$631 | \$869 | \$735 | \$937 | N/A  | N/A | \$589 |
| 85 plus                    | \$663 | \$913 | \$773 | \$985 | N/A  | N/A | \$619 |
| 64 or younger <sup>2</sup> | N/A   | N/A   | N/A   | N/A   | N/A  | N/A | N/A   |

**Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance.**

#### Single-party rates

| Age range                  | A     | C       | D       | F       | Hi F  | K     | N     |
|----------------------------|-------|---------|---------|---------|-------|-------|-------|
| 65 to 66                   | \$190 | \$258   | \$220   | \$277   | \$92  | \$117 | \$177 |
| 67 to 68                   | \$199 | \$271   | \$230   | \$291   | \$97  | \$122 | \$186 |
| 69 to 70                   | \$218 | \$297   | \$253   | \$321   | \$106 | \$135 | \$204 |
| 71 to 72                   | \$251 | \$341   | \$289   | \$367   | \$122 | \$154 | \$234 |
| 73 to 74                   | \$274 | \$373   | \$317   | \$406   | \$135 | \$177 | \$258 |
| 75 to 76                   | \$317 | \$422   | \$359   | \$465   | \$155 | \$194 | \$297 |
| 77 to 78                   | \$340 | \$450   | \$385   | \$503   | \$167 | \$212 | \$321 |
| 79 to 80                   | \$352 | \$482   | \$413   | \$517   | \$172 | \$227 | \$329 |
| 81 to 82                   | \$372 | \$507   | \$432   | \$546   | \$181 | \$240 | \$348 |
| 83 to 84                   | \$391 | \$533   | \$453   | \$574   | \$191 | \$251 | \$366 |
| 85 plus                    | \$410 | \$560   | \$476   | \$602   | \$200 | \$264 | \$384 |
| 64 or younger <sup>2</sup> | \$970 | \$1,322 | \$1,108 | \$1,427 | \$474 | \$594 | \$909 |

#### Two-party rates<sup>1</sup> do not apply

## Region 7

Napa, Alameda, Contra Costa, Siskiyou, and Yolo counties

### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

#### Single-party rates

| Age range                  | A     | C     | D     | F     | Hi F  | K     | N     |
|----------------------------|-------|-------|-------|-------|-------|-------|-------|
| 65 to 66                   | \$106 | \$146 | \$123 | \$157 | \$48  | \$66  | \$100 |
| 67 to 68                   | \$112 | \$152 | \$129 | \$165 | \$52  | \$68  | \$106 |
| 69 to 70                   | \$138 | \$187 | \$160 | \$203 | \$67  | \$85  | \$129 |
| 71 to 72                   | \$159 | \$215 | \$182 | \$232 | \$77  | \$98  | \$148 |
| 73 to 74                   | \$173 | \$236 | \$201 | \$256 | \$85  | \$112 | \$163 |
| 75 to 76                   | \$201 | \$267 | \$227 | \$294 | \$98  | \$123 | \$187 |
| 77 to 78                   | \$215 | \$285 | \$243 | \$318 | \$106 | \$134 | \$203 |
| 79 to 80                   | \$222 | \$305 | \$261 | \$326 | \$108 | \$142 | \$207 |
| 81 to 82                   | \$236 | \$320 | \$273 | \$345 | \$115 | \$151 | \$220 |
| 83 to 84                   | \$247 | \$338 | \$286 | \$363 | \$120 | \$159 | \$231 |
| 85 plus                    | \$259 | \$353 | \$300 | \$380 | \$126 | \$167 | \$242 |
| 64 or younger <sup>2</sup> | \$613 | \$834 | \$699 | \$899 | \$298 | \$375 | \$572 |

#### Two-party rates<sup>1</sup>

| Age range                  | A     | C     | D     | F     | Hi F | K   | N     |
|----------------------------|-------|-------|-------|-------|------|-----|-------|
| 65 to 66                   | \$206 | \$286 | \$240 | \$308 | N/A  | N/A | \$194 |
| 67 to 68                   | \$199 | \$279 | \$233 | \$305 | N/A  | N/A | \$187 |
| 69 to 70                   | \$251 | \$349 | \$295 | \$381 | N/A  | N/A | \$233 |
| 71 to 72                   | \$293 | \$405 | \$339 | \$439 | N/A  | N/A | \$271 |
| 73 to 74                   | \$321 | \$447 | \$377 | \$487 | N/A  | N/A | \$301 |
| 75 to 76                   | \$377 | \$509 | \$429 | \$563 | N/A  | N/A | \$349 |
| 77 to 78                   | \$405 | \$545 | \$461 | \$611 | N/A  | N/A | \$381 |
| 79 to 80                   | \$419 | \$585 | \$497 | \$627 | N/A  | N/A | \$389 |
| 81 to 82                   | \$447 | \$615 | \$521 | \$665 | N/A  | N/A | \$415 |
| 83 to 84                   | \$469 | \$651 | \$547 | \$701 | N/A  | N/A | \$437 |
| 85 plus                    | \$493 | \$681 | \$575 | \$735 | N/A  | N/A | \$459 |
| 64 or younger <sup>2</sup> | N/A   | N/A   | N/A   | N/A   | N/A  | N/A | N/A   |

**Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance.**

#### Single-party rates

| Age range                  | A     | C     | D     | F       | Hi F  | K     | N     |
|----------------------------|-------|-------|-------|---------|-------|-------|-------|
| 65 to 66                   | \$126 | \$174 | \$147 | \$187   | \$57  | \$79  | \$119 |
| 67 to 68                   | \$134 | \$181 | \$154 | \$197   | \$62  | \$81  | \$126 |
| 69 to 70                   | \$165 | \$223 | \$191 | \$242   | \$80  | \$101 | \$154 |
| 71 to 72                   | \$190 | \$256 | \$217 | \$277   | \$92  | \$117 | \$177 |
| 73 to 74                   | \$206 | \$282 | \$240 | \$305   | \$101 | \$134 | \$194 |
| 75 to 76                   | \$240 | \$319 | \$271 | \$351   | \$117 | \$147 | \$223 |
| 77 to 78                   | \$256 | \$340 | \$290 | \$379   | \$126 | \$160 | \$242 |
| 79 to 80                   | \$265 | \$364 | \$311 | \$389   | \$129 | \$169 | \$247 |
| 81 to 82                   | \$282 | \$382 | \$326 | \$412   | \$137 | \$180 | \$262 |
| 83 to 84                   | \$295 | \$403 | \$341 | \$433   | \$143 | \$190 | \$276 |
| 85 plus                    | \$309 | \$421 | \$358 | \$453   | \$150 | \$199 | \$289 |
| 64 or younger <sup>2</sup> | \$731 | \$995 | \$834 | \$1,073 | \$356 | \$447 | \$682 |

#### Two-party rates<sup>1</sup> do not apply

## Region 8

All remaining California counties not listed in Regions 1-7 and 9 (includes San Francisco, San Mateo, Fresno, and Santa Clara counties, etc.)

### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

#### Single-party rates

| Age range                  | A     | C     | D     | F     | Hi F  | K     | N     |
|----------------------------|-------|-------|-------|-------|-------|-------|-------|
| 65 to 66                   | \$102 | \$139 | \$118 | \$150 | \$45  | \$58  | \$95  |
| 67 to 68                   | \$111 | \$150 | \$127 | \$161 | \$49  | \$62  | \$102 |
| 69 to 70                   | \$117 | \$167 | \$141 | \$181 | \$58  | \$72  | \$111 |
| 71 to 72                   | \$140 | \$191 | \$162 | \$207 | \$66  | \$83  | \$132 |
| 73 to 74                   | \$155 | \$209 | \$178 | \$226 | \$72  | \$95  | \$144 |
| 75 to 76                   | \$176 | \$237 | \$201 | \$260 | \$83  | \$105 | \$165 |
| 77 to 78                   | \$191 | \$251 | \$217 | \$281 | \$90  | \$114 | \$180 |
| 79 to 80                   | \$196 | \$271 | \$231 | \$289 | \$92  | \$122 | \$184 |
| 81 to 82                   | \$209 | \$284 | \$242 | \$306 | \$98  | \$129 | \$195 |
| 83 to 84                   | \$219 | \$298 | \$253 | \$321 | \$102 | \$136 | \$204 |
| 85 plus                    | \$229 | \$312 | \$266 | \$336 | \$107 | \$142 | \$215 |
| 64 or younger <sup>2</sup> | \$543 | \$739 | \$620 | \$796 | \$265 | \$319 | \$506 |

#### Two-party rates<sup>1</sup>

| Age range                  | A     | C     | D     | F     | Hi F | K   | N     |
|----------------------------|-------|-------|-------|-------|------|-----|-------|
| 65 to 66                   | \$198 | \$272 | \$230 | \$294 | N/A  | N/A | \$184 |
| 67 to 68                   | \$197 | \$275 | \$229 | \$297 | N/A  | N/A | \$179 |
| 69 to 70                   | \$209 | \$309 | \$257 | \$337 | N/A  | N/A | \$197 |
| 71 to 72                   | \$255 | \$357 | \$299 | \$389 | N/A  | N/A | \$239 |
| 73 to 74                   | \$285 | \$393 | \$331 | \$427 | N/A  | N/A | \$263 |
| 75 to 76                   | \$327 | \$449 | \$377 | \$495 | N/A  | N/A | \$305 |
| 77 to 78                   | \$357 | \$477 | \$409 | \$537 | N/A  | N/A | \$335 |
| 79 to 80                   | \$367 | \$517 | \$437 | \$553 | N/A  | N/A | \$343 |
| 81 to 82                   | \$393 | \$543 | \$459 | \$587 | N/A  | N/A | \$365 |
| 83 to 84                   | \$413 | \$571 | \$481 | \$617 | N/A  | N/A | \$383 |
| 85 plus                    | \$433 | \$599 | \$507 | \$647 | N/A  | N/A | \$405 |
| 64 or younger <sup>2</sup> | N/A   | N/A   | N/A   | N/A   | N/A  | N/A | N/A   |

**Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance.**

#### Single-party rates

| Age range                  | A     | C     | D     | F     | Hi F  | K     | N     |
|----------------------------|-------|-------|-------|-------|-------|-------|-------|
| 65 to 66                   | \$122 | \$166 | \$141 | \$179 | \$54  | \$69  | \$113 |
| 67 to 68                   | \$132 | \$179 | \$152 | \$192 | \$58  | \$74  | \$122 |
| 69 to 70                   | \$140 | \$199 | \$168 | \$216 | \$69  | \$86  | \$132 |
| 71 to 72                   | \$167 | \$228 | \$193 | \$247 | \$79  | \$99  | \$157 |
| 73 to 74                   | \$185 | \$249 | \$212 | \$270 | \$86  | \$113 | \$172 |
| 75 to 76                   | \$210 | \$283 | \$240 | \$310 | \$99  | \$125 | \$197 |
| 77 to 78                   | \$228 | \$299 | \$259 | \$335 | \$107 | \$136 | \$215 |
| 79 to 80                   | \$234 | \$323 | \$276 | \$345 | \$110 | \$146 | \$220 |
| 81 to 82                   | \$249 | \$339 | \$289 | \$365 | \$117 | \$154 | \$233 |
| 83 to 84                   | \$261 | \$356 | \$302 | \$383 | \$122 | \$162 | \$243 |
| 85 plus                    | \$273 | \$372 | \$317 | \$401 | \$128 | \$169 | \$256 |
| 64 or younger <sup>2</sup> | \$648 | \$882 | \$740 | \$950 | \$316 | \$381 | \$604 |

#### Two-party rates<sup>1</sup> do not apply

## Region 9

Sacramento, Amador, Calaveras, Colusa, El Dorado, Tehama, and Marin counties

### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

#### Single-party rates

| Age range                  | A     | C     | D     | F     | Hi F  | K     | N     |
|----------------------------|-------|-------|-------|-------|-------|-------|-------|
| 65 to 66                   | \$100 | \$141 | \$116 | \$152 | \$46  | \$56  | \$98  |
| 67 to 68                   | \$104 | \$148 | \$121 | \$161 | \$49  | \$59  | \$102 |
| 69 to 70                   | \$115 | \$156 | \$133 | \$169 | \$56  | \$65  | \$107 |
| 71 to 72                   | \$132 | \$179 | \$151 | \$193 | \$64  | \$75  | \$124 |
| 73 to 74                   | \$144 | \$197 | \$167 | \$213 | \$70  | \$85  | \$136 |
| 75 to 76                   | \$167 | \$222 | \$190 | \$246 | \$81  | \$93  | \$156 |
| 77 to 78                   | \$179 | \$237 | \$203 | \$264 | \$87  | \$102 | \$168 |
| 79 to 80                   | \$185 | \$253 | \$216 | \$272 | \$90  | \$109 | \$173 |
| 81 to 82                   | \$196 | \$266 | \$227 | \$287 | \$95  | \$115 | \$183 |
| 83 to 84                   | \$205 | \$281 | \$238 | \$301 | \$100 | \$121 | \$192 |
| 85 plus                    | \$216 | \$294 | \$250 | \$317 | \$105 | \$127 | \$202 |
| 64 or younger <sup>2</sup> | \$510 | \$696 | \$584 | \$750 | \$249 | \$284 | \$478 |

#### Two-party rates<sup>1</sup>

| Age range                  | A     | C     | D     | F     | Hi F | K   | N     |
|----------------------------|-------|-------|-------|-------|------|-----|-------|
| 65 to 66                   | \$194 | \$276 | \$226 | \$298 | N/A  | N/A | \$190 |
| 67 to 68                   | \$183 | \$271 | \$217 | \$297 | N/A  | N/A | \$179 |
| 69 to 70                   | \$205 | \$287 | \$241 | \$313 | N/A  | N/A | \$189 |
| 71 to 72                   | \$239 | \$333 | \$277 | \$361 | N/A  | N/A | \$223 |
| 73 to 74                   | \$263 | \$369 | \$309 | \$401 | N/A  | N/A | \$247 |
| 75 to 76                   | \$309 | \$419 | \$355 | \$467 | N/A  | N/A | \$287 |
| 77 to 78                   | \$333 | \$449 | \$381 | \$503 | N/A  | N/A | \$311 |
| 79 to 80                   | \$345 | \$481 | \$407 | \$519 | N/A  | N/A | \$321 |
| 81 to 82                   | \$367 | \$507 | \$429 | \$549 | N/A  | N/A | \$341 |
| 83 to 84                   | \$385 | \$537 | \$451 | \$577 | N/A  | N/A | \$359 |
| 85 plus                    | \$407 | \$563 | \$475 | \$609 | N/A  | N/A | \$379 |
| 64 or younger <sup>2</sup> | N/A   | N/A   | N/A   | N/A   | N/A  | N/A | N/A   |

**Tobacco rates – only applies if you've used tobacco products in the past 24 months and you are not eligible for guaranteed acceptance.**

#### Single-party rates

| Age range                  | A     | C     | D     | F     | Hi F  | K     | N     |
|----------------------------|-------|-------|-------|-------|-------|-------|-------|
| 65 to 66                   | \$119 | \$168 | \$138 | \$181 | \$55  | \$67  | \$117 |
| 67 to 68                   | \$124 | \$177 | \$144 | \$192 | \$58  | \$70  | \$122 |
| 69 to 70                   | \$137 | \$186 | \$159 | \$202 | \$67  | \$78  | \$128 |
| 71 to 72                   | \$157 | \$214 | \$180 | \$230 | \$76  | \$89  | \$148 |
| 73 to 74                   | \$172 | \$235 | \$199 | \$254 | \$84  | \$101 | \$162 |
| 75 to 76                   | \$199 | \$265 | \$227 | \$293 | \$97  | \$111 | \$186 |
| 77 to 78                   | \$214 | \$283 | \$242 | \$315 | \$104 | \$122 | \$200 |
| 79 to 80                   | \$221 | \$302 | \$258 | \$324 | \$107 | \$130 | \$206 |
| 81 to 82                   | \$234 | \$317 | \$271 | \$342 | \$113 | \$137 | \$218 |
| 83 to 84                   | \$245 | \$335 | \$284 | \$359 | \$119 | \$144 | \$229 |
| 85 plus                    | \$258 | \$351 | \$298 | \$378 | \$125 | \$152 | \$241 |
| 64 or younger <sup>2</sup> | \$608 | \$830 | \$697 | \$895 | \$297 | \$339 | \$570 |

#### Two-party rates<sup>1</sup> do not apply

## Endnotes

1. Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed on to the subscriber. Two-party rates do not apply to High Deductible Plan F and Plan K. Two-party rates do not apply to tobacco users. Welcome to Medicare Rate Savings do not apply to High Deductible Plan F, Plan K, and Plan N.
2. If you are 64 or younger and do not have end-stage renal disease, you may apply for Blue Shield of California Medicare Supplement coverage as described in Blue Shield's *Guaranteed Acceptance Guide*. Blue Shield of California does not offer coverage if you are 64 or younger unless you qualify for guaranteed acceptance. Two-party rates are not available to those 64 or younger.

Pending regulatory approval.

## 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 Medicare Supplement plans

Summary of benefits and provisions

Benefit Plans A, C, D, F, High Deductible F, K, and N

Last updated: May 2017

Blue Shield of California rates effective: April 1, 2016

# Blue Shield of California Medicare Supplement plans

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

|   |   |
|---|---|
| Comparison chart of the 10 standard Medicare Supplement plans ..... | 3 |
|---|---|

## **Charts comparing Blue Shield's seven Medicare Supplement plans**

|  |    |
|--|----|
| Plan A .....   | 5  |
| Plan C .....   | 8  |
| Plan D .....   | 11 |
| Plan F .....   | 14 |
| High Deductible Plan F.....                            | 17 |
| Plan K .....   | 20 |
| Plan N .....   | 24 |
| Enrolling in our plans .....                           | 28 |
| Conditions of coverage .....                           | 32 |
| Principal exclusions and limitations on benefits ..... | 35 |



# Benefit chart of Medicare Supplement plans sold on or after January 1, 2017

Medicare supplement contracts can be sold in only standard plans. This chart shows the benefits included in each plan. Every insurance company must offer Plan A. Some plans may not be available. Blue Shield offers Plans A, C, D, F, High Deductible F, K, and N, which are shaded in gray in the chart below.

## 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.

**Comparison Chart of the 10 Standard Medicare Supplement Plans**

| A  | B  | C  | D  | F   | F* | G  | K  | L  | M  | N   |
|--|--|--|--|---|----|--|--|--|--|---|
| Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance* |    | Basic, including 100% Part B coinsurance | Hospitalization and preventive care paid at 100%; other basic benefits paid at 50% | Hospitalization and preventive care paid at 100%; other basic benefits paid at 75% | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER |
|  |  | Skilled Nursing Facility Coinsurance     | Skilled Nursing Facility Coinsurance     | Skilled Nursing Facility Coinsurance      |    | Skilled Nursing Facility Coinsurance     | 50% Skilled Nursing Facility Coinsurance   | 75% Skilled Nursing Facility Coinsurance   | Skilled Nursing Facility Coinsurance     | Skilled Nursing Facility Coinsurance  |
|  | Part A Deductible                        | Part A Deductible                        | Part A Deductible                        | Part A Deductible                         |    | Part A Deductible                        | 50% Part A Deductible  | 75% Part A Deductible  | 50% Part A Deductible                    | Part A Deductible   |
|  |  | Part B Deductible                        |  | Part B Deductible                         |    |  |  |  |  |   |
|  |  |  |  | Part B Excess (100%)                      |    | Part B Excess (100%)                     |  |  |  |   |
|  |  | Foreign Travel Emergency                 | Foreign Travel Emergency                 | Foreign Travel Emergency                  |    | Foreign Travel Emergency                 |  |  | Foreign Travel Emergency                 | Foreign Travel Emergency  |
|  |  |  |  |   |    |  | Calendar-year maximum copayment \$5,120; paid at 100% after maximum reached        | Calendar-year maximum copayment \$2,560; paid at 100% after maximum reached        |  |   |
| SilverSneakers Fitness                   |  | SilverSneakers Fitness                   | SilverSneakers Fitness                   | SilverSneakers Fitness                    |    |  | SilverSneakers Fitness   |  |  | SilverSneakers Fitness  |

\* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar-year \$2,200 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,200. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

## 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 charge for all contracts like yours in the state. Because plan dues are based on age, your dues will increase when you turn 67, 69, 71, 73, 75, 77, 79, 81, 83 and/or 85 years old.

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 control. 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, P.O. Box 7168, San Francisco, CA 94120**. 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                     |
|---|--|------------------------------------|-----------------------------|
| <b>HOSPITALIZATION*</b> – Semiprivate room and board, general nursing, and miscellaneous services and supplies  |  |                                    |                             |
| First 60 days   | All but \$1,316  | \$0                                | \$1,316 (Part A deductible) |
| 61 <sup>st</sup> through 90 <sup>th</sup> day   | All but \$329 a day  | \$329 a day                        | \$0                         |
| 91 <sup>st</sup> day and after:<br>while using 60 lifetime reserve days   | All but \$658 a day  | \$658 a day                        | \$0                         |
| Once lifetime reserve days are used   |  |                                    |                             |
| • Additional 365 days   | \$0  | 100% of Medicare-eligible expenses | \$0**                       |
| • Beyond the additional 365 days  | \$0  | \$0                                | All costs                   |
| <b>SKILLED NURSING FACILITY CARE*</b> – You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital |  |                                    |                             |
| First 20 days   | All approved amounts   | \$0                                | \$0                         |
| 21 <sup>st</sup> through 100 <sup>th</sup> day  | All but \$164.50 a day   | \$0                                | Up to \$164.50 a day        |
| 101 <sup>st</sup> day and after   | \$0  | \$0                                | All costs                   |
| <b>BLOOD</b>  |  |                                    |                             |
| First 3 pints   | \$0  | 3 pints                            | \$0                         |
| Additional amounts  | 100%   | \$0                                | \$0                         |
| <b>HOSPICE CARE</b>   |  |                                    |                             |
| 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 \$183 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                   |
|---|---------------|---------------|---------------------------|
| <b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |               |                           |
| First \$183 of Medicare-approved amounts*   | \$0           | \$0           | \$183 (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                 |
| <b>BLOOD</b>  |               |               |                           |
| First 3 pints   | \$0           | All costs     | \$0                       |
| Next \$183 of Medicare-approved amounts*  | \$0           | \$0           | \$183 (Part B deductible) |
| Remainder of Medicare-approved amounts  | 80%           | 20%           | \$0                       |
| <b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>   |               |               |                           |
|   | 100%          | \$0           | \$0                       |

# PLAN A

## PARTS A & B

\* Once you have been billed \$183 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                   |
|--|---------------|-----------|---------------------------|
| <b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b>                     |               |           |                           |
| Medically necessary skilled care services and medical supplies         | 100%          | \$0       | \$0                       |
| Durable medical equipment<br>First \$183 of Medicare-approved amounts* | \$0           | \$0       | \$183 (Part B deductible) |
| Remainder of Medicare-approved amounts                                 | 80%           | 20%       | \$0                       |

## OTHER BENEFITS – NOT COVERED BY MEDICARE

| SERVICES   | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|--|---------------|-----------|---------|
| <b>BASIC GYM ACCESS THROUGH SILVERSNEAKERS FITNESS</b> |               |           |         |
|  | \$0           | 100%      | \$0     |

# PLAN C

## 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   |
|---|--|------------------------------------|-----------|
| <b>HOSPITALIZATION*</b> – Semiprivate room and board, general nursing, and miscellaneous services and supplies  |  |                                    |           |
| First 60 days   | All but \$1,316  | \$1,316<br>(Part A deductible)     | \$0       |
| 61 <sup>st</sup> through 90 <sup>th</sup> day   | All but \$329 a day  | \$329 a day                        | \$0       |
| 91 <sup>st</sup> day and after:<br>While using 60 lifetime reserve days   | All but \$658 a day  | \$658 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 |
| <b>SKILLED NURSING FACILITY CARE*</b> – You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital |  |                                    |           |
| First 20 days   | All approved amounts   | \$0                                | \$0       |
| 21 <sup>st</sup> through 100 <sup>th</sup> day  | All but \$164.50 a day   | Up to \$164.50 a day               | \$0       |
| 101 <sup>st</sup> day and after   | \$0  | \$0                                | All costs |
| <b>BLOOD</b>  |  |                                    |           |
| First 3 pints   | \$0  | 3 pints                            | \$0       |
| Additional amounts  | 100%   | \$0                                | \$0       |
| <b>HOSPICE CARE</b>   |  |                                    |           |
| 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 C

