Blue Shield TotalDual Plan (HMO D-SNP) offered by California Physicians' Service (dba Blue Shield of California)

Annual Notice of Changes for 2024

Introduction

You are currently enrolled as a member of our plan. Next year, there will be some changes to our benefits, coverage, rules, and costs. This *Annual Notice of Changes* tells you about the changes and where to find more information about them. To get more information about costs, benefits, or rules please review the *Member Handbook,* which is located on our website at blueshieldca.com/MAPDdocuments2024. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

Additional resources

- This document is available for free in Arabic, Armenian, Cambodian, Chinese, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese.
- You can get this *Annual Notice of Changes* for free in other formats, such as large print, braille, or audio. Call 1-800-452-4413 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.
    - If you would like to receive your plan materials online, log in to your account at blueshieldca.com/login, click My profile on the top right under your initials, go to Communication preferences and select "Go paperless" as your delivery preference. If you do not have an account, go to blueshieldca.com/login and click Create account and you can select your delivery preference as you create your account.
    - You can make a standing request to get this document in a language other than English or in an alternate format now and in the future. To make a request, please contact Blue Shield TotalDual Plan Customer Care. Your preferred language and format will be kept on file for future communications. To make any updates on your preferences, please contact Blue Shield TotalDual Plan Customer Care.
- We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at 1-800-452-4413 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week. Someone that speaks English can help you. This is a free service.

Table of Contents

A. Disclaimers

- Blue Shield of California is an HMO D-SNP plan with a Medicare contract and a contract with the California State Medicaid Program. Enrollment in Blue Shield of California depends on contract renewal.
- When this document says “we,” “us,” or “our,” it means California Physicians’ Service (dba Blue Shield of California). When it says “plan” or “our plan,” it means Blue Shield TotalDual Plan.

B. Reviewing your Medicare and Medi-Cal coverage for next year

It is important to review your coverage now to make sure it will still meet your needs next year. If it doesn’t meet your needs, you may be able to leave our plan. Refer to **Section D** for more information on changes to your benefits for next year.

If you choose to leave our plan, your membership will end on the last day of the month in which your request was made. You will still be in the Medicare and Medi-Cal programs as long as you are eligible.

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section E2**.
- Medi-Cal options and services in **Section E2**.

B1. Information about Blue Shield TotalDual Plan

- California Physicians’ Service dba Blue Shield of California is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to members.
- Coverage under Blue Shield TotalDual Plan is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.
- When this *Annual Notice of Changes* says “we,” “us,” “our,” or “our plan,” it means the Medicare Medi-Cal Plan.

B2. Important things to do

- **Check if there are any changes to our benefits and costs that may affect you.**
  - Are there any changes that affect the services you use?
  - Review benefit and cost changes to make sure they will work for you next year.
  - Refer to **Section D1** for information about benefit and cost changes for our plan.
- **Check if there are any changes to our prescription drug coverage that may affect you.**
  - Will your drugs be covered? Are they in a different cost-sharing tier? Can you use the same pharmacies?
  - Review changes to make sure our drug coverage will work for you next year.
  - Refer to **Section D2** for information about changes to our drug coverage.
  - Your drug costs may have risen since last year.
    - Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year.
    - Keep in mind that your plan benefits determine exactly how much your own drug costs may change.
- **Check if your providers and pharmacies will be in our network next year.**
  - Are your doctors, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use?
  - Refer to **Section C** for information about our *Provider and Pharmacy Directory*.
- **Think about your overall costs in the plan.**

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How do the total costs compare to other coverage options?

- **Think about whether you are happy with our plan.**

If you decide to stay with 2024 Blue Shield TotalDual Plan:	**If you decide to change plans:**
If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you automatically stay enrolled in 2024 Blue Shield TotalDual Plan.	If you decide other coverage will better meet your needs, you may be able to switch plans (refer to **Section E2** for more information). If you enroll in a new plan, or change to Original Medicare, your new coverage will begin on the first day of the following month.

C. Changes to our network providers and pharmacies

Our provider and pharmacy networks have changed for 2024.

Please review the 2024 *Provider and Pharmacy Directory* to find out if your providers or pharmacy are in our network. An updated *Provider and Pharmacy Directory* is located on our website at blueshieldca.com/medicare. You may also call Customer Care at the numbers at the bottom of the page for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

It's important that you know that we may also make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook*.

D. Changes to benefits and costs for next year

D1. Changes to benefits and costs for medical services

We're changing our coverage for certain medical services and what you pay for these covered medical services next year. The table below describes these changes.

	2023 (this year)	2024 (next year)
Annual Out-of-Pocket Maximum