## MEDICARE (PART B)

### MEDICAL SERVICES – PER CALENDAR YEAR

\* Once you have been billed \$183 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   |
|---|---------------|---------------------------|-----------|
| <b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |                           |           |
| First \$183 of Medicare-approved amounts*   | \$0           | \$183 (Part B deductible) | \$0       |
| Remainder of Medicare-approved amounts  | Generally 80% | Generally 20%             | \$0       |
| Part B excess charges (above Medicare-approved amounts)   | \$0           | \$0                       | All costs |
| <b>BLOOD</b>  |               |                           |           |
| First 3 pints   | \$0           | All costs                 | \$0       |
| Next \$183 of Medicare-approved amounts*  | \$0           | \$183 (Part B deductible) | \$0       |
| Remainder of Medicare-approved amounts  | 80%           | 20%                       | \$0       |
| <b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>   |               |                           |           |
|   | 100%          | \$0                       | \$0       |

# PLAN C

## PARTS A & B

\* Once you have been billed \$183 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 |
|--|---------------|---------------------------|---------|
| <b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b>                     |               |                           |         |
| Medically necessary skilled care services and medical supplies         | 100%          | \$0                       | \$0     |
| Durable medical equipment<br>First \$183 of Medicare-approved amounts* | \$0           | \$183 (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  |
|---|---------------|---|--|
| <b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>   |               |   |  |
| Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA |               |   |  |
| 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 |
| <b>BASIC GYM ACCESS THROUGH SILVERSNEAKERS FITNESS</b>  |               |   |  |
|   | \$0           | 100%  | \$0  |



# PLAN D

## 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   |
|---|--|------------------------------------|-----------|
| <b>HOSPITALIZATION*</b> – Semiprivate room and board, general nursing, and miscellaneous services and supplies  |  |                                    |           |
| First 60 days   | All but \$1,316  | \$1,316<br>(Part A deductible)     | \$0       |
| 61 <sup>st</sup> through 90 <sup>th</sup> day   | All but \$329 a day  | \$329 a day                        | \$0       |
| 91 <sup>st</sup> day and after:<br>While using 60 lifetime reserve days   | All but \$658 a day  | \$658 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 |
| <b>SKILLED NURSING FACILITY CARE*</b> – You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital |  |                                    |           |
| First 20 days   | All approved amounts   | \$0                                | \$0       |
| 21 <sup>st</sup> through 100 <sup>th</sup> days   | All but \$164.50 a day   | Up to \$164.50 a day               | \$0       |
| 101 <sup>st</sup> day and after   | \$0  | \$0                                | All costs |
| <b>BLOOD</b>  |  |                                    |           |
| First 3 pints   | \$0  | 3 pints                            | \$0       |
| Additional amounts  | 100%   | \$0                                | \$0       |
| <b>HOSPICE CARE</b>   |  |                                    |           |
| 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 D

## MEDICARE (PART B)

### MEDICAL SERVICES – PER CALENDAR YEAR

\* Once you have been billed \$183 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                   |
|---|---------------|---------------|---------------------------|
| <b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |               |                           |
| First \$183 of Medicare-approved amounts*   | \$0           | \$0           | \$183 (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                 |
| <b>BLOOD</b>  |               |               |                           |
| First 3 pints   | \$0           | All costs     | \$0                       |
| Next \$183 of Medicare-approved amounts*  | \$0           | \$0           | \$183 (Part B deductible) |
| Remainder of Medicare-approved amounts  | 80%           | 20%           | \$0                       |
| <b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>   |               |               |                           |
|   | 100%          | \$0           | \$0                       |

# PLAN D

## PARTS A & B

\* Once you have been billed \$183 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                   |
|--|---------------|-----------|---------------------------|
| <b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b>                     |               |           |                           |
| Medically necessary skilled care services and medical supplies         | 100%          | \$0       | \$0                       |
| Durable medical equipment<br>First \$183 of Medicare-approved amounts* | \$0           | \$0       | \$183 (Part B deductible) |
| Remainder of Medicare-approved amounts                                 | 80%           | 20%       | \$0                       |

## OTHER BENEFITS – NOT COVERED BY MEDICARE

| SERVICES  | MEDICARE PAYS | PLAN PAYS                                     | YOU PAY  |
|---|---------------|---|--|
| <b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA |               |   |  |
| 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 |
| <b>BASIC GYM ACCESS THROUGH SILVERSNEAKERS FITNESS</b>  |               |   |  |
|   | \$0           | 100%  | \$0  |

# PLAN F

## 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   |
|---|--|------------------------------------|-----------|
| <b>HOSPITALIZATION*</b> – Semiprivate room and board, general nursing, and miscellaneous services and supplies  |  |                                    |           |
| First 60 days   | All but \$1,316  | \$1,316 (Part A deductible)        | \$0       |
| 61 <sup>st</sup> through 90 <sup>th</sup> day   | All but \$329 a day  | \$329 a day                        | \$0       |
| 91 <sup>st</sup> day and after:<br>While using 60 lifetime reserve days   | All but \$658 a day  | \$658 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 |
| <b>SKILLED NURSING FACILITY CARE*</b> – You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital |  |                                    |           |
| First 20 days   | All approved amounts   | \$0                                | \$0       |
| 21 <sup>st</sup> through 100 <sup>th</sup> day  | All but \$164.50 a day   | Up to \$164.50 a day               | \$0       |
| 101 <sup>st</sup> day and after   | \$0  | \$0                                | All costs |
| <b>BLOOD</b>  |  |                                    |           |
| First 3 pints   | \$0  | 3 pints                            | \$0       |
| Additional amounts  | 100%   | \$0                                | \$0       |
| <b>HOSPICE CARE</b>   |  |                                    |           |
| 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

## MEDICARE (PART B)

### MEDICAL SERVICES – PER CALENDAR YEAR

\* Once you have been billed \$183 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 |
|---|---------------|---------------------------|---------|
| <b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |                           |         |
| First \$183 of Medicare-approved amounts*   | \$0           | \$183 (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     |
| <b>BLOOD</b>  |               |                           |         |
| First 3 pints   | \$0           | All costs                 | \$0     |
| Next \$183 of Medicare-approved amounts*  | \$0           | \$183 (Part B deductible) | \$0     |
| Remainder of Medicare-approved amounts  | 80%           | 20%                       | \$0     |
| <b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>   |               |                           |         |
|   | 100%          | \$0                       | \$0     |

# PLAN F

## PARTS A & B

\* Once you have been billed \$183 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 |
|--|---------------|---------------------------|---------|
| <b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b>                     |               |                           |         |
| Medically necessary skilled care services and medical supplies         | 100%          | \$0                       | \$0     |
| Durable medical equipment<br>First \$183 of Medicare-approved amounts* | \$0           | \$183 (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  |
|---|---------------|---|--|
| <b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA |               |   |  |
| 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 |
| <b>BASIC GYM ACCESS THROUGH SILVERSNEAKERS FITNESS</b>  |               |   |  |
|   | \$0           | 100%  | \$0  |

# HIGH DEDUCTIBLE PLAN F

## 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.

\*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar-year \$2,200 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,200. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

| SERVICES  | MEDICARE PAYS  | AFTER YOU PAY \$2,200 DEDUCTIBLE,** PLAN PAYS | IN ADDITION TO \$2,200 DEDUCTIBLE,** YOU PAY |
|---|--|---|--|
| <b>HOSPITALIZATION*</b> – Semiprivate room and board, general nursing, and miscellaneous services and supplies  |  |   |  |
| First 60 days   | All but \$1,316  | \$1,316 (Part A deductible)                   | \$0  |
| 61 <sup>st</sup> through 90 <sup>th</sup> day   | All but \$329 a day  | \$329 a day                                   | \$0  |
| 91 <sup>st</sup> day and after:<br>While using 60 lifetime reserve days   | All but \$658 a day  | \$658 a day                                   | \$0  |
| Once lifetime reserve days are used   |  |   |  |
| • Additional 365 days   | \$0  | 100% of Medicare eligible expenses            | \$0***                                       |
| • Beyond the additional 365 days  | \$0  | \$0   | All costs                                    |
| <b>SKILLED NURSING FACILITY CARE*</b> – You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital |  |   |  |
| First 20 days   | All approved amounts   | \$0   | \$0  |
| 21 <sup>st</sup> through 100 <sup>th</sup> day  | All but \$164.50 a day   | Up to \$164.50 a day                          | \$0  |
| 101 <sup>st</sup> day and after   | \$0  | \$0   | All costs                                    |
| <b>BLOOD</b>  |  |   |  |
| First 3 pints   | \$0  | 3 pints                                       | \$0  |
|   | 100%   | \$0   | \$0  |
| <b>HOSPICE CARE</b>   |  |   |  |
| 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.

# HIGH DEDUCTIBLE PLAN F

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

\* Once you have been billed \$183 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.

\*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar-year \$2,200 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,200. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

| SERVICES  | MEDICARE PAYS | AFTER YOU PAY \$2,200 DEDUCTIBLE,** PLAN PAYS | IN ADDITION TO \$2,200 DEDUCTIBLE,** YOU PAY |
|---|---------------|---|--|
| <b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |   |  |
| First \$183 of Medicare-approved amounts*   | \$0           | \$183 (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  |
| <b>BLOOD</b>  |               |   |  |
| First 3 pints   | \$0           | All costs                                     | \$0  |
| Next \$183 of Medicare-approved amounts*  | \$0           | \$183 (Part B deductible)                     | \$0  |
| Remainder of Medicare-approved amounts  | 80%           | 20%   | \$0  |
| <b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>   |               |   |  |
|   | 100%          | \$0   | \$0  |



# HIGH DEDUCTIBLE PLAN F

## PARTS A & B

\* Once you have been billed \$183 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.

\*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar-year \$2,200 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,200. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

| SERVICES   | MEDICARE PAYS | AFTER YOU PAY \$2,200 DEDUCTIBLE,** PLAN PAYS | IN ADDITION TO \$2,200 DEDUCTIBLE,** YOU PAY |
|--|---------------|---|--|
| <b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b>                     |               |   |  |
| Medically necessary skilled care services and medical supplies         | 100%          | \$0   | \$0  |
| Durable medical equipment<br>First \$183 of Medicare-approved amounts* | \$0           | \$183 (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  |
|---|---------------|---|--|
| <b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA |               |   |  |
| 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 |
| <b>BASIC GYM ACCESS THROUGH SILVERSNEAKERS FITNESS</b>  |               |   |  |
|   | \$0           | 100%  | \$0  |

# PLAN K

\* You will pay half the cost-sharing of some covered services until you reach the calendar-year maximum copayment of \$5,120 each calendar year. The amounts that count toward your calendar-year maximum are noted with diamonds (◆) in the chart below. Once you reach the calendar-year maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this maximum does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"), and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

## 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*                           |
|---|------------------------|------------------------------------|------------------------------------|
| <b>HOSPITALIZATION**</b> – Semiprivate room and board, general nursing, and miscellaneous services and supplies   |                        |                                    |                                    |
| First 60 days   | All but \$1,316        | \$658 (50% of Part A deductible)   | \$658 (50% of Part A deductible) ◆ |
| 61 <sup>st</sup> through 90 <sup>th</sup> day   | All but \$329 a day    | \$329 a day                        | \$0                                |
| 91 <sup>st</sup> day and after:<br>While using 60 lifetime reserve days   | All but \$658 a day    | \$658 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                          |
| <b>SKILLED NURSING FACILITY CARE**</b> – You must meet Medicare's requirements, including having been in a hospital for at least 3 days and having entered a Medicare-approved facility within 30 days after leaving the hospital |                        |                                    |                                    |
| First 20 days   | All approved amounts   | \$0                                | \$0                                |
| 21 <sup>st</sup> through 100 <sup>th</sup> day  | All but \$164.50 a day | Up to \$82.25 a day (50%)          | Up to \$82.25 a day (50%) ◆        |
| 101 <sup>st</sup> day and after   | \$0                    | \$0                                | All costs                          |

\*\*\* 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 K

## MEDICARE (PART A)

### HOSPITAL SERVICES – PER BENEFIT PERIOD (CONTINUED)

| SERVICES   | MEDICARE PAYS  | PLAN PAYS                    | YOU PAY*                       |
|--|--|------------------------------|--------------------------------|
| <b>BLOOD</b>   |  |                              |                                |
| First 3 pints  | \$0  | 50%                          | 50% ♦                          |
| Additional amounts   | 100%   | \$0                          | \$0                            |
| <b>HOSPICE CARE</b>  |  |                              |                                |
| 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 | 50% of copayment/coinsurance | 50% of copayment/coinsurance ♦ |

# PLAN K

## MEDICARE (PART B)

### MEDICAL SERVICES – PER CALENDAR YEAR

\*\*\*\* Once you have been billed \$183 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*   |
|---|--|--|--|
| <b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment |  |  |  |
| First \$183 of Medicare-approved amounts****  | \$0  | \$0                                    | \$183 (Part B deductible)<br>**** ♦  |
| Preventive Benefits for Medicare covered services   | Generally 75% or more of Medicare-approved amounts | Remainder of Medicare-approved amounts | All costs above Medicare-approved amounts  |
| Remainder of Medicare-approved amounts  | Generally 80%                                      | Generally 10%                          | Generally 10% ♦  |
| Part B excess charges (above Medicare-approved amounts)   | \$0  | \$0                                    | All costs (and they do not count toward calendar-year maximum copayment of \$5,120)* |
| <b>BLOOD</b>  |  |  |  |
| First 3 pints   | \$0  | 50%                                    | 50% ♦  |
| Next \$183 of Medicare-approved amounts****   | \$0  | \$0                                    | \$183 (Part B deductible)<br>**** ♦  |
| Remainder of Medicare-approved amounts  | Generally 80%                                      | Generally 10%                          | Generally 10% ♦  |
| <b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>   |  |  |  |
|   | 100%   | \$0                                    | \$0  |

\* This plan limits your calendar-year copayments for Medicare-approved amounts to \$5,120 per year. However, this maximum does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

# PLAN K

## PARTS A & B

\*\*\*\* Once you have been billed \$183 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*                    |
|--|---------------|-----------|-----------------------------|
| <b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b>             |               |           |                             |
| Medically necessary skilled care services and medical supplies | 100%          | \$0       | \$0                         |
| Durable medical equipment                                      | \$0           | \$0       | \$183 (Part B deductible) ◆ |
| First \$183 of Medicare-approved amounts****                   |               |           |                             |
| Remainder of Medicare-approved amounts                         | 80%           | 10%       | 10% ◆                       |

## OTHER BENEFITS – NOT COVERED BY MEDICARE

| SERVICES   | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|--|---------------|-----------|---------|
| <b>BASIC GYM ACCESS THROUGH SILVERSNEAKERS FITNESS</b> |               |           |         |
|  | \$0           | 100%      | \$0     |

\* Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for people with Medicare.

# 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*  |
|---|--|------------------------------------|-----------|
| <b>HOSPITALIZATION*</b> – Semiprivate room and board, general nursing, and miscellaneous services and supplies  |  |                                    |           |
| First 60 days   | All but \$1,316  | \$1,316 (Part A deductible)        | \$0       |
| 61 <sup>st</sup> through 90 <sup>th</sup> day   | All but \$329 a day  | \$329 a day                        | \$0       |
| 91 <sup>st</sup> day and after:<br>While using 60 lifetime reserve days   | All but \$658 a day  | \$658 a day                        | \$0       |
| Once lifetime reserve days are used   |  |                                    |           |
| • Additional 365 days   | \$0  | 100% of Medicare eligible expenses | \$0**     |
| • Beyond the additional 365 days  | \$0  | \$0                                | All costs |
| <b>SKILLED NURSING FACILITY CARE*</b> – You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital |  |                                    |           |
| First 20 days   | All approved amounts   | \$0                                | \$0       |
| 21 <sup>st</sup> through 100 <sup>th</sup> day  | All but \$164.50 a day   | Up to \$164.50 a day               | \$0       |
| 101 <sup>st</sup> day and after   | \$0  | \$0                                | All costs |
| <b>BLOOD</b>  |  |                                    |           |
| First 3 pints   | \$0  | 3 pints                            | \$0       |
| Additional amounts  | 100%   | \$0                                | \$0       |
| <b>HOSPICE CARE</b>   |  |                                    |           |
| 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 \$183 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  |
|---|---------------|--|--|
| <b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment |               |  |  |
| First \$183 of Medicare-approved amounts*   | \$0           | \$0  | \$183 (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  |
| <b>BLOOD</b>  |               |  |  |
| First 3 pints   | \$0           | All costs  | \$0  |
| Next \$183 of Medicare-approved amounts*  | \$0           | \$0  | \$183 (Part B deductible)  |
| Remainder of Medicare-approved amounts  | 80%           | 20%  | \$0  |
| <b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>   |               |  |  |
|   | 100%          | \$0  | \$0  |

# PLAN N

## PARTS A & B

\* Once you have been billed \$183 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                   |
|--|---------------|-----------|---------------------------|
| <b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b>                     |               |           |                           |
| Medically necessary skilled care services and medical supplies         | 100%          | \$0       | \$0                       |
| Durable medical equipment<br>First \$183 of Medicare-approved amounts* | \$0           | \$0       | \$183 (Part B deductible) |
| Remainder of Medicare-approved amounts                                 | 80%           | 20%       | \$0                       |

## OTHER BENEFITS – NOT COVERED BY MEDICARE

| SERVICES  | MEDICARE PAYS | PLAN PAYS                                     | YOU PAY  |
|---|---------------|---|--|
| <b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA |               |   |  |
| 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 |
| <b>BASIC GYM ACCESS THROUGH SILVERSNEAKERS FITNESS</b>  |               |   |  |
|   | \$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 including the “Applying is easy” introduction.

Be sure to check the information on the application carefully, keep the yellow 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, C, D, F, High Deductible F, K, 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, C, D, F, High Deductible F, K, 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.
- 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 **(888) 713-0000**. 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. PST 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 a 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 Notice Regarding Replacement form, which is included with this Summary of Benefits.

## Billing options

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

1. **Easy\$Pay** – Pay your plan dues with Blue Shield's quick and convenient Easy\$Pay<sup>SM</sup> program, an automatic electronic transfer on the 1<sup>st</sup> or 15<sup>th</sup> of the month 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.**

An Easy\$Pay authorization form, which includes more information, is included with this Summary of Benefits for your consideration.

2. **Quarterly billing** – Blue Shield will bill you once every three months.
3. **Monthly billing** – Blue Shield will send you a bill each month.

With Options 2 and 3, 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 Agreement for failure to pay the required dues. If the Agreement is being cancelled because you failed to pay the required dues when owed, then coverage will end 30 days after the date for which the dues are due. 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 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' written 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. PST on the 30<sup>th</sup> 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 Confirming Termination of Coverage," Blue Shield will allow you two coverage reinstatements per rolling 12-month period, if the amounts owed are paid within 15 days of the date the "Notice Confirming Termination of Coverage" is mailed to you.

If your request for reinstatement and payment of all outstanding amounts is not received within the required 15 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.

## Value of health services

In 2015, the ratio of the value of health services provided to the amount Blue Shield collected in plan dues was 67.6%.

## 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.

A statement describing Blue Shield's policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Blue Shield's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices," which you may obtain either 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.
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).
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.
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.

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.

## Endnotes

1. Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed on to the subscriber. Two-party rates do not apply to High Deductible Plan F and Plan K. Two-party rates do not apply to tobacco users. Welcome to Medicare Rate Savings do not apply to High Deductible Plan F, Plan K, and Plan N.
2. If you are 64 or younger and do not have end-stage renal disease, you may apply for Blue Shield of California Medicare Supplement coverage as described in Blue Shield's *Guaranteed Acceptance Guide*. Blue Shield of California does not offer coverage if you are 64 or younger unless you qualify for guaranteed acceptance. Two-party rates are not available to those 64 or younger.

## 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**

# Guaranteed acceptance guide

## Blue Shield of California Medicare Supplement plans

If you have recently become eligible for Medicare or lost or ended your health coverage with another plan, you may qualify for guaranteed acceptance in a Blue Shield Medicare Supplement plan in certain situations. This guide will help you determine whether you qualify for guaranteed acceptance. **If you are age 64 or younger with end-stage renal disease, you are not eligible to enroll.**

**Important:** Please note that this guide is only a summary and is intended to help you identify the different situations that may qualify you for guaranteed acceptance in a Blue Shield Medicare Supplement plan. It does not contain all the details of each situation. Please remember that laws regulating guaranteed acceptance plans change frequently. So, some information in this guide may no longer be accurate. Please ask your sales representative or your attorney to confirm that you qualify for guaranteed acceptance.

If you and your spouse or domestic partner are applying for a two-party rate contract, both of you must be age 65 or older, be enrolled in both Medicare Parts A and B, apply for the same plan type, and each complete an application. Under a two-party contract, both of you must qualify for guaranteed acceptance. Either person who does not qualify for guaranteed acceptance will be subject to underwriting.

For more information about guaranteed acceptance, please contact your agent or your Blue Shield sales representative at:

Woodland Hills Regional Sales Office **(888) 713-0000**, [TTY: **711**] for the hearing impaired, 8 a.m. to 5:30 p.m., Monday through Friday, excluding holidays.

Or, if you are already a subscriber, contact Customer Service at the following number:

**(800) 248-2341**, TTY: **711** for the hearing impaired, 8 a.m. to 5:30 p.m., Monday through Friday, excluding holidays.

You may also contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP offers health 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.

## How to use this guide:

1. If you believe a situation applies to you, review your plan choices and when to apply.
2. Decide which plan type you want to apply for, based on plan descriptions found in Blue Shield's *Summary of Benefits and Provisions* booklet.
3. Write the corresponding situation number in the Guaranteed Acceptance section of your application.

If you qualify for guaranteed acceptance, do not complete the Statement of Health or the Authorization for Release of Medical Records sections of the application. If you do not qualify for guaranteed acceptance, you must complete these sections.

4. If you believe you qualify for guaranteed acceptance, please fill out the appropriate supporting information in the Current Insurance Coverage information section of the enrollment form, or attach proof of prior coverage as outlined in the table below.
5. Do not return this guide with your application. Keep it as a reference along with your other important Blue Shield materials.

|   |   |  |
|---|---|--|
| 1 | <b>Situation</b>                          | You are: <ul style="list-style-type: none"><li>• Enrolled in Medicare <i>and</i> are age 65 or older; or</li><li>• New to Medicare, are age 64 or younger, <i>and</i> do not have end-stage renal disease</li></ul>  |
|   | <b>Your plan choices</b>                  | <b>Plan A, C, D, F, High Deductible F, K, or N</b>   |
|   | <b>When to apply</b>                      | <ul style="list-style-type: none"><li>• If you are age 65 or older: Blue Shield must receive your application within six (6) months, beginning with the first day of the first month in which you are both age 65 or older, <i>and</i> you are enrolled for benefits under Medicare Part B.</li><li>• If you are age 64 or younger: Blue Shield must receive your application within six (6) months of your enrollment in Medicare Part B, or if you are notified retroactively of eligibility for Medicare, within six (6) months of notice of eligibility.</li></ul> |
|   | <b>You must supply this documentation</b> | Be sure to fill out the following sections of your enrollment application: <ul style="list-style-type: none"><li>• Medicare Parts A and B effective dates and your Medicare number.</li><li>• In addition, if you are age 64 or younger, please complete the Current Insurance Coverage information section indicating you do not have end-stage renal disease.</li></ul>  |

|   |   |   |
|---|---|---|
| 2 | <b>Situation</b>                          | You currently have a Medicare Supplement plan and want to switch to a different Medicare Supplement plan.   |
|   | <b>Your plan choices</b>                  | You have an annual open enrollment period, during which you may transfer to any Medicare Supplement plan that offers benefits equal to or lesser than those provided in your current plan. <sup>4</sup> Call Blue Shield at the number on the previous page to see which plans you qualify for. |
|   | <b>When to apply</b>                      | Blue Shield must receive your application within thirty (30) days of your birthday.   |
|   | <b>You must supply this documentation</b> | A completed copy of Blue Shield's Notice to Applicant Regarding Replacement of Medicare Supplement Coverage, which can be found in the plan presale kit, immediately following the enrollment application, plus proof of your current plan type/insurance carrier.                              |

|          |   |  |
|----------|---|--|
| <b>3</b> | <b>Situation</b>                          | <p>You enrolled with one of the following:</p> <ul style="list-style-type: none"> <li>• A Medicare Advantage Plan;<sup>1</sup></li> <li>• A Medicare cost or similar organization operating under demonstration project authority before April 1, 1999;</li> <li>• A healthcare prepayment plan; or</li> <li>• A Medicare Select policy;</li> </ul> <p>and any of the following apply:</p> <ul style="list-style-type: none"> <li>• The certification of the organization or plan is being terminated;</li> <li>• The organization is terminating or discontinuing the plan in the service area in which you reside; or</li> <li>• You are no longer eligible because you moved outside the service area.</li> </ul> |
|          | <b>Your plan choices</b>                  | <b>Plan A, C, D, F, High Deductible F, K, or N</b>   |
|          | <b>When to apply</b>                      | If your coverage is being involuntarily terminated, <sup>2</sup> you may submit your application anytime after you receive the notice of termination, but no later than sixty-three (63) days after the date coverage is terminated. However, if you are enrolled in a Medicare Advantage Plan, you must apply within one hundred twenty-three (123) days of the date your coverage is terminated.   |
|          | <b>You must supply this documentation</b> | Be sure to complete the Current Insurance Coverage information section (including the end date and reason for coverage ending) of your signed Medicare Supplement plan application. <sup>3</sup>   |
| <b>4</b> | <b>Situation</b>                          | You received notice of termination, or your coverage was terminated from any employer-sponsored health plan, including an employer-sponsored retiree health plan. This includes termination for loss of eligibility due to divorce or death of a spouse.   |
|          | <b>Your plan choices</b>                  | <b>Plan A, C, D, F, High Deductible F, K, or N</b>   |
|          | <b>When to apply</b>                      | Blue Shield must receive your application within six (6) months of the notice of termination, or if no notice is received, within six (6) months of the date your employer-sponsored health coverage ended.  |
|          | <b>You must supply this documentation</b> | Be sure to complete the Current Insurance Coverage information section (including the end date) of your signed Medicare Supplement plan application. <sup>3</sup>  |
| <b>5</b> | <b>Situation</b>                          | You enrolled in a Medicare Supplement plan, but you lost coverage because you moved outside the plan's service area.   |
|          | <b>Your plan choices</b>                  | <b>Plan A, C, D, F, High Deductible F, K, or N</b>   |
|          | <b>When to apply</b>                      | Blue Shield must receive your application within six (6) months of the date coverage is terminated.  |
|          | <b>You must supply this documentation</b> | Be sure to complete the Current Insurance Coverage information section of your signed Medicare Supplement plan application. You must also provide documentation to support the reason for termination, and a copy of the prior coverage termination notice with your name and termination date or a Certificate of Prior Coverage.   |

|          |   |  |
|----------|---|--|
| <b>6</b> | <b>Situation</b>                          | Upon first becoming eligible for Medicare Part A at age 65, you enrolled in a Medicare Advantage Plan, <sup>1</sup> or with a Program of All-Inclusive Care for the Elderly (PACE) provider, and then disenrolled from the plan or program within twelve (12) months of the effective date of that enrollment.   |
|          | <b>Your plan choices</b>                  | <b>Plan A, C, D, F, High Deductible F, K, or N</b>   |
|          | <b>When to apply</b>                      | If you are voluntarily terminating your coverage, you may submit an application sixty (60) days before the effective date of termination, but no later than sixty-three (63) days after the date coverage is terminated.   |
|          | <b>You must supply this documentation</b> | Be sure to complete the Current Insurance Coverage information section (including the end date) of your signed Medicare Supplement plan application. <sup>3</sup>  |
| <b>7</b> | <b>Situation</b>                          | You were enrolled in a Medicare Supplement plan and subsequently enrolled in a Medicare Advantage Plan <sup>1</sup> or with a PACE provider, <i>and</i> : <ul style="list-style-type: none"> <li>• Your coverage was involuntarily terminated within twelve (12) months of the effective date of enrollment; <i>and</i></li> <li>• You then enrolled in another Medicare Advantage Plan or PACE provider plan and disenrolled from that plan within twenty-four (24) months of the effective date with the first plan.</li> </ul>  |
|          | <b>Your plan choices</b>                  | <ul style="list-style-type: none"> <li>• <b>Plan A, C, D, F, High Deductible F, K, or N;</b> or</li> <li>• The Medicare Supplement plan you had previously, if it is still offered for sale by that insurer.</li> </ul>  |
|          | <b>When to apply</b>                      | If your coverage is being involuntarily terminated, <sup>2</sup> you may submit your application anytime after you receive the notice of termination, but no later than sixty-three (63) days after the date coverage is terminated; however, if you are enrolled in a Medicare Advantage Plan, you must apply within one hundred twenty-three (123) days of the date coverage is terminated.  |
|          | <b>You must supply this documentation</b> | Be sure to complete the Current Insurance Coverage information section (including the end date and reason for coverage ending) of your signed Medicare Supplement plan application. <sup>3</sup>   |
| <b>8</b> | <b>Situation</b>                          | You are 65 or older, are enrolled with a PACE provider, and any of the following situations that permit termination of enrollment apply: <ul style="list-style-type: none"> <li>• The certification of the organization is being terminated;</li> <li>• The organization is terminating or discontinuing services in the service area in which you reside;</li> <li>• You are no longer eligible, because you moved outside the service area;</li> <li>• The organization substantially violated a material provision of the contract with the Centers for Medicare &amp; Medicaid Services (CMS); or</li> <li>• The organization or its agent materially misrepresented a provision of the program in marketing the contract to you.</li> </ul> |
|          | <b>Your plan choices</b>                  | <ul style="list-style-type: none"> <li>• <b>Plan A, C, D, F, High Deductible F, K or N;</b> or</li> <li>• The Medicare Supplement plan you had previously, if it is still offered for sale by that insurer.</li> </ul>   |
|          | <b>When to apply</b>                      | <ul style="list-style-type: none"> <li>• If your coverage is being involuntarily terminated,<sup>2</sup> you may submit your application anytime after you receive the notice of termination, but no later than sixty-three (63) days after the date coverage is terminated.</li> <li>• If you are voluntarily terminating your coverage, you may submit an application sixty (60) days before the effective date of termination, but no later than sixty-three (63) days after the date coverage is terminated.</li> </ul>  |
|          | <b>You must supply this documentation</b> | Be sure to complete the Current Insurance Coverage information section (including the end date and reason for coverage ending) of your signed Medicare Supplement plan application. <sup>3</sup>   |

|          |   |  |
|----------|---|--|
| <b>9</b> | <b>Situation</b>                          | <p>You terminated enrollment in a Medicare Supplement plan and subsequently enrolled, for the first time, in any of the following:</p> <ul style="list-style-type: none"> <li>• A Medicare Advantage Plan;<sup>1</sup></li> <li>• A Medicare cost or similar organization operating under demonstration project authority before April 1, 1999;</li> <li>• A PACE provider; or</li> <li>• A Medicare Select policy.</li> </ul> <p>You then disenrolled within the first 12 months.</p> |
|          | <b>Your plan choices</b>                  | <p><b>Plan A, C, D, F, High Deductible F, K, or N</b></p> <ul style="list-style-type: none"> <li>• The Medicare Supplement plan you had previously, if it is still offered for sale by that insurer.</li> </ul>  |
|          | <b>When to apply</b>                      | If you are voluntarily terminating your coverage, you may submit an application sixty (60) days before the effective date of termination, but no later than sixty-three (63) days after the date coverage is terminated.   |
|          | <b>You must supply this documentation</b> | Be sure to complete the Current Insurance Coverage information section (including the end date) of your signed Medicare Supplement plan application. <sup>3</sup>  |

|           |   |  |
|-----------|---|--|
| <b>10</b> | <b>Situation</b>                          | <p>You terminated enrollment in a Medicare Supplement plan and subsequently enrolled, for the first time, with any of the following:</p> <ul style="list-style-type: none"> <li>• A Medicare Advantage Plan;<sup>1</sup></li> <li>• A Medicare cost or similar organization operating under demonstration project authority before April 1, 1999;</li> <li>• A PACE provider plan; or</li> <li>• A Medicare Select policy.</li> </ul> <p>However, your coverage was involuntarily terminated within twelve (12) months of the effective date of enrollment. You then enrolled in another similar plan and disenrolled from that plan within twenty-four (24) months of the effective date of the first plan.</p> |
|           | <b>Your plan choices</b>                  | <ul style="list-style-type: none"> <li>• <b>Plan A, C, D, F, High Deductible F, K, or N; or</b></li> <li>• The Medicare Supplement plan you had previously, if it is still offered by that issuer.</li> </ul>  |
|           | <b>When to apply</b>                      | If your coverage is being involuntarily terminated, <sup>2</sup> you may submit your application anytime after you receive the notice of termination, but no later than sixty-three (63) days after the date coverage is terminated. However, if you are enrolled in a Medicare Advantage Plan, you must apply within one hundred twenty-three (123) days of the date coverage is terminated.  |
|           | <b>You must supply this documentation</b> | Be sure to complete the Current Insurance Coverage information section (including the name and end date of your three previous carriers) of your signed Medicare Supplement plan application. <sup>3</sup>   |



|           |   |   |
|-----------|---|---|
| <b>11</b> | <b>Situation</b>                          | <p>You enrolled in an employer-sponsored health plan that supplements Medicare, and either of the following apply:</p> <ul style="list-style-type: none"> <li>• The plan either terminates or ceases to provide all of those supplemental health benefits to you; or</li> <li>• The employer no longer provides you with insurance that covers all of the payment for the 20% coinsurance.</li> </ul>   |
|           | <b>Your plan choices</b>                  | <b>Plan A, C, D, F, High Deductible F, K, or N</b>  |
|           | <b>When to apply</b>                      | <p>You may submit an application to Blue Shield during the guaranteed acceptance period, which starts from the later of the following two dates, and ends sixty-three (63) days after the date coverage is terminated:</p> <ul style="list-style-type: none"> <li>• The date you received a notice of termination, or if no notice is received, on the date you received notice denying the claim because of termination of benefits; or</li> <li>• The date coverage is terminated.</li> </ul>   |
|           | <b>You must supply this documentation</b> | Be sure to complete the Current Insurance Coverage information section (including the end date and reason for coverage ending) of your signed Medicare Supplement plan application. <sup>3</sup>  |
| <b>12</b> | <b>Situation</b>                          | <p>You are a Medicare-eligible military retiree, spouse or dependent, and you lost access to healthcare services because:</p> <ul style="list-style-type: none"> <li>• The military base closed;</li> <li>• The military base no longer offers services; or</li> <li>• You relocated.</li> </ul>  |
|           | <b>Your plan choices</b>                  | <b>Plan A, C, D, F, High Deductible F, K, or N</b>  |
|           | <b>When to apply</b>                      | Blue Shield must receive your application within six (6) months of the date you lost access to healthcare services at the military base.  |
|           | <b>You must supply this documentation</b> | Documentation to support the reason you no longer have access to healthcare services at the military base.  |
| <b>13</b> | <b>Situation</b>                          | <p>You enrolled in one of the following:</p> <ul style="list-style-type: none"> <li>• A Medicare Advantage Plan;<sup>1</sup></li> <li>• A Medicare cost or similar organization operating under demonstration project authority before April 1, 1999;</li> <li>• A healthcare prepayment plan;</li> <li>• A Medicare Supplement plan; or</li> <li>• A Medicare Select policy;</li> </ul> <p>but coverage terminated because you demonstrated:</p> <ul style="list-style-type: none"> <li>• The company substantially violated a material provision of the contract; or</li> <li>• The company or its agent materially misrepresented a provision of the plan in marketing the contract to you.</li> </ul> |
|           | <b>Your plan choices</b>                  | <b>Plan A, C, D, F, High Deductible F, K, or N</b>  |
|           | <b>When to apply</b>                      | You may submit an application sixty (60) days before the effective date of termination, but no later than sixty-three (63) days after the date coverage is terminated.  |
|           | <b>You must supply this documentation</b> | Be sure to complete the Current Insurance Coverage information section (including the end date and reason for coverage ending) of your signed Medicare Supplement plan application. <sup>3</sup>  |



**14**

|  |   |
|--|---|
| <b>Situation</b>                                 | You enrolled in a Blue Shield Medicare Advantage Plan, <sup>1</sup> and Blue Shield either: <ul style="list-style-type: none"> <li>• Reduced any of its benefits;</li> <li>• Increased the amount of cost-sharing or premium; or</li> <li>• Discontinued (for other than quality of care) a contract with a provider currently furnishing services to you.</li> </ul> |
| <b>Your plan choices</b>                         | <b>Plan A, C, D, F, High Deductible F, K, or N</b>  |
| <b>When to apply</b>                             | You may submit an application sixty (60) days before the effective date of termination, but no later than sixty-three (63) days after the date coverage is terminated.  |
| <b>Blue Shield must obtain this verification</b> | Blue Shield will verify Medicare Advantage Plan termination within Blue Shield's eligibility system.  |

**15**

|   |  |
|---|--|
| <b>Situation</b>                          | You enrolled in a Medicare Supplement plan, but coverage stopped because: <ul style="list-style-type: none"> <li>• The company filed for bankruptcy or is insolvent; or</li> <li>• Of other involuntary termination of coverage under the contract.</li> </ul>   |
| <b>Your plan choices</b>                  | <b>Plan A, C, D, F, High Deductible F, K, or N</b>   |
| <b>When to apply</b>                      | You may submit an application to Blue Shield during the guaranteed acceptance period, which starts from the earlier of the following two dates, and ends sixty-three (63) days after coverage terminates: <ul style="list-style-type: none"> <li>• The date you receive notice of termination, bankruptcy, insolvency or other similar notice; or</li> <li>• The date coverage is terminated.</li> </ul> |
| <b>You must supply this documentation</b> | Be sure to complete the Current Insurance Coverage information section of your signed Medicare Supplement plan application and provide documentation to support the reason for termination, and a copy of the prior coverage termination notice with your name and termination date or a Certificate of Prior Coverage.  |

**16**

|   |   |
|---|---|
| <b>Situation</b>                          | You are enrolled in Medicare Part B and have been notified that because of an increase in your income or assets, you meet one of the following: <ul style="list-style-type: none"> <li>• You are no longer eligible for Medi-Cal benefits.</li> <li>• You are only eligible for Medi-Cal benefits with a share-of-cost (and you certify at the time of application with Blue Shield you have not met the share of the cost).</li> </ul> |
| <b>Your plan choices</b>                  | <b>Plan A, C, D, F, High Deductible F, K, or N</b>  |
| <b>When to apply</b>                      | Blue Shield must receive your application within six (6) months of the date coverage is terminated.   |
| <b>You must supply this documentation</b> | A copy of the notice of termination from the Medi-Cal Program, or the notice that your share-of-cost is increasing due to a change in income/assets.  |

**Situation**

You enrolled in a Medicare Advantage Plan<sup>1</sup> and that plan either:

- Reduced any of its benefits;
- Increased the amount of cost-sharing for physicians, hospital or drug copayments by 15% or more;
- Increased premium by 15% or more; or
- Discontinued (for other than quality of care) a contract with a provider currently furnishing services to you.

In addition, no Medicare Supplement plan is available from that issuer, a subsidiary of the parent company of the issuer, or a network that contracts with the parent company of the issuer.

**Your plan choices**

**Plan A, C, D, F, High Deductible F, K, or N**

**When to apply**

You may submit an application during the Annual Election Period for a Medicare Advantage Plan, except when the Medicare Advantage Plan has discontinued its relationship with a provider currently furnishing services to you, in which case you may submit an application sixty (60) days before the effective date of termination, but no later than sixty-three (63) days after the date coverage is terminated.

**You must supply this documentation**

Be sure to complete the Current Insurance Coverage information section (including the end date and reason for coverage ending) of your signed Medicare Supplement plan application.<sup>3</sup>

**Endnotes**

1. A Medicare Advantage Plan can be any of the following: a Medicare managed care (HMO) plan, Medicare preferred provider organization (PPO) plan, Medicare private fee-for-service (PFFS) plan, or specialized Medicare Advantage Plan.
2. Involuntarily terminated coverage does not include termination for nonpayment of dues, certain disruptive behavior, or if the plan is terminated for all individuals within the service area.
3. Blue Shield reserves the right to request a copy of the prior coverage termination notice with your name and termination date, or a Certificate of Prior Coverage.
4. A 1990 standardized Medicare Supplement benefit plan shall be deemed to offer benefits equal to those provided by its equivalent 2010 standardized Medicare Supplement benefit plan. For example, a 1990 standardized Medicare Supplement benefit plan A shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare Supplement benefit plan A.

application form



# Applying is easy

## You have two options:

1. Work with your broker to use our online plan comparison tool, and immediately **enroll online**.
2. While enrolling online is faster and easier, you can also choose to fill out the **paper application** in this booklet. Here's how:
  - Tear out the application.
  - Fill it out completely.
  - Be sure to sign where indicated.
  - Keep the yellow copy for yourself.
  - Fax it to us at **844-266-1850** or mail it to the address on the first page of the application.

### Other things to consider:

- ✓ If you are applying for a two-party contract, both parties must complete their own application.
- ✓ To take advantage of a fast and convenient way of having your health plan dues automatically deducted from your bank account, complete the Easy\$Pay portion of the enrollment application.
- ✓ Please include the first payment for your Medicare Supplement plan dues only, along with your application. Blue Shield will refund your payment if you are not approved for enrollment.



Application for  
**Blue Shield of California**  
**Medicare Supplement plans**

blue  of california

**Here's how to apply**

- 1 Provide ALL requested information and print clearly in blue or black ink.
- 2 Sign and date in all places indicated.
- 3 Within 30 days of your signature date, please fax or mail your completed application to:  
Fax: (844) 266-1850  
Address: Medicare Supplement Applications  
P.O. Box 3008  
Lodi, CA 95241-9969

**Personal information**

|   |   |           |
|---|---|-----------|
| First name  | Middle initial  | Last name |
| Home address  |   |           |
| City  | State   | ZIP       |
| Home telephone<br>( )   | Email address   |           |
| Mailing address (if different from above)   |   |           |
| City  | State   | ZIP       |
| Billing address (if different from above)   |   |           |
| City  | State   | ZIP       |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female   | Date of birth<br>____ - ____ - ____<br>Month Day Year |           |
| Medicare number   | Social Security number                                |           |
| I'm entitled to: <input type="checkbox"/> Hospital (Part A) effective date _____<br><input type="checkbox"/> Medical (Part B) effective date _____  |   |           |
| Please check the plan type you are applying for: <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> High Deductible F <input type="checkbox"/> K <input type="checkbox"/> N |   |           |
| Requested effective date: The 1 <sup>st</sup> day of ____ - ____ - ____<br>Month Year   |   |           |
| Language preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____   |   |           |
| Are you currently a Blue Shield of California member? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, please provide member ID number _____   |   |           |

White copy: Give to your Blue Shield agent or mail to Blue Shield's Underwriting Department with your first payment.  
Yellow copy: Keep with your important Blue Shield documents and information.





Application for  
**Blue Shield of California**  
**Medicare Supplement plans**

blue  of california

**Here's how to apply**

- 1 Provide ALL requested information and print clearly in blue or black ink.
- 2 Sign and date in all places indicated.
- 3 Within 30 days of your signature date, please fax or mail your completed application to:  
Fax: (844) 266-1850  
Address: Medicare Supplement Applications  
P.O. Box 3008  
Lodi, CA 95241-9969

**Personal information**

|   |   |           |  |
|---|---|-----------|--|
| First name  | Middle initial  | Last name |  |
| Home address  |   |           |  |
| City  | State   | ZIP       |  |
| Home telephone<br>(      )  | Email address   |           |  |
| Mailing address (if different from above)   |   |           |  |
| City  | State   | ZIP       |  |
| Billing address (if different from above)   |   |           |  |
| City  | State   | ZIP       |  |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female   | Date of birth<br>____ - ____ - ____<br>Month      Day      Year |           |  |
| Medicare number   | Social Security number  |           |  |
| I'm entitled to: <input type="checkbox"/> Hospital (Part A) effective date _____<br><input type="checkbox"/> Medical (Part B) effective date _____  |   |           |  |
| Please check the plan type you are applying for: <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> High Deductible F <input type="checkbox"/> K <input type="checkbox"/> N |   |           |  |
| Requested effective date: The 1 <sup>st</sup> day of ____ - ____ - ____<br>Month      Year  |   |           |  |
| Language preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____   |   |           |  |
| Are you currently a Blue Shield of California member? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, please provide member ID number _____   |   |           |  |

White copy: Give to your Blue Shield agent or mail to Blue Shield's Underwriting Department with your first payment.  
Yellow copy: Keep with your important Blue Shield documents and information.



## Guaranteed acceptance

---

If you think you qualify for guaranteed acceptance, please write the number of the qualifying situation, as described in the enclosed Blue Shield Guaranteed Acceptance Guide, in the space below. Then attach proof of prior coverage as a separate sheet, and sign and date the sheet.

**I believe I qualify for guaranteed acceptance based on situation number** \_\_\_\_\_ .

If applying for guaranteed acceptance under situation No. 2 on the enclosed Blue Shield Guaranteed Acceptance Guide, please complete the Notice of Replacement of Coverage form and submit with your completed enrollment application.

## Two-party contracts

---

**You and your spouse or domestic partner may qualify for a TWO-PARTY CONTRACT.** Both individuals must be age 65 or older, enrolled in both Medicare Parts A and B, and apply for the same plan type. Either person who does not qualify for guaranteed acceptance (see above) will be subject to underwriting.

### Each individual must complete their own application:

If you and your spouse/domestic partner are applying for a two-party contract, please check this box: ☐

Please provide:

1. Your spouse/domestic partner's name: \_\_\_\_\_
2. Spouse/domestic partner's Social Security number or Blue Shield ID number: \_\_\_\_\_
3. Spouse/domestic partner's authorization to change their contract to a two-party contract by signing below:

Spouse/domestic partner signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name \_\_\_\_\_

## Payment information

---

To determine the monthly dues amount, refer to Blue Shield's rate tables included in this booklet. If you are not approved, Blue Shield will refund your payment amount. If your application is approved, you will receive a bill indicating the amount and the date your next payment is due. Blue Shield will also send you an approval letter, an *Evidence of Coverage and Health Service Agreement*, and a member identification card as proof of approval.

Select your initial payment choice:

- ☐ Easy\$Pay<sup>SM</sup> (Automatic monthly debit from your checking or savings account. Save \$3 each month. You must complete the Easy\$Pay authorization on the next page, even if you are currently on Easy\$Pay with another Blue Shield plan)
- ☐ Check enclosed with this application
- ☐ Payment for two-party contract is included on spouse/domestic partner's application\*

If you are not using Easy\$Pay, please indicate how you would like to receive your paper bill going forward.

- ☐ Quarterly billing    ☐ Monthly billing

\* If you are applying for a two-party contract for you and your spouse/domestic partner and paying by check, please enclose only one check for the applicable two-party rate, which can be found in the Summary of Benefits. Easy\$Pay payments will automatically be debited at the applicable two-party rate.



## Guaranteed acceptance

---

If you think you qualify for guaranteed acceptance, please write the number of the qualifying situation, as described in the enclosed Blue Shield Guaranteed Acceptance Guide, in the space below. Then attach proof of prior coverage as a separate sheet, and sign and date the sheet.

**I believe I qualify for guaranteed acceptance based on situation number** \_\_\_\_\_ .

If applying for guaranteed acceptance under situation No. 2 on the enclosed Blue Shield Guaranteed Acceptance Guide, please complete the Notice of Replacement of Coverage form and submit with your completed enrollment application.

## Two-party contracts

---

**You and your spouse or domestic partner may qualify for a TWO-PARTY CONTRACT.** Both individuals must be age 65 or older, enrolled in both Medicare Parts A and B, and apply for the same plan type. Either person who does not qualify for guaranteed acceptance (see above) will be subject to underwriting.

### Each individual must complete their own application:

If you and your spouse/domestic partner are applying for a two-party contract, please check this box: ☐

Please provide:

1. Your spouse/domestic partner's name: \_\_\_\_\_
2. Spouse/domestic partner's Social Security number or Blue Shield ID number: \_\_\_\_\_
3. Spouse/domestic partner's authorization to change their contract to a two-party contract by signing below:

Spouse/domestic partner signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name \_\_\_\_\_

## Payment information

---

To determine the monthly dues amount, refer to Blue Shield's rate tables included in this booklet. If you are not approved, Blue Shield will refund your payment amount. If your application is approved, you will receive a bill indicating the amount and the date your next payment is due. Blue Shield will also send you an approval letter, an *Evidence of Coverage and Health Service Agreement*, and a member identification card as proof of approval.

Select your initial payment choice:

- ☐ Easy\$Pay<sup>SM</sup> (Automatic monthly debit from your checking or savings account. Save \$3 each month. You must complete the Easy\$Pay authorization on the next page, even if you are currently on Easy\$Pay with another Blue Shield plan)
- ☐ Check enclosed with this application
- ☐ Payment for two-party contract is included on spouse/domestic partner's application\*

If you are not using Easy\$Pay, please indicate how you would like to receive your paper bill going forward.

- ☐ Quarterly billing    ☐ Monthly billing

\* If you are applying for a two-party contract for you and your spouse/domestic partner and paying by check, please enclose only one check for the applicable two-party rate, which can be found in the Summary of Benefits. Easy\$Pay payments will automatically be debited at the applicable two-party rate.



If you selected Easy\$Pay as your monthly dues payment option, please fill out this page. If not, please skip to page 4.

## Easy\$Pay Authorization form

|  |      |   |     |
|--|------|---|-----|
| Debit date: <input type="checkbox"/> 1st of the month <input type="checkbox"/> 15th of the month |      | Type of account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings |     |
| Bank routing/transit number:   |      | Bank account number:  |     |
| Name of financial institution:   |      | Branch telephone number:  |     |
| Name(s) on bank account  |      |   |     |
| Branch address   | City | State   | ZIP |

## Authorization and signature(s)

I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to initiate debits (and/or make corrections to previous debits, as necessary) to the bank account identified on this form on the payment date, and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. I understand that charges may occur two to three days prior to the payment date indicated on this form. I also authorize my financial institution to reduce the balance of my account by the amount of such debits (and/or corrections to previous debits). I will maintain sufficient collected funds in my account for the full amount of each payment. If the automatic debit transaction ever fails (e.g., no funds are available), Blue Shield will mail a bill to me at my address on record, and I will be responsible for making my payment by check or money order, along with a returned item service charge.

### Notice to change/cancel required

I will continue to be debited/charged the amount of dues/premium owed until I cancel this automatic payment authorization upon at least 10 calendar days' notice before a debit/charge is to occur. To cancel this automatic payment authorization, or if there are changes to my account being debited/charged, I must contact Customer Service at **(800) 248-2341** [TTY: **711**].

Blue Shield may cancel this authorization at any time upon notice to me.

By signing below, I agree to the terms and conditions of this authorization form, and I acknowledge that I have received a copy of this form (if the bank account is a joint account, all account holders must sign). I acknowledge that all payment transactions must comply with the provisions of U.S. law. I will make payments by check or money order until my automatic payment service has been activated.

Account holder signature

Print name

Social Security number

Date

Signature

Print name

Social Security number

Date





If you selected Easy\$Pay as your monthly dues payment option, please fill out this page. If not, please skip to page 4.

## Easy\$Pay Authorization form

|  |      |   |     |
|--|------|---|-----|
| Debit date: <input type="checkbox"/> 1st of the month <input type="checkbox"/> 15th of the month |      | Type of account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings |     |
| Bank routing/transit number:   |      | Bank account number:  |     |
| Name of financial institution:   |      | Branch telephone number:  |     |
| Name(s) on bank account  |      |   |     |
| Branch address   | City | State   | ZIP |

## Authorization and signature(s)

I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to initiate debits (and/or make corrections to previous debits, as necessary) to the bank account identified on this form on the payment date, and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. I understand that charges may occur two to three days prior to the payment date indicated on this form. I also authorize my financial institution to reduce the balance of my account by the amount of such debits (and/or corrections to previous debits). I will maintain sufficient collected funds in my account for the full amount of each payment. If the automatic debit transaction ever fails (e.g., no funds are available), Blue Shield will mail a bill to me at my address on record, and I will be responsible for making my payment by check or money order, along with a returned item service charge.

### Notice to change/cancel required

I will continue to be debited/charged the amount of dues/premium owed until I cancel this automatic payment authorization upon at least 10 calendar days' notice before a debit/charge is to occur. To cancel this automatic payment authorization, or if there are changes to my account being debited/charged, I must contact Customer Service at **(800) 248-2341** [TTY: **711**].

Blue Shield may cancel this authorization at any time upon notice to me.

By signing below, I agree to the terms and conditions of this authorization form, and I acknowledge that I have received a copy of this form (if the bank account is a joint account, all account holders must sign). I acknowledge that all payment transactions must comply with the provisions of U.S. law. I will make payments by check or money order until my automatic payment service has been activated.

Account holder signature

Print name

Social Security number

Date

Signature

Print name

Social Security number

Date



## Current insurance coverage information (required for all submissions)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance contract, or that you had certain rights to buy such a contract, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. The Blue Shield Guaranteed Acceptance Guide describes the different situations in which you may be eligible for guaranteed issue of a Medicare Supplement plan. It is important to note that the time period of eligibility for guaranteed issuance may vary by situation, and you must apply within this time period to be eligible for guaranteed acceptance. **Please include a copy of the notice from your prior insurer with your application.**

**Please answer all questions to the best of your knowledge.** (Please mark Yes or No below with an X.)

- 1 ☐ Yes ☐ No a. Did you turn 65 years of age in the last six months?  
☐ Yes ☐ No b. Did you enroll in Medicare Part B in the last six months?  
c. If Yes, what is the effective date? \_\_\_\_\_
- 2 ☐ Yes ☐ No Are you covered for medical assistance through California's Medi-Cal program?  
NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.  
**If Yes,**  
☐ Yes ☐ No a. Will Medi-Cal pay your premiums for this Medicare Supplement plan contract?  
☐ Yes ☐ No b. Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?
- 3 ☐ Yes ☐ No a. If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave the "END" blank.  
Start \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Carrier name: \_\_\_\_\_ Plan type: \_\_\_\_\_  
End \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Reason for coverage ending: \_\_\_\_\_  
**If Yes,**  
☐ Yes ☐ No b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan contract?  
☐ Yes ☐ No c. Was this your first time in this type of Medicare plan?  
☐ Yes ☐ No d. Did you drop a Medicare Supplement plan contract to enroll in the Medicare plan?
- 4 ☐ Yes ☐ No a. Do you have another Medicare Supplement plan policy or certificate or contract in force?  
b. If so, with what company? \_\_\_\_\_ What plan do you have? \_\_\_\_\_  
☐ Yes ☐ No c. If so, do you intend to replace your current Medicare Supplement plan policy or certificate with this contract?
- 5 ☐ Yes ☐ No Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?  
a. If so, what companies and what kind of policy?  
Carrier name: \_\_\_\_\_ Carrier phone No.: \_\_\_\_\_  
Plan type: \_\_\_\_\_ Current ID No.: \_\_\_\_\_  
b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave the "END" blank.) Start \_\_\_\_ / \_\_\_\_ / \_\_\_\_ End \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- 6 ☐ Yes ☐ No Are you under age 65?  
**If Yes,** a. Do you have end-stage renal disease? ☐ Yes ☐ No

**You may contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP provides health 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.**

**A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Managed Health Care's consumer toll-free telephone number (1-888-HMO-2219), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Managed Health Care's website ([www.dmhc.ca.gov](http://www.dmhc.ca.gov)).**



## Current insurance coverage information (required for all submissions)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance contract, or that you had certain rights to buy such a contract, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. The Blue Shield Guaranteed Acceptance Guide describes the different situations in which you may be eligible for guaranteed issue of a Medicare Supplement plan. It is important to note that the time period of eligibility for guaranteed issuance may vary by situation, and you must apply within this time period to be eligible for guaranteed acceptance. **Please include a copy of the notice from your prior insurer with your application.**

**Please answer all questions to the best of your knowledge.** (Please mark Yes or No below with an X.)

- 1 ☐ Yes ☐ No a. Did you turn 65 years of age in the last six months?  
☐ Yes ☐ No b. Did you enroll in Medicare Part B in the last six months?  
c. If Yes, what is the effective date? \_\_\_\_\_
- 2 ☐ Yes ☐ No Are you covered for medical assistance through California's Medi-Cal program?  
NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.  
**If Yes,**  
☐ Yes ☐ No a. Will Medi-Cal pay your premiums for this Medicare Supplement plan contract?  
☐ Yes ☐ No b. Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?
- 3 ☐ Yes ☐ No a. If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave the "END" blank.  
Start \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Carrier name: \_\_\_\_\_ Plan type: \_\_\_\_\_  
End \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Reason for coverage ending: \_\_\_\_\_  
**If Yes,**  
☐ Yes ☐ No b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan contract?  
☐ Yes ☐ No c. Was this your first time in this type of Medicare plan?  
☐ Yes ☐ No d. Did you drop a Medicare Supplement plan contract to enroll in the Medicare plan?
- 4 ☐ Yes ☐ No a. Do you have another Medicare Supplement plan policy or certificate or contract in force?  
b. If so, with what company? \_\_\_\_\_ What plan do you have? \_\_\_\_\_  
☐ Yes ☐ No c. If so, do you intend to replace your current Medicare Supplement plan policy or certificate with this contract?
- 5 ☐ Yes ☐ No Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?  
a. If so, what companies and what kind of policy?  
Carrier name: \_\_\_\_\_ Carrier phone No.: \_\_\_\_\_  
Plan type: \_\_\_\_\_ Current ID No.: \_\_\_\_\_  
b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave the "END" blank.) Start \_\_\_\_ / \_\_\_\_ / \_\_\_\_ End \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- 6 ☐ Yes ☐ No Are you under age 65?  
**If Yes,** a. Do you have end-stage renal disease? ☐ Yes ☐ No

**You may contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP provides health 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.**

**A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Managed Health Care's consumer toll-free telephone number (1-888-HMO-2219), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Managed Health Care's website ([www.dmhc.ca.gov](http://www.dmhc.ca.gov)).**



## Terms, conditions, and authorizations

**Information regarding Medicare Supplement plan coverage:** Before you apply, it's important that you read the following information, then sign and date at the end of this application.

- 1 You do not need more than one Medicare Supplement plan policy or contract.
- 2 If you purchase this contract, you may want to evaluate your existing health coverage to decide if you need multiple coverage.
- 3 You may be eligible for benefits under Medi-Cal or Medicaid, and may not need a Medicare Supplement plan contract.
- 4 If after purchasing this contract you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement plan contract can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstituted if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 5 If you are eligible for, and have enrolled in, a Medicare Supplement plan contract by reason of disability, and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement plan contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement plan contract under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 6 Counseling services are available in California to provide advice concerning your purchase of Medicare Supplement plan coverage and concerning medical assistance through the Medi-Cal program, including your benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). You may obtain information regarding counseling services from the State Department of Aging.

## Conditions of membership

- 1 This application and the Statement of Health, together with the *Evidence of Coverage and Health Service Agreement* and any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.
- 2 I will not receive coverage from Blue Shield unless Blue Shield's Underwriting Department approves this application. Blue Shield is not liable for bills incurred before the effective date of coverage.
- 3 Only Blue Shield can approve this application. I understand that any insurance agent, broker, or sales representative cannot grant approval, change terms, or waive requirements.
- 4 I acknowledge receipt of the Summary of Benefits and a copy of this application. I have read the Summary of Benefits and the terms, and conditions of coverage set forth above. With my signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage and the authorizations I have provided.

**Applicant's signature**

**Date**





## Terms, conditions, and authorizations

**Information regarding Medicare Supplement plan coverage:** Before you apply, it's important that you read the following information, then sign and date at the end of this application.

- 1 You do not need more than one Medicare Supplement plan policy or contract.
- 2 If you purchase this contract, you may want to evaluate your existing health coverage to decide if you need multiple coverage.
- 3 You may be eligible for benefits under Medi-Cal or Medicaid, and may not need a Medicare Supplement plan contract.
- 4 If after purchasing this contract you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement plan contract can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstituted if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 5 If you are eligible for, and have enrolled in, a Medicare Supplement plan contract by reason of disability, and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement plan contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement plan contract under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 6 Counseling services are available in California to provide advice concerning your purchase of Medicare Supplement plan coverage and concerning medical assistance through the Medi-Cal program, including your benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). You may obtain information regarding counseling services from the State Department of Aging.

## Conditions of membership

- 1 This application and the Statement of Health, together with the *Evidence of Coverage and Health Service Agreement* and any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.
- 2 I will not receive coverage from Blue Shield unless Blue Shield's Underwriting Department approves this application. Blue Shield is not liable for bills incurred before the effective date of coverage.
- 3 Only Blue Shield can approve this application. I understand that any insurance agent, broker, or sales representative cannot grant approval, change terms, or waive requirements.
- 4 I acknowledge receipt of the Summary of Benefits and a copy of this application. I have read the Summary of Benefits and the terms, and conditions of coverage set forth above. With my signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage and the authorizations I have provided.

**Applicant's signature**

**Date**



**Producer information (for producer use only): Producer name and ID is required**TMO/GMO/Agency name \_\_\_\_\_  
(please print appointed agency name)TMO/GMO/Agency ID No. \_\_\_\_\_  
(please print agency ID)Producer name \_\_\_\_\_  
(please print writing agent name)Producer ID No. \_\_\_\_\_  
(please print agent ID number)

Producer email address \_\_\_\_\_

Producer phone number \_\_\_\_\_

**Section 1 – Please list any other health insurance policies or plan contracts sold to the applicant as follows:**

List policies and plan contracts sold that are still in force: \_\_\_\_\_

\_\_\_\_\_

List policies and plan contracts sold in the past five years that are no longer in force: \_\_\_\_\_

\_\_\_\_\_

**Section 2 – If the applicant did not complete the Statement of Health section (is guaranteed acceptance), you do not need to complete this section.**

A producer who assists an applicant or applicants in submitting an application to a health plan or insurer has a duty to assist the applicant(s) in providing answers to health questions accurately and completely.

This attestation must be completed by the producer and submitted with each Blue Shield Medicare Supplement plan application. This form is available for use with Medicare Supplement plan applications not containing a producer attestation with these questions and shall become part of the original application.

**Review and select one of the following:**

- ☐ I did not assist the applicant/applicants in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me.
- ☐ I assisted the applicant/applicants in submitting this application. All information in the health questionnaire was provided by them. I advised the applicant(s) that they should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that, if information is withheld, that could result in their coverage being cancelled later. The applicant(s) indicated to me that they understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to \$10,000.

**Today's date (required)****Producer's signature (required)****Print name**

**Notice:** Please ensure each part of the application is complete. In the event of missing or incomplete information, Blue Shield may contact your applicant directly to obtain complete information.



**Producer information (for producer use only): Producer name and ID is required**TMO/GMO/Agency name \_\_\_\_\_  
(please print appointed agency name)TMO/GMO/Agency ID No. \_\_\_\_\_  
(please print agency ID)Producer name \_\_\_\_\_  
(please print writing agent name)Producer ID No. \_\_\_\_\_  
(please print agent ID number)

Producer email address \_\_\_\_\_

Producer phone number \_\_\_\_\_

**Section 1 – Please list any other health insurance policies or plan contracts sold to the applicant as follows:**

List policies and plan contracts sold that are still in force: \_\_\_\_\_

\_\_\_\_\_

List policies and plan contracts sold in the past five years that are no longer in force: \_\_\_\_\_

\_\_\_\_\_

**Section 2 – If the applicant did not complete the Statement of Health section (is guaranteed acceptance), you do not need to complete this section.**

A producer who assists an applicant or applicants in submitting an application to a health plan or insurer has a duty to assist the applicant(s) in providing answers to health questions accurately and completely.

This attestation must be completed by the producer and submitted with each Blue Shield Medicare Supplement plan application. This form is available for use with Medicare Supplement plan applications not containing a producer attestation with these questions and shall become part of the original application.

**Review and select one of the following:**

- ☐ I did not assist the applicant/applicants in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me.
- ☐ I assisted the applicant/applicants in submitting this application. All information in the health questionnaire was provided by them. I advised the applicant(s) that they should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that, if information is withheld, that could result in their coverage being cancelled later. The applicant(s) indicated to me that they understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to \$10,000.

**Today's date (required)****Producer's signature (required)****Print name**

**Notice:** Please ensure each part of the application is complete. In the event of missing or incomplete information, Blue Shield may contact your applicant directly to obtain complete information.



## Statement of health

**Blue Shield does not collect or use genetic information in Underwriting. No genetic information, including family medical history, and no information related to HIV testing should be provided.**

**If you qualify for guaranteed acceptance, do not complete this section.** (See the Guaranteed Acceptance section for qualifying information.) Otherwise, please answer Yes or No to each of the following questions:

- 1** Have you, within the past three years, received treatment or been hospitalized for any of the conditions listed below?  
If Yes, please explain the condition and indicate the date of treatment at the end of this section.
- |  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | a. Brain or nervous system disorders such as multiple sclerosis, Parkinson's disease, Huntington's chorea, dementia, Alzheimer's, paralysis, stroke, etc.  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | b. Respiratory system disorders such as chronic obstructive lung disease, emphysema, cystic fibrosis, etc.   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | c. Cardiovascular disorders such as heart disease, high blood pressure, angina, coronary artery disease, clotting disorders, etc.  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | d. Gastrointestinal disorders such as liver cirrhosis, hepatitis B or C, ulcerative colitis, etc.  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | e. Musculoskeletal system disorders such as rheumatoid arthritis, herniated or bulging discs, etc.   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | f. Metabolic disorders such as diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, etc., or immune system disorders such as lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT, HIVID, or pentamidine therapy.* |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | g. Cancer or malignant tumors.   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | h. Have you received treatment or been hospitalized for any other condition than those listed above?   |
- 2** ☐ Yes ☐ No Do you have a pacemaker or artificial heart valve, or have you had transplant surgery or heart surgery such as angioplasty or bypass? If Yes, please explain the condition and indicate the date of treatment at the end of this section.
- 3** ☐ Yes ☐ No Have you been bed-ridden or confined to a hospital, nursing home, convalescent hospital, or other institution within the past three years? If Yes, please explain the confinement and indicate the date of confinement at the end of this section.
- 4** ☐ Yes ☐ No Are you currently taking medication? If Yes, please list at the end of this section all medications you are currently taking, and the condition for which the medication is prescribed.
- 5** ☐ Yes ☐ No Have you used any tobacco-related products in the last 24 months?

If you answered Yes to any of the above questions, please provide additional information and dates associated with the condition, as well as current status of the condition. If additional space is required, please use additional sheets as necessary, and sign and date each sheet.

| Condition or medication | Date | Explanation/current status |
|-------------------------|------|----------------------------|
|                         |      |                            |
|                         |      |                            |
|                         |      |                            |

\* California law prohibits an HIV test from being required or used by healthcare service plans as a condition of obtaining coverage.

I alone am responsible for the accuracy and completeness of the information provided in this application. I have personally reviewed all information provided on this application. To the best of my knowledge and belief, all information on this application, including all information provided in the Statement of Health section, is accurate, true, and complete. I understand that coverage may be cancelled or rescinded if Blue Shield determines that information on this application is materially inaccurate, not true, or incomplete. I further understand that I must provide Blue Shield with any new information that arises after the submission of this application but before my enrollment with Blue Shield begins.

**Signature<sup>†</sup>**

**Date**

<sup>†</sup> Your signature is required in this section only if completing the Statement of Health.





## Statement of health

**Blue Shield does not collect or use genetic information in Underwriting. No genetic information, including family medical history, and no information related to HIV testing should be provided.**

**If you qualify for guaranteed acceptance, do not complete this section.** (See the Guaranteed Acceptance section for qualifying information.) Otherwise, please answer Yes or No to each of the following questions:

- 1** Have you, within the past three years, received treatment or been hospitalized for any of the conditions listed below?  
If Yes, please explain the condition and indicate the date of treatment at the end of this section.
- |  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | a. Brain or nervous system disorders such as multiple sclerosis, Parkinson's disease, Huntington's chorea, dementia, Alzheimer's, paralysis, stroke, etc.  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | b. Respiratory system disorders such as chronic obstructive lung disease, emphysema, cystic fibrosis, etc.   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | c. Cardiovascular disorders such as heart disease, high blood pressure, angina, coronary artery disease, clotting disorders, etc.  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | d. Gastrointestinal disorders such as liver cirrhosis, hepatitis B or C, ulcerative colitis, etc.  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | e. Musculoskeletal system disorders such as rheumatoid arthritis, herniated or bulging discs, etc.   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | f. Metabolic disorders such as diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, etc., or immune system disorders such as lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT, HIVID, or pentamidine therapy.* |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | g. Cancer or malignant tumors.   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | h. Have you received treatment or been hospitalized for any other condition than those listed above?   |
- 2** ☐ Yes ☐ No Do you have a pacemaker or artificial heart valve, or have you had transplant surgery or heart surgery such as angioplasty or bypass? If Yes, please explain the condition and indicate the date of treatment at the end of this section.
- 3** ☐ Yes ☐ No Have you been bed-ridden or confined to a hospital, nursing home, convalescent hospital, or other institution within the past three years? If Yes, please explain the confinement and indicate the date of confinement at the end of this section.
- 4** ☐ Yes ☐ No Are you currently taking medication? If Yes, please list at the end of this section all medications you are currently taking, and the condition for which the medication is prescribed.
- 5** ☐ Yes ☐ No Have you used any tobacco-related products in the last 24 months?

If you answered Yes to any of the above questions, please provide additional information and dates associated with the condition, as well as current status of the condition. If additional space is required, please use additional sheets as necessary, and sign and date each sheet.

| Condition or medication | Date | Explanation/current status |
|-------------------------|------|----------------------------|
|                         |      |                            |
|                         |      |                            |
|                         |      |                            |

\* California law prohibits an HIV test from being required or used by healthcare service plans as a condition of obtaining coverage.

I alone am responsible for the accuracy and completeness of the information provided in this application. I have personally reviewed all information provided on this application. To the best of my knowledge and belief, all information on this application, including all information provided in the Statement of Health section, is accurate, true, and complete. I understand that coverage may be cancelled or rescinded if Blue Shield determines that information on this application is materially inaccurate, not true, or incomplete. I further understand that I must provide Blue Shield with any new information that arises after the submission of this application but before my enrollment with Blue Shield begins.

**Signature<sup>†</sup>**

**Date**

<sup>†</sup> Your signature is required in this section only if completing the Statement of Health.



By signing below, you are authorizing the release of your healthcare information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent, to Blue Shield of California for the purpose of reviewing your application for Blue Shield coverage.

Further, by signing below you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization, health plan, or your insurance agent for the purpose of investigating or valuating any claim for benefits.

You have the right to refuse to sign this authorization. However, Blue Shield has the right to condition your eligibility for coverage and enrollment determinations if you choose not to sign the authorization below unless you qualify for enrollment on the basis of guaranteed acceptance.

You are entitled to a copy of this authorization after you sign it.

**Expiration:** This authorization will remain valid until 1) for 30 months from the date of this authorization for the purposes of processing your application, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health services agreement/policy.

**Right to revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation.

**If you qualify for guaranteed acceptance, do not sign this release.** (See the Guaranteed Acceptance section for qualifying information.)

**Signature**

Date \_\_\_\_\_



By signing below, you are authorizing the release of your healthcare information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent, to Blue Shield of California for the purpose of reviewing your application for Blue Shield coverage.

Further, by signing below you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization, health plan, or your insurance agent for the purpose of investigating or valuating any claim for benefits.

You have the right to refuse to sign this authorization. However, Blue Shield has the right to condition your eligibility for coverage and enrollment determinations if you choose not to sign the authorization below unless you qualify for enrollment on the basis of guaranteed acceptance.

You are entitled to a copy of this authorization after you sign it.

**Expiration:** This authorization will remain valid until 1) for 30 months from the date of this authorization for the purposes of processing your application, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health services agreement/policy.

**Right to revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation.

**If you qualify for guaranteed acceptance, do not sign this release.** (See the Guaranteed Acceptance section for qualifying information.)

**Signature**

Date \_\_\_\_\_



## Dental PPO plans

---

### Affordable dental plans and dental + vision package for Medicare Supplement plan members.

Please see the *Blue Shield Dental plans and dental + vision package* flier in this enrollment kit for more information.

---

To sign up for Blue Shield dental coverage, select a plan below:

#### Dental plan options (check one):

- ☐ Specialty Duo dental + vision package<sup>SM\*</sup>
- ☐ Dental PPO 1000                      ☐ Dental PPO 1500                      ☐ No dental plan
- 

You can save \$3 each month for the first six months on your dental or dental + vision plan rates if you enroll in a dental or dental + vision plan **at the same time** you enroll in any Blue Shield Medicare Supplement plan.

---

#### Conditions of coverage

- Dental benefits aren't subject to any health plan deductible requirements.
  - If your dental or dental + vision coverage is cancelled for any reason (by you or by Blue Shield), you may apply for reinstatement, but you will have to wait six months to reapply.
- 

#### For two-party enrollment

If you are enrolled in a Medicare Supplement plan with a two-party contract, you may enjoy the convenience of a single bill and lower rates for you and your spouse/domestic partner. Keep the same convenience when you choose your dental plan by matching your dental PPO plan or dental + vision package enrollment with your Medicare Supplement plan enrollment. You and your spouse/domestic partner need to select and both enroll in the same dental PPO plan or dental + vision package in order to receive one bill that combines Medicare Supplement plan and dental PPO plan or dental + vision package rates. If only one of you wants to enroll in a dental PPO plan or dental + vision package, or if you each want different dental PPO plans or dental + vision package, your two-party agreement for the Medicare Supplement plan will be affected. In order to enroll in the dental plans or dental + vision package in this way, you will need to change your two-party contract and rate to individual contracts and single-party rates.

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). Specialty Duo package includes both Specialty Duo Dental Plan and Specialty Duo Vision Plan for Medicare Supplement plan members.





## Dental PPO plans

---

### Affordable dental plans and dental + vision package for Medicare Supplement plan members.

Please see the *Blue Shield Dental plans and dental + vision package* flier in this enrollment kit for more information.

---

To sign up for Blue Shield dental coverage, select a plan below:

#### Dental plan options (check one):

- ☐ Specialty Duo dental + vision package<sup>SM\*</sup>
- ☐ Dental PPO 1000                      ☐ Dental PPO 1500                      ☐ No dental plan
- 

You can save \$3 each month for the first six months on your dental or dental + vision plan rates if you enroll in a dental or dental + vision plan **at the same time** you enroll in any Blue Shield Medicare Supplement plan.

---

#### Conditions of coverage

- Dental benefits aren't subject to any health plan deductible requirements.
  - If your dental or dental + vision coverage is cancelled for any reason (by you or by Blue Shield), you may apply for reinstatement, but you will have to wait six months to reapply.
- 

#### For two-party enrollment

If you are enrolled in a Medicare Supplement plan with a two-party contract, you may enjoy the convenience of a single bill and lower rates for you and your spouse/domestic partner. Keep the same convenience when you choose your dental plan by matching your dental PPO plan or dental + vision package enrollment with your Medicare Supplement plan enrollment. You and your spouse/domestic partner need to select and both enroll in the same dental PPO plan or dental + vision package in order to receive one bill that combines Medicare Supplement plan and dental PPO plan or dental + vision package rates. If only one of you wants to enroll in a dental PPO plan or dental + vision package, or if you each want different dental PPO plans or dental + vision package, your two-party agreement for the Medicare Supplement plan will be affected. In order to enroll in the dental plans or dental + vision package in this way, you will need to change your two-party contract and rate to individual contracts and single-party rates.

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). Specialty Duo package includes both Specialty Duo Dental Plan and Specialty Duo Vision Plan for Medicare Supplement plan members.





## NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT OR MEDICARE ADVANTAGE COVERAGE

Blue Shield of California, 6300 Canoga Avenue, Woodland Hills, CA 91367

### Save this notice! It may be important to you in the future.

According to your application, you intend to lapse or otherwise terminate an existing Medicare Supplement policy or contract or Medicare Advantage plan and replace it with a contract to be issued by Blue Shield. Your contract to be issued by Blue Shield will provide 30 days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or plan contract only if, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

#### Statement to applicant by plan, solicitor, solicitor firm or other representative:

- (1) I have reviewed your current medical or health coverage. To the best of my knowledge, the replacement of coverage involved in this transaction does not duplicate coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement contract is being purchased for the following reason (check one):
  - ☐ Additional benefits
  - ☐ No change in benefits, but lower premiums or charges
  - ☐ Fewer benefits and lower premiums or charges
  - ☐ Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D
  - ☐ Disenrollment from a Medicare Advantage plan
  - ☐ Reasons for disenrollment: Other (please specify): \_\_\_\_\_
- (2) If the issuer of the Medicare supplement contract being applied for does not impose, or is otherwise prohibited from imposing, preexisting condition limitations, please skip to statement 3 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.
- (3) State law provides that your replacement Medicare Supplement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.
- (4) If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.
- (5) **Do not cancel your present Medicare Supplement coverage until you have received your new contract and are sure you want to keep it.**

\_\_\_\_\_  
(Signature of Solicitor, Solicitor Firm, or Other Representative)

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Typed Name of Plan, Solicitor, or Solicitor Firm)

\_\_\_\_\_  
(Date – Month, Day, Year)

\_\_\_\_\_  
(Mailing Address of Plan, Solicitor's, or Solicitor's Firm)





## NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT OR MEDICARE ADVANTAGE COVERAGE

Blue Shield of California, 6300 Canoga Avenue, Woodland Hills, CA 91367

### Save this notice! It may be important to you in the future.

According to your application, you intend to lapse or otherwise terminate an existing Medicare Supplement policy or contract or Medicare Advantage plan and replace it with a contract to be issued by Blue Shield. Your contract to be issued by Blue Shield will provide 30 days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or plan contract only if, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

#### Statement to applicant by plan, solicitor, solicitor firm or other representative:

- (1) I have reviewed your current medical or health coverage. To the best of my knowledge, the replacement of coverage involved in this transaction does not duplicate coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement contract is being purchased for the following reason (check one):
  - ☐ Additional benefits
  - ☐ No change in benefits, but lower premiums or charges
  - ☐ Fewer benefits and lower premiums or charges
  - ☐ Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D
  - ☐ Disenrollment from a Medicare Advantage plan
  - ☐ Reasons for disenrollment: Other (please specify): \_\_\_\_\_
- (2) If the issuer of the Medicare supplement contract being applied for does not impose, or is otherwise prohibited from imposing, preexisting condition limitations, please skip to statement 3 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.
- (3) State law provides that your replacement Medicare Supplement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.
- (4) If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.
- (5) **Do not cancel your present Medicare Supplement coverage until you have received your new contract and are sure you want to keep it.**

\_\_\_\_\_  
(Signature of Solicitor, Solicitor Firm, or Other Representative)

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Typed Name of Plan, Solicitor, or Solicitor Firm)

\_\_\_\_\_  
(Date – Month, Day, Year)

\_\_\_\_\_  
(Mailing Address of Plan, Solicitor's, or Solicitor's Firm)



dental plan and  
package options for  
Medicare Supplement plan  
members







# Affordable dental plan and package options for Medicare Supplement plan members

Last updated: January 2016

Blue Shield of California rates effective: April 1, 2016

# Something to smile about

## Make the choice, make it Blue Shield

As a Blue Shield Medicare Supplement plan member, you're eligible for dental or combined dental + vision coverage. Blue Shield offers two comprehensive dental PPO plans and a dental and vision plan package – Specialty Duo<sup>SM</sup><sup>1</sup> – that includes comprehensive dental and vision coverage to give you the additional protection that both your mouth and eyes deserve.

## Good reasons to enroll

### Dental plan advantages:

- An extensive network of more than 37,000 general and specialty care dentist locations in California, and over 297,500 nationwide<sup>2</sup>
- Three annual teeth cleanings, plus annual X-rays and oral cancer screening covered at 100% when using network providers
- No waiting period for dental checkups, cleanings, fillings, X-rays or basic services
- Wide range of major restorative dental services and procedures, including crowns, endodontics, periodontics, oral surgery and prosthetics at low network rates<sup>3</sup>

### Specialty Duo<sup>SM</sup> dental + vision package advantages:

- Includes all dental benefits of the Dental PPO 1500 plan
- Access to more than 6,700 ophthalmologists, optometrists, opticians and retail stores in California, and over 22,000 locations nationwide<sup>2</sup>
- A \$0 copayment for annual eye exam
- A \$25 copayment for materials such as lenses and low-vision aids
- A \$100 frame allowance that can be used toward any pair of frames
- Benefit for non-prescription sunglasses for members who have had LASIK or PRK surgery

## Get covered

When you consider it, you can't afford to be without dental or dental + vision coverage. And with Blue Shield's dental plans, you can have the dental or the dental + vision coverage you've always wanted.

### Monthly rates effective April 1, 2016:

|                        | Specialty Duo dental + vision package <sup>1</sup> | Dental PPO 1500 | Dental PPO 1000 |
|------------------------|--|-----------------|-----------------|
| Individual             | \$58.60  | \$47.40         | \$35.90         |
| Two-party <sup>6</sup> | \$117.20   | \$94.80         | \$71.80         |

### Did you know?

You may be surprised to learn that more than 90% of all common diseases have oral symptoms.<sup>4</sup> In addition, eye exams can often detect serious chronic conditions such as diabetes, hypertension, and high cholesterol.<sup>5</sup> Whether you need treatment or just want preventive care, it's never too late to get on track and choose a Blue Shield dental or combined dental + vision coverage to help maintain your overall health.

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

## Choose from two dental PPO plans and the dental + vision package

With a Blue Shield dental PPO plan, you'll have the freedom to choose any dentist you want. However, your out-of-pocket costs for covered services will be lower when using a network dentist versus a non-network dentist. For more details, please refer to the following dental plan chart for the dental plan that suits you best.

### Dental PPO highlights matrix

The following information is intended to help you compare coverage benefits, and is a summary only. You should consult the *Evidence of Coverage and Health Service Agreement* for a detailed description of coverage benefits and limitations.

|  | <b>Dental PPO 1500</b>   |  | <b>Dental PPO 1000</b>   |  |
|--|--|--|--|--|
| <b>Calendar-year deductible</b> (per member)   | \$50/person  |  | \$75/person  |  |
| <b>Calendar-year maximum</b>   | \$1,500 (\$1,000 may be used for non-network dentist) <sup>7</sup> |  | \$1,000 (\$750 may be used for non-network dentist) <sup>7</sup> |  |
| <b>Service</b>   | <b>With network dentist, Blue Shield pays:</b>                     | <b>With non-network dentist,<sup>8</sup> Blue Shield pays:</b> | <b>With network dentist, Blue Shield pays:</b>                   | <b>With non-network dentist,<sup>8</sup> Blue Shield pays:</b> |
| <b>Diagnostic and preventive care</b><br>(not subject to plan deductibles with network dentists; includes routine oral exams, X-rays, and three teeth-cleanings annually)                                  | 100%   | 80%  | 100%   | 50%  |
| <b>Basic services</b><br>(includes anesthesia, palliative treatment, and restorative dentistry)  | 80%  | 70%  | 50%  | 50%  |
| <b>Major services<sup>3</sup></b><br>12-month waiting period (includes crown buildups, endodontics, periodontics, oral surgery, crowns, prosthetics, inlays, onlays, jacket, posts and cores, and veneers) | 50%  | 50%  | 50%  | 50%  |

# Specialty Duo dental + vision package for Medicare Supplement plan members\*,<sup>1</sup>



Want convenience? We've combined the benefits of the Dental PPO 1500 plan with comprehensive vision benefits into a single package. With the Specialty Duo dental + vision package, you also get the freedom to choose the providers of your choice, with access to one of the state's largest dental networks and one of the state's largest vision networks. For more details of the dental and vision components of this package, please refer to the benefit highlights below.

## Specialty Duo dental plan\*<sup>1</sup> highlight matrix

Offers the same benefits highlight as those of the Dental PPO 1500 plan. See the highlights matrix on page 2. For a complete list of the benefits, exclusions, and limitations of the Specialty Duo dental plan, please refer to the *Specialty Duo Dental plan for Medicare Supplement members*.

## Specialty Duo vision plan\*<sup>1</sup> highlight matrix

This chart is only a summary. For a complete list of the benefits, exclusions, and limitations of the Specialty Duo vision plan, please refer to the *Specialty Duo Vision plan for Medicare Supplement members*. There is a 90-day waiting period for vision care services.

| Service and eyewear   | Plan coverage when provided<br>by network providers | Plan coverage when provided<br>by non-network providers |
|---|---|---|
| <b>Comprehensive examination – every 12 months</b>  |   |   |
| Ophthalmologic  | 100%  | Up to a maximum of \$60                                 |
| Optometric  | 100%  | Up to a maximum of \$50                                 |
| <b>Lenses<sup>9,10</sup> – every 24 months</b> (or 12 months with a prescription change)          |   |   |
| Single vision   | 100%  | Up to a maximum of \$43                                 |
| Bifocal   | 100%  | Up to a maximum of \$60                                 |
| Trifocal  | 100%  | Up to a maximum of \$75                                 |
| Aphakic or lenticular monofocal   | 100%  | Up to a maximum of \$120                                |
| Aphakic or lenticular multifocal  | 100%  | Up to a maximum of \$200                                |
| <b>Frame – every 24 months</b>  | Up to a maximum of \$100 <sup>11</sup>              | Up to a maximum of \$40                                 |
| <b>Contact lenses<sup>10,12</sup> – every 24 months</b> (or 12 months with a prescription change) |   |   |
| Non-elective (medically necessary) <sup>14</sup>  |   |   |
| Hard  | 100%  | Up to a maximum of \$200                                |
| Soft  | 100%  | Up to a maximum of \$250                                |
| Elective contact lenses (cosmetic/convenience)  | Up to a maximum of \$120                            | Up to a maximum of \$120                                |
| <b>Plano sunglasses<sup>12,14</sup></b> (non-prescription)  | Up to a maximum of \$100 <sup>12</sup>              | Not covered   |

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

## For two-party agreement holders

If you are enrolled in a Medicare Supplement plan with a two-party agreement, you may enjoy the convenience of a single bill for you and your spouse or domestic partner. Keep the same convenience when you choose your dental plan by matching your dental plan or dental + vision package enrollment with your Medicare Supplement plan enrollment. You and your spouse or domestic partner need to select and enroll in the same dental PPO plan or dental + vision package.

If only one of you wants to enroll in the dental PPO plan or dental + vision package, or if you each want different plans, your two-party contract for the Medicare Supplement plan will be affected. To enroll in the dental plans in this way, you will need to change your two-party contract to an individual contract, then select the dental PPO or dental + vision package for you and your spouse or domestic partner.

## Become a member today!

If you are applying to become a Medicare Supplement plan member, sign up for a Blue Shield dental plan or the Specialty Duo dental + vision package by selecting a plan on the Medicare Supplement plan application. If you're already a Blue Shield Medicare Supplement plan subscriber, please fill out the separate application for our dental and dental + vision plans.

If you have questions, contact your Blue Shield agent today or call toll-free **(877) 890-7587**, 9 a.m. to 4:30 p.m. TTY users can call toll-free **711**, 8 a.m. to 6 p.m. weekdays, excluding holidays.

To find a dentist or vision care provider, or see if your dentist or vision care provider is in our network, visit **blueshieldca.com** and click on *Find a Provider*. Or for a list of dentists or vision care providers in your area, contact Member Services at **(888) 679-8928** or TTY at **711**, 8 a.m. to 5:30 p.m., Monday through Thursday, and 9 a.m. to 5:30 p.m. on Fridays, excluding holidays.

## Healthy teeth and eyes, healthy you

- 1 Specialty Duo package includes both Specialty Duo dental plan and Specialty Duo vision plan for Medicare Supplement plan members.
- 2 Dental providers in and out of California are available through a contracted dental plan administrator. Vision providers in and out of California are available through a contracted vision plan administrator.
- 3 Dental PPO 1000, Dental PPO 1500, and Specialty Duo dental plan for Medicare Supplement plan members have a 12-month waiting period for major restorative services and procedures (such as crowns), endodontics, periodontics, oral surgery and removable or fixed prosthetics.
- 4 "Prevent Oral Health Problems: Visit a Dentist Twice a Year," Academy of General Dentistry, January 2007.
- 5 "The Eyes are the Windows to Wellness," Employee Benefit News, August 1, 2009.
- 6 If you have a two-party Medicare Supplement plan contract, you and your spouse/ domestic partner need to select and enroll in the same dental PPO plan or dental + vision package in order to receive one bill that combines Medicare Supplement plan and dental PPO plan or dental + vision package rates.
- 7 Each calendar year, the member is responsible for all charges incurred after the plan has paid these amounts for covered dental services.
- 8 The coinsurance percentage indicated is a percentage of allowed amounts that we pay to providers. Non-network providers can charge more than our allowable amount. When members use non-network providers, they must pay the applicable copayment/coinsurance plus any amount that exceeds our allowable amount. Charges in excess of the allowable amount do not count toward the calendar-year deductible or copayment maximum.
- 9 Each pair of lenses includes a pink or rose tint No. 1 or No. 2 in the allowance and up to 61mm in size.
- 10 A prescription change means any of the following: a change in prescription of 0.50 diopter or more; a shift in axis of astigmatism of 15 degrees; a difference in vertical prism greater than 1 prism diopter; or a change in lens type.
- 11 When the participating provider uses wholesale or warehouse pricing, the maximum allowable frame allowance will be as follows: wholesale allowance – \$66.04; warehouse allowance – \$69.09. Note that this pricing replaces the frame allowance shown in the Summary of Benefits. Network providers using wholesale or warehouse pricing are identified in the Directory of Network Vision Providers. You pay any cost above the allowed amount.
- 12 In lieu of lenses and frame.
- 13 A report from the provider and prior authorization from a contracted vision plan administrator is required.
- 14 For members who have had PRK, LASIK or custom LASIK vision correction surgery only, this benefit of plano sunglasses allowance is equal to the plan's frame allowance. An eye exam by a network provider is required to verify laser surgery, or a note from the surgeon who performed the laser surgery is required to verify laser surgery. Available once every 24 months in lieu of other frames and lenses.

# Blue Shield Dental PPO Plan for Medicare Supplement Plan Subscribers

## **Disclosure Form**

Effective April 1, 2016

[blueshieldca.com](http://blueshieldca.com)

## Notice

This Disclosure Form is only a summary of the Dental PPO Plan. The *Evidence of Coverage and Health Service Agreement* (EOC) should be consulted to determine governing contractual provisions.

The EOC booklet contains the terms and conditions of coverage of the Blue Shield Dental PPO Plan. It is your right to view the EOC prior to enrollment in the Dental PPO Plan. After you enroll, you will automatically receive an EOC booklet.

Please read this Disclosure Form and the EOC carefully and completely so that you understand which services are covered and the limitations and exclusions that apply to the Dental PPO Plan. If you have special healthcare needs, you should read carefully those sections that apply to you. A Dental PPO Matrix summarizing key elements of the Dental PPO Plan is attached to this Disclosure Form.

To obtain a copy of the EOC, or if you have questions about the benefits of the Dental PPO Plan, please contact the Dental Customer Service Department at (888) 679-8928 or TTY (800) 241-1823.



| <b>Table of contents</b>  | <b>Page</b> |
|---|-------------|
| Introduction to the Blue Shield of California Dental PPO plan ..... | 4           |
| Principal benefits and coverages .....                              | 5           |
| Principal exclusions and limitations on benefits.....               | 5           |
| Prepayment fees.....  | 9           |
| Other charges.....  | 9           |
| Choice of providers .....   | 9           |
| Liability of subscriber or enrollee for payment .....               | 10          |
| Continuity of care by a terminated provider .....                   | 10          |
| Financial responsibility for continuity of care services.....       | 10          |
| Reimbursement provisions .....                                      | 11          |
| Utilization review .....  | 11          |
| Facilities.....   | 11          |
| Renewal provisions .....  | 11          |
| Termination of benefits .....                                       | 11          |
| Grievance process .....   | 13          |
| Ratio of healthcare services .....                                  | 13          |
| External independent medical review.....                            | 13          |
| Department of Managed Health Care review .....                      | 13          |
| Confidentiality of personal and health information.....             | 14          |
| Access to information .....   | 14          |
| Definitions .....   | 15          |
| Dental PPO Matrix.....  | 17          |
| Claims submission information.....                                  | 19          |

# Introduction to the Blue Shield of California Dental PPO Plan for Medicare Supplement Plan Subscribers

**This Plan is an individual dental PPO plan made available for Medicare Supplement Plan Subscribers. This is not a Medicare Supplement Plan.** Note: You must be currently enrolled in a Blue Shield of California Medicare Supplement Plan to be eligible to apply.

If you have questions about your Benefits, contact Blue Shield's Dental Customer Service before dental services are received.

Blue Shield of California's dental plans are designed to reduce the cost of dental care to you, the Subscriber. In order to reduce your costs, much greater responsibility is placed on you for managing the Benefits provided under the dental plans.

Blue Shield of California's dental plans are administered by a Dental Plan Administrator. A Dental Plan Administrator is a dental care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to underwrite and administer the delivery of dental services through a network of Participating Dentists.

## **Before Obtaining Dental Services**

You are responsible for assuring that the Dentist you choose is a Participating Dentist.

Note: A Participating Dentist's status may change. It is your obligation to verify whether the Dentist you choose is currently a Participating Dentist, in case there have been any changes to the list of Participating Dentists. A list of Participating Dentists located in your area can be obtained by contacting the Dental Plan Administrator at **(888) 679-8928**. You may also access a list of Participating Dentists through Blue Shield's Internet site located at **blueshieldca.com**. You are also responsible for following the Precertification of Dental Benefits Program, which includes obtaining or assuring that the Participating or non-participating Dentist obtains precertification of Benefits.

Note: The Dental Plan Administrator will respond to all requests for precertification and prior authorization within five business days from receipt of the request. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Subscriber, or when the Subscriber is experiencing severe pain, the Dental Plan Administrator will respond as soon as possible to accommodate the Subscriber's condition, not to exceed 72 hours from receipt of the request.

Failure to meet these responsibilities will not necessarily result in the denial of Benefits. However, by following the precertification process, both you and your Dentist will know in advance which services are covered and the Benefits that are payable.

### **Principal benefits and coverages**

The services covered, and the amount you pay, depend on the provider you choose when you need dental care. Please refer to the Dental PPO Matrix that is attached to and is part of this Disclosure Form. Also, refer to the EOC, which you will receive after you enroll. These documents offer more detailed information on the Benefits and coverage included in your Dental PPO Plan (Plan).

### **Principal exclusions and limitations on benefits**

#### **General Limitations**

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

- 1 One (1) in a four (4) month period:
  - a. Routine prophylaxis.
- 2 One (1) in a six (6) month period:
  - a. Periodic oral exam;
  - b. Bitewing x-rays (maximum four (4) per year);
  - c. Recementations if the crown or inlay was provided by other than the original dentist; not eligible if the dentist is doing the recementation of a service he/she provided within twelve (12) months;
3. One (1) in twelve (12) month period:
  - a. Denture (complete or partial) reline;
  - b. Oral cancer screening.
4. One in twenty-four (24) months:
  - a. Full mouth debridement;
  - b. Scaling and root planning per area;
  - c. Occlusal guards;
  - d. Diagnostic casts.
5. One in thirty-six (36) months:
  - a. Mucogingival surgery per area;
  - b. Osseous surgery per quad;
  - c. Gingival flap per quad;
  - d. Gingivectomy per quad;
  - e. Gingivectomy per tooth;
  - f. Bone replacement grafts for periodontal purposes;
  - g. Guided tissue regeneration for periodontal purposes.
6. One (1) in a five (5) year period:
  - a. Full mouth series and panoramic x-rays;
  - b. Single crowns;
  - c. Single post and core buildups;
  - d. Crown buildup including pins;
  - e. Prefabricated post and core;
  - f. Cast post and core in addition to crown;
  - g. Complete dentures;
  - h. Partial dentures;
  - i. Fixed partial denture (bridge) pontics;
  - j. Fixed partial denture (bridge) abutments;
  - k. Abutment post and core buildups;
  - l. Diagnostic cast.

7. Oral surgery services are limited to removal of teeth, bony protuberances and frenectomy.

8. An Alternate Benefit Provision (ABP) may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist. For example, an alternate of a partial denture will be applied when there are bilaterally missing teeth or more than 3 teeth missing in one quadrant or in the anterior region. The ABP does not commit the Member to the less costly treatment. However, if the Member and the dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed for the ABP.

9. General or IV Sedation is covered for:

- a. 3 or more surgical extractions;
- b. 1 or more impactions;
- c. Full mouth or arch alveoloplasty;
- d. Surgical root recovery from sinus;
- e. Medical problem contraindicates the use of local anesthesia.

General or IV Sedation is not a covered benefit for dental phobic reasons.

10. Restorations, crowns, inlays and onlays - covered only if necessary to treat diseased or accidentally fractured teeth.

11. Root canal treatment – one per tooth per lifetime.

12. Root canal retreatment – one per tooth per lifetime.

#### General exclusions

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

- 1. Charges for services in connection with any treatment to the gums for tumors, cysts, and neoplasms;
- 2. Charges for implants or the removal of implants (surgically or otherwise) and any appliances and/or crown attached to implants;

3. Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage, or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if the Dental Plan Administrator or Blue Shield of California provides payment for such services, it shall be entitled to establish a lien upon such other Benefits up to the amount paid by the Dental Plan Administrator or Blue Shield of California for the treatment of such injury or disease;
4. Charges for vestibuloplasty (i.e., surgical modification of the jaw, gums, and adjacent tissues), and for any procedure, service, or supply including office visits, examination, and diagnosis provided directly or indirectly to treat a muscular, neural, or skeletal disorder, diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint syndrome (TMJ) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint.
5. Congenital mouth malformations or skeletal imbalances, including treatment required as the result of Orthognathic surgery, orthodontic treatment, and oral maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging. Congenital anomalies and developmental malformation include but are not limited to: cleft palate; cleft lip; upper or lower jaw malformations (e.g., prognathism); enamel hypoplasia (defective development); fluorosis (a type of enamel discoloration); treatment involving or required by supernumerary teeth; and anodontia (congenitally missing teeth);
6. All prescription and non-prescription drugs;
7. Charges for services performed by a close relative or by a person who ordinarily resides in the Subscriber's home;
8. Services, procedures, or supplies which are not reasonably necessary for the care of the Subscriber's dental condition according to broadly accepted standards of professional care or which are Experimental or Investigational in Nature, or which do not have uniform professional endorsement;
9. Services, procedures, or supplies which are not reasonably necessary for the care of the Member's dental condition according to broadly accepted standards of professional care or which are Experimental or Investigational in Nature or which do not have uniform professional endorsement;
10. Procedures which are principally cosmetic in nature, such as bleaching, veneers, and personalization or characterization of dentures;
11. The replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, onlay, etc.) within five (5) years of its installation
12. Myofunctional therapy; biofeedback procedures; athletic mouth guards; precision or semi-precision attachments; denture duplication; oral hygiene instruction; treatment of jaw fractures; sealants;
13. Orthognathic surgery, including but not limited to, osteotomy, ostectomy, and other services or supplies to augment or reduce the upper or

lower jaw;

14. Charges for services in connection with orthodontia;
15. Alloplastic bone grafting materials;
16. Bone grafting done for socket preservation after tooth extraction or in preparation for implants;
- 17.. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
18. Extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues);
19. Dental services performed in a hospital or any related hospital fee;
20. Any service, procedure, or supply for which the prognosis for long-term success is not reasonably favorable as determined by the Dental Plan Administrator and its dental consultants;
21. For which the Subscriber is not legally obligated to pay, or for Covered Services for which no charge is made to the Subscriber;
22. Treatment as a result of accidental injury including setting of fractures or dislocation;
23. Treatment for which payment is made by any governmental agency, including any foreign government;
24. Charges for prosthetic appliances, fixed or removable, which are related to periodontal treatment;
25. Charges for onlays or crowns installed as multiple abutments;
26. Charges for dental appointments which are not kept;
27. Charges for services incident to any intentionally self-inflicted injury;
28. General anesthesia including intravenous and inhalation sedation, except when of Dental Necessity;  
  
General anesthesia is considered dentally necessary when its use is:

- a. In accordance with covered oral surgery procedures and generally accepted professional standards; and
- b. Not furnished primarily for the convenience of the patient, the attending Dentist, or other provider; or
- c. Due to the existence of a specific medical condition;

Patient apprehension or patient anxiety will not constitute Dental Necessity.

A Dental Plan Administrator reserves the right to review the use of general anesthesia to determine Dental Necessity;

29. Removal of 3rd molar (wisdom) teeth other than for Dental Necessity. Dental Necessity is defined as a pathological condition which includes horizontal, medial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericoronitis alone is not dental necessity;
30. Periodontal splinting of teeth by any method including, but not limited to, crowns, fillings, appliances or any other method that splints or connects teeth together;
31. Any service, procedure, or supply which is received or started prior to the Subscriber's Effective Date of coverage. For the purpose of this Limitation, the date on which a procedure shall be considered to have started is defined as follows:
  - a. For full dentures or partial dentures: on the date the final impression is taken;
  - b. For fixed bridges, crowns, onlays: On the date the teeth are first prepared;
  - c. For root canal therapy: on the

- later of the date the pulp chamber opened or the date canals are explored to the apex;
- d. For periodontal surgery: on the date the surgery is actually performed;
  - e. For all other services: on the date the service is performed.

- 32. Services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein.

### **Prepayment fees**

Monthly Dues for this Plan are attached to this Disclosure Form.

Initial Dues are payable on the Effective Date of this Plan, and subsequent Dues are payable on the same date of each succeeding month. All Dues must be paid to Blue Shield of California. Payment of Dues will continue the Benefits of this Plan

up to the date immediately before the next date due, but not after.

### **Other charges**

#### ***Deductibles, Copayments, and Benefit Maximums***

Certain Benefits of this Plan require the application of deductibles, Copayments, and charges in excess of benefit maximums and/or may be subject to maximum payments. Please refer to the Dental PPO Matrix, which is attached to this Disclosure Form, to find information regarding the Dues for the Plan, the various deductibles, and benefit maximums that are applicable to the Plan.

### **PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.**

#### **Choice of dental providers**

With Blue Shield of California's dental plans, you receive greater Benefits when using Dental Providers.

Dental Providers agree to accept the Dental Plan Administrator's payment,



plus your payment of any applicable deductible and Copayment, as payment in full for Covered Services. This is not true of non-participating Dentists.

In some instances, the non-participating Dentist's Allowable Amount may be higher than the Allowable Amount for a Dental Provider; however, if you go to a non-participating Dentist, your reimbursement for a service by that non-participating Dentist may be less than the amount billed. The Subscriber is responsible for all differences between the amount you are reimbursed and the amount billed by non-participating Dentists. It is therefore to your advantage to obtain dental services from participating Dental Providers.

Dental Providers submit claims for payment after their services have been rendered. These payments go directly to the Dental Provider. You or your non-participating Dentist also submits claims for payment after services have been rendered. If you receive services from non-participating Dentists, you have the option of having payments sent directly to the non-participating Dentist or sent directly to you. The Dental Plan Administrator will notify you of its determination within 30 days after receipt of the claim.

Dentists do not receive financial incentives or bonuses from Blue Shield of California.

A list of Dental Providers located in your area can be obtained by contacting the Dental Plan Administrator at (888) 702-4171. You may also access a list of Dental Providers through Blue Shield's Internet site located at [blueshieldca.com](http://blueshieldca.com).

### **Liability of Subscriber or enrollee for payment**

You are responsible for assuring that the Dentist you choose is a Dental Provider. A Dental Provider's status may change. It is your obligation to verify whether the Dentist you choose is currently a Dental Provider; in case there have been changes to the list of Dental Providers. You are also responsible for following the precertification of Benefits.

### **Continuity of care by a terminated provider**

Subscribers who are being treated for acute dental conditions, serious chronic dental conditions, or who have received authorization from a now-terminated provider for dental surgery or another dental procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving the Dental Plan Administrator's network of Participating Dentists. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

### **Financial responsibility for continuity of care services**

If a Subscriber is entitled to receive services from a terminated provider under the preceding continuity of care provision, the responsibility of the Subscriber to that provider for services rendered under the continuity of care provision shall be no greater than for the same services rendered by a Participating Dentist in the same geographic area.



## **Reimbursement provisions**

### **Procedure for filing a claim**

Claims for Covered Services should be submitted on a dental claim form which may be obtained from the Dental Plan Administrator or Blue Shield of California. Have your Dentist complete the form and mail it to the Dental Plan Administrator service center shown on the last page of this booklet.

The Dental Plan Administrator will provide payments in accordance with the provisions of the EOC and Health Services Agreement. You will receive an Explanation of Benefits after the claim has been processed.

All claims for reimbursement must be submitted to the Dental Plan Administrator within one year after the month of service. The Dental Plan Administrator will notify you of its determination within 30 days after receipt of the claim.

### **Utilization review**

State law requires that Plans disclose to Subscribers and providers the process used to authorize or deny services under the Plan.

Blue Shield has completed documentation of this process ("Utilization Review"), as required under Section 1363.5 of the California Health and Safety Code.

To request a copy of the document describing this utilization review process, call the Member Service Department at (800) 585-8111.

### **Facilities**

Directories of Dental Providers are available on our Web site **blueshieldca.com** or by calling (888) 702-4171.

## **Renewal provisions**

Blue Shield of California will offer to renew the agreement except in the following instances:

1. Non-payment of Dues;
2. Fraud, misrepresentation, or omission of information on the application;
3. Termination of Plan type by Blue Shield of California;
4. Termination of the Subscriber's Medicare Supplement Plan coverage.

## **Termination of Benefits**

### **Cancellation/reinstatement of the agreement**

1. Blue Shield of California may terminate your EOC and Health Services Agreement together with all like agreements by giving 90 days' written notice. No Subscriber shall be terminated individually by Blue Shield of California for any cause other than as provided under this section. A Subscriber desiring to terminate his or her EOC and Health Services Agreement shall give Blue Shield of California 30 days' written notice.

The EOC and Health Services Agreement may be cancelled by Blue Shield of California for false representations to, or concealment of, material facts from Blue Shield of California in any health statement, application, or any written instruction furnished to Blue Shield of California by the Subscriber at any time before or after issuance of the EOC and Health Services Agreement, or fraud or deception in enrollment. The EOC and Health Services Agreement may also be cancelled if the Subscriber fails or refuses to provide access to documents and other information that was provided in the application for coverage.

Cancellation in such instances shall be effective as of the original Effective Date of coverage, without prior notice to the Subscriber.

Blue Shield of California may terminate the EOC and Health Services Agreement for cause immediately upon written notice for the following:

- a. Material information that is false or misrepresented information provided on the enrollment application or given to Blue Shield of California;
- b. Permitting use of your Blue Shield of California ID card by someone other than yourself to obtain services;
- c. Obtaining or attempting to obtain services under the EOC and Health Services Agreement by means of false, materially misleading, or fraudulent information, acts, or omissions;
- d. Abusive or disruptive behavior which (1) threatens the life or well-being of Blue Shield of California personnel and providers of services; or (2) substantially impairs the ability of Blue Shield of California to arrange for services to the Subscriber; or (3) substantially impairs the ability of providers of service to furnish services to the Subscriber or to other patients.
- e. Blue Shield of California may terminate this Agreement for cause upon thirty (30) days' written notice if the Subscriber moves out of California.

Blue Shield of California shall, within 30 days of the notice of termination or cancellation, return to the Subscriber the amount of prepaid Dues, if any, minus any monies paid by Blue Shield of California for incurred claims that Blue Shield of California determines will not have been earned as of such terminating date. However, Blue Shield of California reserves the right to recoup all payments from the Subscriber for incurred charges,

which exceed the Dues, paid by the Subscriber, if the EOC and Health Services Agreement is cancelled for fraud or deception.

2. Cancellation of the EOC and Health Services Agreement for nonpayment of Dues:

If the EOC and Health Services Agreement is being cancelled because of failure to pay the required Dues when due, then coverage will end retroactively back to the last day of the month for which Dues were paid. This retroactive period will not exceed 60 days from the date of mailing of the Notice Confirming Termination of Coverage. Blue Shield of California will provide notice in a Prospective Notice of Cancellation if Dues have not been received. This notice will provide the following information:

1. That Dues due have not been paid, and that the EOC and Health Services Agreement will be cancelled if the required dues are not paid within 15 days from the date the Prospective Notice of Cancellation is mailed;
2. The specific date and time when coverage will end if Dues are not paid;
3. Information regarding the consequences of any failure to pay the Dues within 15 days.

Within five (5) business days of canceling or not renewing the EOC and Health Services Agreement, Blue Shield of California will mail a Notice Confirming Termination of Coverage, which will provide the following:

- a. That the EOC and Health Services Agreement has been cancelled, and the reasons for cancellation;
- b. The specific date and time when coverage ended;

- c. Information regarding the availability of reinstatement of coverage under the EOC and Health Services Agreement.
- 3. Cancellation for any reason of a Blue Shield dental plan (by yourself or Blue Shield), requires a wait period of 12 months from the date of cancellation before a Subscriber can reapply.

### **Grievance process**

Blue Shield of California has established a grievance procedure for receiving, resolving, and tracking subscribers' grievances with Blue Shield of California. For more information on this process, see the Grievance Process section of the EOC.

### **Ratio of dental services**

The minimum target loss ratio of premium costs to dental services excluding copayments, deductibles, and any member expenses is estimated to be 60%. This ratio was calculated after provider discounts were applied.

### **External independent medical review**

State law requires Blue Shield to disclose to members the availability of an external independent review process when your grievance involves a claim or services for which coverage was denied by Blue Shield or by a Dental Provider in whole or in part on the grounds that the service is not a dental necessity or is experimental or investigational. You may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. For further information about whether you qualify, or for more information about

how this review process works, see the External Independent Medical Review section in the EOC.

### **Department of Managed Health Care review**

The California Department of Managed Health Care is responsible for regulating healthcare service plans. If you have a grievance against your health Plan, you should first telephone your health Plan at the Customer Service number in your EOC, and use your health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an independent medical review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services.

The Department also has a toll-free telephone number (888) HMO-2219 and a TTY line, (877) 688-9891. The Department's Internet Web site, [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov), has complaint forms, IMR application forms, and instructions online.

In the event that Blue Shield should cancel or refuse to renew the enrollment

for you or your dependents, and you feel that such action was due to reasons of health or utilization of Benefits, you or your dependents may request a review by the Department of Managed Health Care Director.

### **Confidentiality of personal and health information**

Blue Shield is committed to protecting your personal and health information in each of the settings in which such information is received or exchanged.

When you complete an application for coverage, your signature authorizes Blue Shield to collect personal and health information that includes both your medical information and individually identifiable information about you, such as your address, telephone number, or other individual information. If you become a Blue Shield subscriber, this general consent allows Blue Shield to communicate with your physicians and other providers regarding treatment and payment decisions.

Blue Shield also participates in quality measurement activities that may require us to access your personal and health information. We have policies to protect this information from inappropriate disclosure, and we release this information only if aggregated or encoded. We will not disclose, sell, or otherwise use your personal and health information unless permitted by law and to the extent necessary to administer the health Plan. We will obtain written authorization from you to use your personal and health information for any other purpose. For any of our prospective or current members unable to give consent, we have a policy in place to protect your rights, and that permits your legally authorized

representative to give consent on your behalf. Blue Shield also will not release your personal and health information to your employer without your specific authorization, unless such release is permitted by law.

Through its contracts with providers, Blue Shield has policies in place to allow you to inspect your medical records maintained by your provider and, when needed, to include a written statement from you. You also have the right to review personal and health information that may be maintained by Blue Shield.

If you are a prospective, current, or former member and need more detailed information about Blue Shield's Corporate Confidentiality policy, it is available on Blue Shield's Web site at **blueshieldca.com** or by calling Customer Service.

A statement describing blue shield's policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

### **Access to Information**

Blue Shield of California may need information from medical providers, from other carriers or other entities, or from you, in order to administer benefits and eligibility provisions of this agreement. You agree that any provider or entity can disclose to Blue Shield of California that information that is reasonably needed by Blue Shield of California. You agree to assist

Blue Shield of California in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield of California with information in your possession. Failure to assist Blue Shield of California in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of benefits until the necessary information is received. Any information received for this purpose by Blue Shield of California will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

## Definitions

**Allowable Amount** – The Dental Plan Administrator Allowance (as defined below) for the Covered Service (or Covered Services) rendered, or the provider's billed charge, whichever is less. The Dental Plan Administrator Allowance is:

1. The amount the Dental Plan Administrator has determined is an appropriate payment for the Covered Service(s) rendered in the provider's geographic area, based upon such factors as the Dental Plan Administrator's evaluation of the value of the Covered Service(s) relative to the value of other Covered Services, market considerations, and provider charge patterns; or
2. Such other amount as the Participating Dentist and the Dental Plan Administrator have agreed will be accepted as payment for the Covered Service(s) rendered; or
3. If an amount is not determined as described in either 1 or 2 above, the

amount the Dental Plan Administrator determines is appropriate considering the particular circumstances and the Covered Services rendered.

**Benefits (Covered Services)** – Those services which a Subscriber is entitled to receive pursuant to the terms of the EOC and Health Services Agreement.

**Copayment** – The fixed dollar amount or a percentage of charges that the Subscriber pays. The Copayment and deductible are the Subscriber's share of the costs of Covered Services.

**Covered Services (Benefits)** – Those services which a Subscriber is entitled to receive pursuant to the terms of the EOC and Health Services Agreement.

**Dental Care Services** – Necessary treatment on or to the teeth or gums, including any appliance or device applied to the teeth or gums, and necessary dental supplies furnished incidental to Dental Care Services.

**Dental Plan Administrator (DPA)** – Blue Shield of California has contracted with the Plan's Dental Plan Administrators. A DPA is a dental care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to underwrite and administer delivery of dental services through a network of Participating Dentists. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from non-participating Dentists.

**Dental Provider** – A Doctor of Dental Surgery who has signed a service contract with the Dental Plan Administrator to provide dental services to Subscribers.

**Dentist** – A duly licensed doctor of dental surgery or other practitioner who is legally



entitled to practice dentistry in the state of California.

**Disclosure Form** – The Disclosure Form is a summary of the Dental PPO Plan.

**Dues** – The monthly pre-payment that is made to Blue Shield of California on behalf of each Subscriber.

**Effective Date** – The date on which an applicant, who has met the enrollment and prepayment requirements of the EOC and Health Services Agreement, is accepted by Blue Shield of California as a Subscriber. The Effective Date for any endorsement shall be the same unless otherwise stated.

**Experimental or Investigational**

**in Nature** – Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical/dental standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the federal government or any agency thereof, or by any state government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered Experimental or Investigational in Nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical/dental standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered Experimental or Investigational in Nature.

**Limitation** – Means any provision other than an exception or a reduction, which restricts coverage under the Plan.

**Participating Dentist** – A Doctor of dental surgery who has signed a service contract with the Dental Plan Administrator to provide dental services to Subscribers.

**Plan** – The Blue Shield of California Dental PPO Plan.

**Subscriber** – An individual who satisfies the eligibility requirements of the agreement, and who is enrolled and accepted by Blue Shield of California as a Subscriber, and has maintained Plan membership in accord with the EOC and Health Services Agreement.

## Dental PPO Matrix

This matrix is a summary only. The *Disclosure* and *Plan Contract* should be consulted for a detailed description of coverage Benefits and limitations.

**THIS CONTRACT IS NOT A MEDICARE SUPPLEMENT. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.**

|  | Dental PPO 1000                                      |                                  | Dental PPO 1500  |                                  |
|--|--|----------------------------------|--|----------------------------------|
|  | Participating<br>Dentist                             | Non-<br>Participating<br>Dentist | Participating<br>Dentist                               | Non-<br>Participating<br>Dentist |
| <b>Deductible</b>  | \$75/person  |                                  | \$50/person  |                                  |
| <b>Calendar-year maximum</b>   | \$1,000 (\$750 may be used for non-network dentists) |                                  | \$1,500 (\$1,000 may be used for non-network dentists) |                                  |
| <b>Diagnostic and preventive care</b><br>(not subject to plan deductibles with network dentists; includes routine oral exams, X-rays, and cleanings)       | 100%   | 50%                              | 100%   | 80%                              |
| <b>Basic Services</b> (includes anesthesia, emergency treatment to relieve pain, restorative dentistry, sealants, and space maintainers)                   | 50%  | 50%                              | 80%  | 70%                              |
| <b>Major Services<sup>2</sup></b><br>12-month waiting period (includes crown buildups, crowns, prosthetics, onlays, jackets, posts and cores, and veneers) | 50%  | 50%                              | 50%  | 50%                              |

<sup>1</sup> The coinsurance percentage indicated is a percentage of allowed amounts that we pay to providers. Non-network providers can charge more than our Allowable Amount. When members use non-network providers, they must pay the applicable Copayment/coinsurance plus any amount that exceeds our Allowable Amount. Charges in excess of the Allowable Amount do not count toward the calendar-year deductible or copayment maximum.

<sup>2</sup> Dental PPO members have a 12-month waiting period for major restorative services and procedures (such as crowns), and removable fixed prosthetics.

Monthly rates

|                              | Dental PPO 1000 | Dental PPO 1500 |
|------------------------------|-----------------|-----------------|
| <b>Individual</b>            | \$35.90         | \$47.40         |
| <b>Two-party<sup>3</sup></b> | \$71.80         | \$94.80         |

<sup>3</sup> Both you and your spouse or domestic partner must be enrolled in a Blue Shield Medicare Supplement plan with a two-party agreement to be eligible for this combined billing option for the dental PPO plan.



### **Claims submission information**

For pre-admission review and for claims submission and information contact Blue Shield of California.

By phone, call Dental Customer Services at  
**(888) 679-8928**

By mail, please direct correspondence to:  
Blue Shield of California  
P.O. Box 272590  
Chico, CA 95927-2590

An Independent Member of the Blue Shield Association A11817 (1/16)



# Disclosure

Specialty Duo Dental Plan

For Medicare Supplement Members

# Blue Shield Life Disclosure Form: Specialty Duo Dental Plan For Medicare Supplement Members

This Disclosure Form is only a summary of your dental plan. The Dental Service Policy should be consulted to determine the terms and conditions governing your coverage. The Certificate of Insurance (COI) booklet describes the terms and conditions of coverage of your Blue Shield Life dental plan. It is your right to view the COI prior to enrollment in the dental plan.

To obtain a copy of the COI or if you have questions about the Benefits of the Plan, please contact the Dental Customer Service Department at (888) 679-8928. The hearing impaired may contact Customer Service by calling the TTY number at (977) 218-7138.

Please read this Disclosure Form carefully and completely so that you understand which services are covered Dental Care Services, and the limitations and exclusions that apply to the Plan.

A benefit summary, summarizing key elements of the Blue Shield Life Dental Plan you are being offered, is provided with this Disclosure Form to assist you in comparing dental plans available to you.

## IMPORTANT

If you opt to receive dental services that are not covered services under this Plan, a Participating Dental Provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at (888) 702-4171 or your insurance broker. To fully understand your coverage, you may wish to carefully review this Disclosure document.

## Table of Contents

|   |    |
|---|----|
| Choice of Dentists .....                                      | 1  |
| Liability of Subscriber or Enrollee for Payment .....         | 1  |
| Facilities.....   | 1  |
| Service Area .....  | 1  |
| Continuity of Care by a Terminated Dentist.....               | 2  |
| Financial Responsibility for Continuity of Care Services..... | 2  |
| Utilization Review .....                                      | 2  |
| Principal Benefits and Coverages.....                         | 2  |
| Principal Exclusions and Limitations on Benefits.....         | 2  |
| GeneralExclusions.....  | 2  |
| Dental Necessity Exclusion.....                               | 4  |
| Alternate Benefit Provision.....                              | 5  |
| General Limitations .....                                     | 5  |
| Premiums.....   | 6  |
| Other Charges .....   | 6  |
| Deductible .....  | 6  |
| Coinsurance and Benefit Maximums .....                        | 6  |
| Plan Changes .....  | 7  |
| Duration of Policy.....                                       | 7  |
| Renewal of Policy.....  | 7  |
| Termination/Reinstatement of the Policy .....                 | 7  |
| Grace Period .....  | 8  |
| Grievance Process .....                                       | 9  |
| California Department of Insurance Review .....               | 9  |
| Confidentiality of Personal and Health Information .....      | 10 |
| Definitions.....  | 10 |

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOUR DENTAL CARE MAY BE OBTAINED.

The Specialty Duo (Dental + Vision) Plan package for Medicare Supplement members consists of a dental plan and a vision plan which is offered at a package rate. This Policy describes the Benefits of the Specialty Duo Dental Plan for Medicare Supplement members, the dental plan in the Specialty Duo (Dental + Vision) package for Medicare Supplement members.

Blue Shield Life's dental plans are administered by a Dental Plan Administrator (DPA) which is an entity that contracts with Blue Shield Life to underwrite and administer the delivery of dental services through a network of Participating Dentists.

## **Choice of Dentists**

The Specialty Duo Dental Plan Smile PPO for Medicare Supplement members is specifically designed for you to use Participating Dentists. Participating Dentists agree to accept a Dental Plan Administrator's payment, plus your payment of any applicable Deductible and Copayment/Coinsurance, as payment in full for Covered Services. This is not true of Non-Participating Dentists.

Participating Dentists submit claims for payment after Dental Care Services have been rendered. Payments for these claims go directly to the Participating Dentist. You or your Non-Participating Dentists submit claims for reimbursement after services have been rendered. If you receive Dental Care Services from Non-Participating Dentists, you have the option of having payments sent directly to the Non-Participating Dentist or sent directly to you. A Dental Plan Administrator will notify you of its

determination within 60 days after receipt of the claim.

Participating Dentists do not receive financial incentives or bonuses from Blue Shield Life.

You may access a Directory of Participating Dentists through Blue Shield Life's Internet site located at <http://www.blueshieldca.com>. The names of Participating Dentists in your area may also be obtained by contacting a Dental Plan Administrator at 1-888-679-8928.

## **Liability of Subscriber or Enrollee for Payment**

You are responsible for assuring that the Dentist you choose is a Participating Dental Provider. A Participating Dental Provider's status may change. It is your obligation to verify whether the Dentist you choose is currently a Participating Dental Provider; in case there have been changes to the list of Participating Dentists. You are also responsible for following the Precertification of Program.

## **Facilities**

Directories of Participating Dentists are available on our website [Blueshieldca.com](http://Blueshieldca.com) or by calling (888) 702-4171.

## **Service Area**

The Service Area of this Plan is identified in the Dental Provider Directory. You and your eligible Dependents must live or work in the Service Area identified in those documents to enroll in this Plan and to maintain eligibility in this Plan.

## **Continuity of Care by a Terminated Dentist**

Insureds who are being treated for acute dental conditions, serious chronic dental conditions, or who are children from birth to 36 months of age; or who have received authorization from a now-terminated provider for dental surgery or another dental procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving the Dental Plan Administrator's network of Participating Dentists. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

## **Financial Responsibility for Continuity of Care Services**

If a Insured is entitled to receive Services from a terminated dentist under the preceding Continuity of Care provision, the responsibility of the Insured to that dentist for Services rendered under the Continuity of Care provision shall be no greater than for the same Services rendered by a Participating Dental Provider in the same geographic area.

## **Utilization Review**

State law requires that insurers disclose to Insureds and providers the process used to authorize or deny services under the Plan.

Blue Shield Life has completed documentation of this process ("Utilization Review"), as required under Section 10123.135 of the California Insurance Code.

To request a copy of the document describing this Utilization Review process, call the Member Service Department at (800) 585-8111.

## **Principal Benefits and Coverages**

The Benefits of the Plan are listed in the Benefits Summary which is provided as part of this booklet. Blue Shield Life payments for these Services, if applicable, are also listed in the Benefit Summary.

## **Principal Exclusions and Limitations on Benefits**

### **General Exclusions**

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

1. Charges for services in connection with any treatment to the gums for tumors, cysts and neoplasms;

2

. Charges for implants or the removal of implants (surgically or otherwise) and any appliances and/or crown attached to implants;

3. Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers compensation law, occupational disease law or similar legislation. However, if a contracted Dental Plan Administrator or Blue Shield Life provides payment for such services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by a contracted Dental Plan Administrator or Blue Shield Life for the treatment of such injury or disease;

4. Charges for vestibuloplasty (i.e., surgical modification of the jaw, gums and adjacent tissues), and for any procedure, service, or supply including office visits, examination, and diagnosis provided directly or indirectly to treat a muscular, neural, or skeletal

disorder, diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint syndrome (TMJ) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint ; 5. Charges for services performed by a close relative or by a person who ordinarily resides in the Member's home;

6. Congenital mouth malformations or skeletal imbalances, including treatment required as the result of Orthognathic surgery, orthodontic treatment, and oral maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging. Congenital anomalies and developmental malformation include but are not limited to: cleft palate; cleft lip; upper or lower jaw malformations (e.g., prognathism); enamel hypoplasia (defective development); fluorosis (a type of enamel discoloration); treatment involving or required by supernumerary teeth; and anodontia (congenitally missing teeth);

7. All prescription and non-prescription drugs;

8. Services, procedures, or supplies which are not reasonably necessary for the care of the Insured's dental condition according to broadly accepted standards of professional care or which are Experimental or Investigational in nature or which do not have uniform professional endorsement;

9. Services and/or appliances that alter the vertical dimension, including, but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition,

erosion or abrasion, appliances or any other method;

10. Procedures which are principally cosmetic in nature, including, but not limited to, bleaching, veneer facings, crowns, personalization or characterization of crowns, bridges and/or dentures;

11. The replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, inlay or onlay, etc.) which has been either lost or stolen within five (5) years of its installation;

12. Myofunctional therapy; biofeedback procedures;athletic mouth-guards; precision or semiprecision attachments; denture duplication; treatment of jaw fractures;

13. Orthognathic surgery, including but not limited to, osteotomy, ostectomy, and other services or supplies to augment or reduce the upper or lower jaw;

14. Charges for services in connection with orthodontia;

15. Alloplastic bone grafting materials;

16.Bone grafting done for socket preservation after tooth extraction or in preparation for implants;

17. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;

18. Any procedure not performed in a dental office setting;

19. Extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues);

20. Dental services performed in a hospital or any related hospital fee;



21. Any service, procedure, or supply for which the prognosis for long term success is not reasonably favorable as determined by a contracted Dental Plan Administrator and its dental consultants;

22. Services for which the Insured is not legally obligated to pay, or for Services for which no charge is made;

23. Treatment as a result of accidental injury including setting of fractures or dislocation;

24. Treatment for which payment is made by any governmental agency, including any foreign government;

25. Charges for prosthetic appliances, fixed or removable, which are related to periodontal treatment; 26. Charges for onlays or crowns installed as multiple abutments;

27. Charges for dental appointments which are not kept;

28. Charges for any inlay restoration;

29. Charges for services incident to any intentionally self-inflicted injury;

30. General anesthesia including intravenous and inhalation sedation, except when of dental necessity.

General anesthesia is considered Dentally Necessary when its use is:

a) In accordance with generally accepted professional standards; and

b) Not furnished primarily for the convenience of the patient, the attending Dentist, or other provider;

c) Due to the existence of a specific medical

condition. Patient apprehension or patient anxiety will not constitute Dental Necessity. A contracted Dental Plan Administrator reserves the right to review the use of general anesthesia to determine Dental Necessity;

31. Removal of 3rd molar (wisdom) teeth other than for Dental Necessity. Dental Necessity is defined as a pathological condition which includes horizontal, medial or distal impactions, or cystic sequelae. Removal of wisdom teeth due to pericoronitis alone is not dental necessity.

32. Periodontal splinting of teeth by any method including, but not limited to, crowns, fillings, appliances or any other method that splints or connects teeth together;

33. For services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein; and

34. Any service, procedure, or supply which is received or started prior to the patient's effective date of coverage. For the purpose of this limitation, the date on which a procedure shall be considered to have

a) For full dentures or partial dentures: on the date the final impression is taken,

b) For fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared,

c) For root canal therapy: on the later of the date the pulp chamber opened or the date canals are explored to the apex,

d) For periodontal surgery: on the date the surgery is actually performed,

e) For all other services: on the date the service is performed.

### **Dental Necessity Exclusion**

All services must be of Dental Necessity. The fact that a Dentist or other plan provider may prescribe, order, recommend, or approve a service or supply does not, in itself, determine Dental Necessity.

### **Alternate Benefits Provision**

If dental standards indicate that a condition can be treated by a less costly alternative to the service proposed by the attending Dentist, the contracted Dental Plan will pay Benefits based upon the less costly service.

### **General Limitations**

The following services, if listed on the Schedule of Benefits, will be subject to Limitations as set forth below:

1. One (1) in a four (4) month period
  - a. Routine prophylaxis
2. One (1) in a six (6) month period:
  - a) Periodic oral exam;
  - b) Bitewing x-rays, maximum for (4) per occurrence; and
  - c) Recementations if the crown was provided by other than the original dentist; not eligible if the dentist is doing the recementation of a service he/she provided within twelve months;
3. One (1) in twelve (12) month period:
  - a) Denture (complete and partial) relines; and
  - b) Oral cancer screening;
4. One in twenty-four (24) months:
  - a) Full mouth debridement;
  - b) Scaling and root planing per area (limited to two (2) quadrants per visit);
  - c) Occlusal guards;
5. One (1) in a thirty-six month period:
  - a) Mucogingival surgery per area;
  - b) Osseous surgery per quad;
  - c) Gingival flap surgery per quad;
  - d) Gingivectomy per quad;
  - e) Gingivectomy per tooth;
  - f) Bone replacement grafts for periodontal purposes;
  - g) Guided tissue regeneration for periodontal purposes
6. One (1) in a five (5) year period:
  - a) Full mouth series and panoramic x-rays;
  - b) Single crowns and onlays;
  - c) Single post and core buildups;
  - d) Crown buildup including pins;
  - e) Prefabricated post and core;
  - f) Cast post and core in addition to crown;
  - g) Complete dentures;
  - h) Partial dentures;
  - i) Fixed partial denture (bridge) pontics;
  - j) Fixed partial denture (bridge) abutments;
  - k) Abutment post and core buildups;
  - l) Diagnostic casts;
7. Oral surgery services are limited to removal of teeth, bony protuberances and frenectomy;
8. The Alternate Benefit Provision (ABP) may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist. For example, an alternate of a partial denture will be applied when there are bilaterally missing teeth or more than 3 teeth missing in one quadrant or in the anterior region. The ABP does not commit the Insured to the less costly treatment. However, if the Insured and the dentist choose the more

expensive treatment, the Insured is responsible for the additional charges beyond those allowed for the ABP;

9. General, IV or Inhalation Sedation is covered for:
- a) 3 or more surgical extractions;
  - b) Dentally Necessary impactions;
  - c) Full mouth or arch alveoloplasty;
  - d) Surgical root recovery from sinus;
  - e) Medical problem contraindicates local anesthesia;

General or IV Sedation is not a covered benefit for dental phobic reasons;

10. Restorations, crowns, and onlays – covered only if necessary to treat diseased or accidentally fractured teeth;
11. Root canal treatment – one per tooth per lifetime;
12. Root canal retreatment – one per tooth per lifetime.

## **Premiums**

Monthly Premiums are as stated in the Dental Policy Appendix. Blue Shield Life offers a variety of options and methods by which you may pay your Premiums. Please call Customer Service at 1-800-431-2809 to discuss these options or visit the Blue Shield Life internet site at <http://www.blueshieldca.com>.

Payments by mail are to be sent to:

Blue Shield Life  
P.O. Box 51827  
Los Angeles, CA 90051-6127

Additional Premiums may be charged in the event that a state or any other taxing authority imposes upon Blue Shield Life a tax or license fee, which is calculated upon, base Premiums or Blue Shield Life's gross

receipts or any portion of either. Premiums may increase from time to time as determined by Blue Shield Life. You will receive sixty (60) days written notice of any changes in the monthly Premiums for this Plan.

## **Other Charges**

### **Deductible**

For dental Plans with a Calendar Year deductible, the deductible applies to all Covered Services and supplies furnished by Participating and Non- Participating Dentists, except as specified in the Benefit Summary which is attached to and made a part of this Disclosure Form. It is the amount which you must pay out of pocket for charges that would otherwise be payable for Dental Care Services and supplies. Charges in excess of the Allowable Amount do not apply toward the deductible. This per Insured deductible applies separately to each covered Insured each Calendar Year, except that no more than the Family deductible amount is required of a Family in a Calendar Year.

The Calendar Year per Insured and Family deductible amounts, if applicable, are listed in the benefit summary.

### **Coinsurance and Benefit Maximums**

#### **Responsibilities**

After any applicable deductible has been satisfied, payments will be provided based on the Allowable Amount determined by the Dental Plan Administrator, to Participating and Non-Participating Dentists for the Benefits of this Plan, subject to the Coinsurance.

The maximum per Insured, per Calendar Year amount payable by Blue Shield Life for Covered Services and supplies provided by any combination of Participating Dentists

and Non-Participating Dentists is listed in the Benefit Summary.

**\*\*NOTE:** if your Plan provides Benefits for Orthodontia, a separate Calendar Year Benefit maximum applies to Orthodontic Services. See the Benefit Summary.

## **Plan Changes**

The Benefits and rates of the Plan are subject to change following at least 60 days' written notice by Blue Shield Life. Benefits for Services or supplies furnished on or after the effective date of any change in Benefits will be provided based on the change.

## **Duration of the Policy**

This Policy shall be renewed upon receipt of prepaid Premiums. Renewal is subject to Blue Shield Life's right to amend this Policy. Any change in Premiums or Benefits, including but not limited to Covered Services, Deductible, Copayment, Coinsurance, and Calendar Year Maximum Payment, are effective after 60 days notice to the Subscriber's address of record with Blue Shield Life.

## **Renewal of the Policy**

Blue Shield Life shall renew this Policy, except under the following conditions:

1. Non-payment of Premiums;
2. Fraud, misrepresentation, or omission;
3. Termination of plan type by Blue Shield Life;
4. Subscriber moves out of California or the Subscriber is no longer a Resident of California;
5. If a bona fide association arranged for the Subscriber's coverage under this

Policy, when that Subscriber's membership in the association ceases.

## **Termination / Reinstatement of the Policy**

This Policy may be terminated or cancelled as follows:

1. Termination by the Subscriber:  
A Subscriber desiring to terminate this Policy shall give Blue Shield Life 30 days written notice.
2. Termination by Blue Shield Life through cancellation:

Blue Shield Life may cancel this Policy immediately upon written notice for the following reasons:

- a. Fraud or deception in obtaining, or attempting to obtain, Benefits under this Policy;
- b. Knowingly permitting fraud or deception by another person in connection with this Policy, such as, without limitation, permitting someone to seek Benefits under this Policy, or improperly seeking payment from Blue Shield Life for Benefits provided;
- c. Abusive or disruptive behavior which:  
(1) threatens the life or well being of Blue Shield Life personnel and providers of Services; or (2) substantially impairs the ability of Blue Shield Life to arrange for Services to the Insured; or (3) substantially impairs the ability of providers of Service to furnish Services to the Insured or to other patients; or
- d. Failure or refusal to provide Blue Shield Life access to documents and

other information necessary to determine eligibility or to administer Benefits under the Plan.

Cancellation of the Policy under this section will terminate the Policy effective as of the date that written notice of termination is mailed to the Subscriber. It is not retroactive to the original Effective date of the Policy.

3. Termination by Blue Shield Life if Subscriber moves out of California:

Blue Shield Life may cancel this Policy upon thirty (30) days written notice if the Subscriber moves out of California.

Within 30 days of the notice of cancellation under sections 2 or 3 above, Blue Shield Life shall refund the prepaid Premiums, if any, that Blue Shield Life determines will not have been earned as of the termination date. Blue Shield Life reserves the right to subtract from any such Premiums refund any amounts paid by Blue Shield Life for Benefits paid or payable by Blue Shield Life prior to the termination date.

4. Termination by Blue Shield Life due to withdrawal of the Policy from the Market:

Blue Shield Life may terminate this Policy together with all like Policies to withdraw it from the market. In such instances you will be given 90 days written notice and the opportunity to enroll in any other individual dental Policy without regard to health status-related factors.

5. Cancellation of the Policy for Nonpayment of Premiums:

Blue Shield Life may cancel this Policy for failure to pay the required Premiums, when due. If the Policy is being cancelled because you failed to pay the

required Premiums when due, then coverage will end 30 days after the date for which these Premiums are due. You will be liable for all Premiums accrued while this Policy continues in force including those accrued during this 30 day grace period.

Within five (5) business days of canceling Policy, the Plan will mail you a Notice Confirming Termination of Coverage, which will inform you of the following:

- a. That the Policy has been cancelled, and the reasons for cancellation; and
- b. The specific date and time when all coverage under this Policy ended.

6. Reinstatement of the Policy after Termination for Non-Payment:

If the Policy is cancelled for nonpayment of Premiums the Plan will permit reinstatement of the Policy or coverage twice during any twelve-month period, without a change in Premiums and without consideration of your medical condition, if the amounts owed are paid within 15 days of the date the Notice Confirming Termination of Coverage is mailed to you.

If your request for reinstatement and payment of all outstanding amounts is not received within the required 15 days, or if the Policy is cancelled more than twice during the preceding twelve-month period, then the Plan is not required to reinstate you, and you will need to reapply for coverage. In this case, the Plan may impose different Premiums and consider your medical condition.

## Grace Period



After payment of the first Premiums, the Subscriber is entitled to a grace period of 31 days for the payment of any Premiums due. During this grace period, the Policy will remain in force. However, the Subscriber will be liable for payment of Premiums accruing during the period the Policy continues in force.

## **Grievance Process**

Subscribers, a designated representative, or a provider on behalf of the Subscriber, may contact the Dental Customer Service Department by telephone, letter or online to request a review of an initial determination concerning a claim or service. Subscribers may contact the Dental Customer Service Department at the telephone number as noted below. If the telephone inquiry to the Dental Customer Service Department does not resolve the question or issue to the Subscriber's satisfaction, the Subscriber may request a grievance at that time, which the Dental Customer Service Representative will initiate on the Subscriber's behalf.

The Subscriber, a designated representative, or a provider on behalf of the Subscriber, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Subscriber may request this Form from the Dental Customer Service Department. If the Subscriber wishes, the Dental Customer Service staff will assist in completing the grievance form. Completed grievance forms must be mailed to a Dental Plan Administrator at the address provided below. The Subscriber may also submit the grievance to the Dental Customer Service Department online by visiting <http://www.blueshieldca.com>.

1-888-679-8928

Blue Shield Life  
Dental Plan Administrator

425 Market Street, 12<sup>th</sup> Floor  
San Francisco, CA 94105

A Dental Plan Administrator will acknowledge receipt of a written grievance within five (5) calendar days. Grievances are resolved within 30 days.

The grievance system allows Subscribers to file grievances for at least 180 days following any incident or action that is the subject of the Subscriber's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

## **California Department of Insurance Review**

The California Department of Insurance is responsible for regulating health insurance. The Department's Consumer Communications Bureau has a toll-free number (1-800-927-HELP (4357) or TDD 1-800-482-4833) to receive complaints regarding health insurance from either the Insured or his or her provider. If you have a complaint against Blue Shield Life, you should contact Blue Shield Life first and use their grievance process. If you need the Department's help with a complaint or grievance that has not been satisfactorily resolved by Blue Shield Life, you may call the Department's toll-free telephone number from 8 a.m. – 6 p.m., Monday – Friday (excluding holidays). You may also submit a complaint in writing to: California Department of Insurance, Consumer Communications Bureau, 300 S. Spring Street, South Tower, Los Angeles, California 90013, or through the website <http://www.insurance.ca.gov>.

## **Confidentiality of Personal and Health Information**

Blue Shield Life 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 Life will not disclose this information without your authorization, except as permitted by law.

Blue Shield Life's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling the Customer Service Department at the number listed in the back of this booklet or accessing Blue Shield Life's Internet site located at <http://www.blueshieldca.com> and printing a copy.

If you are concerned that Blue Shield Life 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 Life Privacy Official  
P. O. Box 272540  
Chico, CA 95927-2540

Toll-Free Telephone Number:  
1-888-266-8080

E-mail Address:  
[BlueShieldca\\_Privacy@blueshieldca.com](mailto:BlueShieldca_Privacy@blueshieldca.com)

A STATEMENT DESCRIBING BLUE  
SHIELD LIFE'S POLICIES AND  
PROCEDURES FOR PRESERVING THE  
CONFIDENTIALITY OF MEDICAL

RECORDS IS AVAILABLE AND WILL BE  
FURNISHED TO YOU UPON REQUEST.

## **Definitions**

**Accidental Injury** - definite trauma resulting from a sudden, unexpected and unplanned event, occurring by chance, caused by an independent external source.

**Allowable Amount** — the Dental Plan Administrator Allowance (as defined below) for the Service (or Services) rendered, or the provider's Billed Charge, whichever is less.

The Dental Plan Administrator Allowance is:

1. the amount the Dental Plan Administrator has determined is an appropriate payment for the Service(s) rendered in the provider's geographic area, based upon such factors as the Dental Plan Administrator's evaluation of the value of the Service(s) relative to the value of other Services, market considerations, and provider charge patterns; or
2. such other amount as the Participating Dental Provider and the Dental Plan Administrator have agreed will be accepted as payment for the Service(s) rendered; or
3. If an amount is not determined as described in either (1.) or (2.) above, the amount the Dental Plan Administrator determines is appropriate considering the particular circumstances and the Services rendered.

**Benefits (Services)** — those services which an Insured is entitled to receive pursuant to the Dental Service Policy.

**Calendar Year** — a period beginning on January 1 of any year and terminating on January 1 of the following year.

**Close Relative** — the spouse, Domestic Partner, child, brother, sister, or parent of a Subscriber or Dependent.

**Coinsurance** — the percentage of the Allowable Amount that an Insured is required to pay for specific Covered Services after meeting any applicable deductible.

**Covered Services (Benefits)** - those Services which an Insured is entitled to receive pursuant to the terms of the Dental Policy.

**Dental Care Services** - Necessary treatment on or to the teeth or gums whether or not caused by Accidental Injury, including any appliance or device applied to the teeth or gums, and necessary dental supplies furnished incidental to Dental Care Services.

**Dental Necessity** - Services which are of Dental Necessity include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat dental disease or injury, and which, as determined by the Dental Plan Administrator, are:

1. Consistent with the symptoms or diagnosis; and
2. not furnished primarily for the convenience of the patient, the attending Dentist or other provider; and
3. furnished at the most appropriate level which can be provided safely and effectively to the patient.

**Dental Plan Administrator (DPA)** - A DPA is an entity that contracts with Blue Shield Life to and administer delivery of dental

services through a network of Participating Dentists.

**Dentist** — a licensed Doctor of Dental Surgery or Doctor of Dental Medicine.

**Dependent** —

1. a Subscriber's legally married spouse who is:
  - a. not covered for Benefits as a Subscriber; and
  - b. not legally separated from the Subscriber;or,
2. a Subscriber's Domestic Partner who is not covered for Benefits as a Subscriber; or,
3. a Subscriber's, spouse's, or Domestic Partner's unmarried child or child who is not one of the partners in a domestic partnership (including any stepchild or child placed for adoption or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction) who is not covered for Benefits as a Subscriber, and who is:
  - a. primarily Dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance; or
  - b. Dependent upon the Subscriber, spouse, or Domestic Partner for medical support pursuant to a court order; and is
  - c. less than 19 years of age; or



d. less than 25 years of age if enrolled as a full-time student and if proof of student status is submitted to and received by Blue Shield Life (Note: This item d. does not apply to a child of a legal guardian unless a court has specifically ordered that the guardianship continue beyond the attainment of age 19). Full-time student means a Dependent must be enrolled in a college, university, vocational, or technical school for a minimum of 12 units as an undergraduate, or 6 units as a graduate student; and who has been enrolled and accepted by Blue Shield Life as a Dependent and has maintained membership in accordance with the Policy.

4. If coverage for a Dependent child would be terminated because of the attainment of age 19 (or age 25, if Dependent has been a full-time student), and the Dependent child is disabled, Benefits for such Dependent will be continued upon the following conditions:

- a. the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;
- b. the Subscriber, spouse, or Domestic Partner submits to Blue Shield Life a Physician's written certification of disability within 60 days from the date of the Employer's or Blue Shield Life's request; and
- c. thereafter, certification of continuing disability and dependency from a Physician is submitted to Blue Shield Life on the following schedule:
  - (1) within 24 months after the month when the Dependent would

otherwise have been terminated; and

(2) annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage under this Plan for any reason other than attained age.

**Domestic Partner** — an individual who is personally related to the Subscriber by a domestic partnership that meets the following requirements:

- 1. Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring;
- 2. Both persons have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex Domestic Partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age.

The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

Emergency Services – Services provided for an unexpected dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- 1. Placing the patient's health in serious jeopardy;
- 2. serious impairment to bodily functions;
- 3. serious dysfunction of any bodily organ or part.

**Experimental or Investigational in Nature**

— any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical/dental standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered Experimental or Investigational in Nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical/dental standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered Experimental or Investigational in Nature.

**Family** — the Subscriber and all enrolled Dependents.

**Dental Policy (Policy)** — the Policy issued by the Plan that establishes the Services that Subscribers and Dependents are entitled to receive from the Plan.

**Insured** — either a Subscriber or an eligible Dependent.

**Non-Participating Dentist** — A Doctor of Dental Surgery or Doctor of Dental Medicine who has not signed a service contract with the Dental Plan Administrator to provide dental services to Insureds.

**Participating Dentist** — a Doctor of Dental Surgery or Doctor of Dental Medicine who has signed a service contract with the Dental Plan Administrator to provide dental services to Insureds.

**Plan** — the Blue Shield Life Specialty Duo Dental Plan for Medicare Supplement members and/or Blue Shield Life.

**Premiums** — the monthly pre-payment that is made to the Plan on behalf of each Insured.

**Service Area** — the geographic area served by the Plan.

**Subscriber** — An individual who satisfies the eligibility requirements of this Policy, and who is enrolled and accepted by the Plan as a Subscriber, and has maintained Plan membership in accord with this Policy.

# Disclosure

## Specialty Duo Vision Plan

### Disclosure for Medicare Supplement Members

An Independent Licensee of the Blue Shield Association

# Blue Shield Life Disclosure Form: Specialty Duo Vision Plan For Medicare Supplement Members

This Disclosure Form is only a summary of your vision Plan. The Vision Policy should be consulted to determine the terms and conditions governing your coverage.

The Certificate of Insurance (COI) booklet describes the terms and conditions of coverage of your Blue Shield Life vision Plan. It is your right to view the COI prior to enrollment in the vision Plan.

To obtain a copy of the COI, or if you have questions about the benefits of the Plan, please contact the vision customer service department at 1-877-601-9083. The hearing impaired may contact customer service by calling the 1-877-735-2929.

Please read this Disclosure Form carefully and completely so that you understand which services are covered Vision Care Services, and the limitations and exclusions that apply to the Plan.

A benefit summary, summarizing key elements of the Blue Shield Life Vision Plan you are being offered, is provided with this Disclosure Form to assist you in comparing vision plans available to you.

## IMPORTANT

If you opt to receive vision services that are not covered services under this Plan, a Participating Vision Provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with vision services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about vision coverage options, you may call member services at (888) 702-4171 or your insurance broker. To fully understand your coverage, you may wish to carefully review this Disclosure document.

## TABLE OF CONTENTS

|  |    |
|--|----|
| Waiting Period.....  | 4  |
| Choice of Providers .....                                      | 4  |
| Continuity of Care By a Terminated Provider.....               | 4  |
| Financial Responsibility for Continuity of Care Services ..... | 4  |
| Payment of Benefits .....                                      | 4  |
| Grace Period.....  | 5  |
| Covered Services and Supplies .....                            | 5  |
| General Exclusions and Limitations .....                       | 6  |
| Termination of Benefits .....                                  | 7  |
| Utilization Review .....                                       | 7  |
| Claims Review.....   | 7  |
| Monthly Premiums .....   | 7  |
| Renewal Provisions .....                                       | 8  |
| Duration of the Policy .....                                   | 8  |
| Termination/Reinstatement of the Policy.....                   | 8  |
| Grievance Process .....  | 10 |
| California Department of Insurance Review .....                | 10 |
| Definitions .....  | 11 |

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOUR VISION CARE MAY BE OBTAINED.

The Specialty Duo (Dental + Vision) Plan package for Medicare Supplement members consists of a dental plan and a vision plan which is offered at a package rate. This disclosure describes the Benefits of the Specialty Duo Vision Plan for Medicare Supplement members, the vision plan in the Specialty Duo (Dental + Vision) package for Medicare Supplement members.

Blue Shield Life's vision plans are administered by a Vision Plan Administrator (VPA) which is an entity that contracts with Blue Shield Life to administer delivery of eyewear and eye exams covered under this Vision Plan through a network of Participating Providers. The contracted VPA also contracts with Blue Shield Life to serve as a claims administrator for the processing of claims for services received from Non-Participating Providers.

### **WAITING PERIOD**

There is a ninety (90) day waiting period before any Benefits are available under this Plan. This Waiting Period begins on the Insured's Effective Date of coverage.

### **CHOICE OF PROVIDERS**

An Insured may select any licensed ophthalmologist, optometrist, or optician to provide Covered Services hereunder, including such providers outside of California. A Directory of

Participating Providers is available on Blue Shield Life's internet site located at [/www.blueshieldca.com](http://www.blueshieldca.com). You may also obtain this information from the VPA by calling the telephone number listed in this vision benefit.

### **CONTINUITY OF CARE BY A TERMINATED PROVIDER**

Insureds who are being treated for acute conditions, serious chronic conditions, or who are children from birth to 36 months of age, or who have received authorization from a now-terminated provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving a Vision Plan Administrator's network of Participating Providers. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

### **FINANCIAL RESPONSIBILITY FOR CONTINUITY OF CARE SERVICES**

If an Insured is entitled to receive Covered Services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Insured to that provider for Covered Services rendered under the Continuity of Care provision shall be no greater than for the same Covered Services rendered by a Participating provider in the same geographic area.

### **PAYMENT OF BENEFITS**

A Participating Provider will submit a claim for Covered Services online to the VPA or by claim form. Participating Providers will accept Blue Shield Life's payment for Covered Services as payment in full except as noted in the Benefit Summary.

When Covered Services are provided by a Non-Participating Provider, you or the Non-Participating Provider must submit a Vision Service Report Form (claim form C-4669-61) which can be obtained from our website located at [www.blueshieldca.com](http://www.blueshieldca.com). This form must be completed in full and submitted with all related receipts to:

Blue Shield Life  
P.O. Box 25208  
Santa Ana, California  
92799-5208

Covered services provided by a non-Participating Provider are reimbursed up to the Allowed Amount under the Benefit Summary. Blue Shield Life will send payments directly to you. You are responsible for the difference between the Non-Participating Provider's charges and the Allowed Amount under the Benefit Summary, as well as any applicable Copayment and charges for frames or lenses above the Allowed Amount.

Information regarding your benefits can be found by consulting your benefit information or by calling Blue Shield Life's customer service at 1-877-601-9083.

Providers do not receive financial incentives or bonuses from Blue Shield Life.

## **GRACE PERIOD**

After payment of the first Premium, the Subscriber is entitled to a grace period of 30 days for the payment of any Premium due. During this grace period, the Policy will remain in force. However, the Subscriber will be liable for payment of Premiums accruing during the period the Policy continues in force.

## **COVERED SERVICES AND SUPPLIES**

Covered Services under this Specialty Duo Vision Plan for Medicare Supplement members are limited to the following:

One comprehensive eye examination in a 12 consecutive-month period. A comprehensive examination represents a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service but need not be performed at one session. The service may include history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination for cycloplegia or mydriasis, tonometry and usually determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation.

You are responsible for a Copayment (as stated in the Summary of Benefits) for the purchase of frames, lenses or contact lenses.



One pair of spectacle lenses in a 24 consecutive-month period or at a 12 month interval if the examination indicates a Prescription Change.

One frame in a 24 consecutive-month period.

One pair of non-elective (medically necessary) contact lenses, which are lenses following cataract surgery; or when contact lenses are the only means to correct visual acuity to 20/40 for keratoconus or 20/60 for anisometropia; or for certain conditions of myopia (12 or more diopters), hyperopia (7 or more diopters) or astigmatism (over 3 diopters) when provided in lieu of other eyewear once every 24 consecutive months or at a 12 month interval if the examination indicates a Prescription Change. A report from the provider and prior authorization from the contracted VPA is required.

Elective Contact Lenses up to the benefit allowance (for cosmetic reasons or for convenience) when provided in lieu of other eyewear once every 24 consecutive months or at a 12 month interval if the examination indicates a Prescription Change.

The contact lens allowance may be used towards a contact lens fitting fee. You are responsible for requesting this information from your provider.

The plano (non-prescription) sunglasses benefit is for Employees only (not Dependents) and only for Employees who have had PRK, LASIK, or custom LASIK vision correction surgery. An eye exam by a

Participating Provider or a note from the surgeon who performed the laser surgery is required to verify laser surgery. The surgeon's note must be submitted with the claim for plano sunglasses. The plano sunglasses benefit is offered in lieu of the frame benefit, not in addition to the frame benefit. This benefit may only be obtained from Participating Providers and only once in a consecutive 24-month period.

## **GENERAL EXCLUSIONS AND LIMITATIONS**

### **GENERAL EXCLUSIONS**

Unless exceptions to the following are specifically made elsewhere in this booklet, no Benefits are provided for:

1. Orthoptics or vision training, subnormal vision aids or non-prescription lenses for glasses when no Prescription Change is indicated;
2. Replacement or repair of lost or broken lenses or frames except as provided under this Policy;
3. Any eye examination required by an employer as a condition of employment;
4. Medical or surgical treatment of the eyes;
5. Contact lenses, except as specifically provided;



6. Contact lens exams, fittings, or evaluations, except as specifically provided;
7. Services for or incident to any injury arising out of, or in the course of any employment for salary, wage or profit if such injury or disease is covered by workers' compensation law, occupational disease law or similar legislation. However, if Blue Shield Life provides payment for such services, it shall be entitled to establish a lien upon such other Benefits up to the amount paid by Blue Shield Life for the treatment of the injury or disease;
8. Services required by any government agency or program, Federal, state, or subdivision thereof;
9. Services and materials for which the Subscriber is not legally obligated to pay, or services or materials for which no charge is made to the Subscriber;
10. Services not specifically listed as a benefit; and
11. Comprehensive examination benefit does not include fitting fees for contact lenses.

## **TERMINATION OF BENEFITS**

Whenever this Policy provides for a date of commencement or termination of any part or all of the coverage herein, such commencement or termination shall be effective at 12:01 A.M. Pacific Time of the commencement date and as of 11:59 p.m. Pacific Time of the termination date.

## **UTILIZATION REVIEW**

State law requires insurers to disclose to insureds and providers the process used to authorize or deny services under the plan.

Blue Shield Life has documented this process ("utilization review"), as required under Section 10123.135 of the California Code.

To request a copy of the document describing this utilization review process, call the vision customer service department at 1-877-601-9083.

## **CLAIMS REVIEW**

The Plan reserves the right to review all claims to determine if any exclusions or limitations apply.

Blue Shield Life may use the Services of vision care consultants, peer review committees of professional societies, and other consultants to evaluate claims.

## **MONTHLY PREMIUMS**

Monthly Premiums are as stated in the Vision Policy. Blue Shield Life offers a variety of options and methods by which you may pay your Premiums. Please call Customer Service to discuss these options or visit the Blue Shield Life internet site at [www.blueshieldca.com](http://www.blueshieldca.com).

Payments by mail are to be sent to:

Blue Shield Life  
P.O. Box 51827  
Los Angeles, CA 90051-6127

Additional Premiums may be charged in the event that a state or any other taxing authority imposes upon Blue Shield Life a tax or license fee, which is calculated upon, base Premiums or Blue Shield Life's gross receipts or any portion of either. Premiums may increase from time to time as determined by Blue Shield Life. You will receive 60 days written notice of any changes in the monthly Premiums for this Plan.

## **RENEWAL PROVISIONS**

Blue Shield Life shall renew this Policy, except under the following conditions:

1. Non-Payment of Premiums;
2. Fraud, misrepresentations, or omission;
3. Termination of plan type by Blue Shield Life;
4. Subscriber moves out of California or the Subscriber is no longer a Resident of California;
5. If a bona fide association arranged for the Subscriber's coverage under this Policy, when that Subscriber's membership in the association ceases.

## **DURATION OF THE POLICY**

This Policy shall be renewed upon receipt of prepaid Premiums. Renewal is subject to Blue Shield Life's right to amend this Policy. Any change in Premiums or benefits, including but not limited to Covered Services, Deductible, Copayment, coinsurance, and Calendar Year

Maximum Payment, are effective after 60 days notice to the Subscriber's address of record with Blue Shield Life.

## **TERMINATION/REINSTATEMENT OF THE POLICY**

This Policy may be terminated or cancelled as follows:

1. Termination by the Subscriber:  
A Subscriber desiring to terminate this Policy shall give Blue Shield Life 30 days written notice.
2. Termination by Blue Shield Life through cancellation:  
Blue Shield Life may cancel this Policy immediately upon written notice for the following reasons:
  - a. Fraud or deception in obtaining, or attempting to obtain, benefits under this Policy;
  - b. Knowingly permitting fraud or deception by another person in connection with this Policy, such as, without limitation, permitting someone to seek benefits under this Policy, or improperly seeking payment from Blue Shield Life for benefits provided;
  - c. Abusive or disruptive behavior which: (1) threatens the life or well being of Blue Shield Life personnel and providers of Services; or (2) substantially impairs the ability of Blue Shield Life to arrange for Services to the Insured; or (3) substantially impairs the ability of providers of Service to furnish Services to the Insured or to other patients; or

Cancellation of the Policy under this section will terminate the Policy effective as of the date that written notice of termination is mailed to the Subscriber. It is not retroactive to the original Effective date of the Policy.

3. Termination by Blue Shield Life if Subscriber moves out of California:

Blue Shield Life may cancel this Policy upon thirty (30) days written notice if the Subscriber moves out of California. See the section entitled Transfer of Coverage for additional information.

Within 30 days of the notice of cancellation under sections 2 or 3 above, Blue Shield Life shall refund the prepaid Premiums, if any, that Blue Shield Life determines will not have been earned as of the termination date. Blue Shield Life reserves the right to subtract from any such Premiums refund any amounts paid by Blue Shield Life for benefits paid or payable by Blue Shield Life prior to the termination date.

4. Termination by Blue Shield Life due to withdrawal of the Policy from the Market:

Blue Shield Life may terminate this Policy together with all like Policies to withdraw it from the market. In such instances you will be given 90 days written notice and the opportunity to enroll in any other individual vision Policy without regard to health status-related factors.

5. Cancellation of the Policy for Nonpayment of Premiums:

Blue Shield Life may cancel this Policy for failure to pay the

required Premiums, when due. If the Policy is being cancelled because you failed to pay the required Premiums when due, then coverage will end 30 days after the date for which these Premiums are due. You will be liable for all Premiums accrued while this Policy continues in force including those accrued during this 30 day grace period.

Within five (5) business days of canceling Policy, the Plan will mail you a Notice Confirming Termination of Coverage, which will inform you of the following:

- a. That the Policy has been cancelled, and the reasons for cancellation; and
- b. The specific date and time when coverage for you ended.

6. Reinstatement of the Policy after Termination for Non-Payment:

If the Policy is cancelled for nonpayment of Premiums the Plan will permit reinstatement of the Policy or coverage twice during any twelve-month period, without a change in Premiums and without consideration of your medical condition, if the amounts owed are paid within 15 days of the date the Notice Confirming Termination of Coverage is mailed to you.

If your request for reinstatement and payment of all outstanding amounts is not received within the required 15 days, or if the Policy is cancelled more than twice during the preceding twelve-month period, then the Plan is not required to reinstate you, and you will need to reapply for coverage. In this case, the Plan may impose different Premiums and consider your medical condition.

The Benefits and rates of the Plan are subject to change following at least 60 days' written notice by Blue Shield Life. Benefits for Services or supplies furnished on or after the Effective Date of any change in Benefits will be provided based on the change.

## **GRIEVANCE PROCESS**

Subscribers, a designated representative, or a provider on behalf of the Subscriber, may contact the Vision Customer Service Department by telephone, letter or online to request a review of an initial determination concerning a claim or service. Subscribers may contact the Vision Customer Service Department at the telephone number as noted below. If the telephone inquiry to the Vision Customer Service Department does not resolve the question or issue to the Subscriber's satisfaction, the Subscriber may request a grievance at that time, which the Vision Customer Service Representative will initiate on the Subscriber's behalf.

The Subscriber, a designated representative, or a provider on behalf of the Subscriber, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Subscriber may request this Form from the Vision Customer Service Department. If the Subscriber wishes, the Vision Customer Service staff will assist in completing the grievance form. Completed grievance forms must be mailed to a Vision Plan Administrator at the address provided below. The Subscriber may also submit the grievance to the Vision

Customer Service Department online by visiting [www.blueshieldca.com](http://www.blueshieldca.com).

1-877-601-9083  
Vision Plan Administrator  
P. O. Box 25208  
Santa Ana, CA 92799-5208

A Vision Plan Administrator will acknowledge receipt of a written grievance within five (5) calendar days. Grievances are resolved within 30 days.

The grievance system allows Subscribers to file grievances for at least 180 days following any incident or action that is the subject of the Subscriber's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

## **CALIFORNIA DEPARTMENT OF INSURANCE REVIEW**

The California Department of Insurance is responsible for regulating health insurance. The Department's Consumer Communications Bureau has a toll-free number 1-800-927-HELP (4357) or TDD 1-800-482-4833 to receive complaints regarding health insurance from either the insured or his or her provider. If you have a complaint against Blue Shield Life, you should contact Blue Shield Life first and use their grievance process. If you need the Department's help with a complaint or grievance that has not been satisfactorily resolved by Blue Shield Life, you may call the Department's toll-free telephone number from 8am – 6pm, Monday – Friday (excluding holidays). You may

also submit a complaint in writing to:

California Department of Insurance  
Consumer Communications Bureau  
300 S. Spring Street, South Tower  
Los Angeles, CA 90013 or through  
the website [www.insurance.ca.gov](http://www.insurance.ca.gov)

## DEFINITIONS

**Blue Shield Life** — Blue Shield of California Life & Health Insurance Company, a California corporation licensed as a life and disability insurer.

**Calendar Year** – A period beginning on January 1 of any year and terminating on January 1 of the following year.

**Copayment** – The amount that an Insured is required to pay for certain Covered Services.

**Covered Services (Benefits)** - Only those services which an Insured is entitled to receive pursuant to the terms of this Policy.

### **Dependent** —

1. A Subscriber's legally married spouse who is:
  - a. Resident of California; and
  - b. Not covered for benefits as a Subscriber; and
  - c. Not legally separated from the Subscriber; or
2. A Subscriber's Domestic Partner, who is:
  - a. Not covered for Benefits as a Subscriber; and
  - b. A Resident of California.
3. A Subscriber's, spouse's, or Domestic Partner's child (including any stepchild or child placed for adoption or any other child for

whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction) not covered for benefits as a Subscriber who is:

- a. Resident of California (unless a full-time student); and
- b. Less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court ordered non-temporary legal guardianship); or

And who has been enrolled and accepted by Blue Shield Life as a Dependent and has maintained membership in accordance with this Policy.

Note: Children of Dependent children (i. e. grandchildren of the Subscriber, spouse, or Domestic Partner) are not Dependents unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

4. If coverage for a Dependent child would be terminated because of the attainment of age 26 and the Dependent child is disabled, benefits for such Dependent will be continued upon the following conditions:
  - a. The child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance and be incapable of self-sustaining employment by reason of physically or mentally disabling injury, illness, or condition;



- b. The Subscriber, spouse, or Domestic Partner submits to the Plan a Physician's written certification of disability within 60 days from the date of the Plan's request; and
- c. Thereafter, certification from a Physician is submitted to the Plan on the following schedule:
  - i. Within 24 months after the month when the Dependent would otherwise have been terminated; and
  - ii. Annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage under this Plan for any reason other than attained age.

**Domestic Partner** — an individual who is personally related to the Subscriber by a domestic partnership that meets the following requirements:

1. Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring;
2. Both persons have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex Domestic Partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age.

The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

Emergency Services – Services provided for an unexpected dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) at the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part.

**Effective Date** – the date an applicant meets all enrollment and prepayment requirements and is accepted by Blue Shield Life.

**Insured** — a Subscriber or Dependent.

**Non-Participating Provider** – a licensed ophthalmologist, optometrist, or dispensing optician who has not certified and not accepted the terms of the Policy.

**Participating Provider** – a licensed ophthalmologist, optometrist, or optician who has certified his willingness to accept the terms and conditions and compensations as payment in full for Covered Services as set forth in this vision benefit.

**Plan** – The Specialty Duo Vision Plan for Medicare Supplement members or Blue Shield of California Life & Health Insurance Company

**Premiums** — the monthly pre-payment that is made to the Plan on behalf of each Insured.

**Prescription Change** – any of the following:

1. A change in prescription of 0.50 diopter or more; or
2. A Shift in axis of astigmatism of 15 degrees; or
3. A difference in vertical prism greater than 1 prism diopter; or
4. A change in lens type (for example contact lenses to glasses or single vision lenses to bifocal lenses).

**Resident of California** – an individual who spends in the aggregate more than 180 days each year within the State of California and has not established a permanent residence in another state or country.

**Subscriber** – An individual who satisfies the eligibility requirements of this Policy, and who is enrolled and accepted by the Plan as a Subscriber, and has maintained Plan membership in accord with this Policy.

**Vision Plan Administrator (VPA)** – Blue Shield Life has contracted with the Plan's Vision Plan Administrator (VPA) to administer delivery of eyewear and eye exams covered under this Plan through a network of Participating Providers. The VPA also contracts with Blue Shield Life to serve as a claims administrator for the processing of claims for services received from Non-Participating Providers.

**Waiting Period** – No Benefits are paid or otherwise available during the first ninety (90) consecutive days of coverage. Each Insured

must satisfy this Waiting Period independently and it is calculated beginning on the Insured's Effective Date of coverage.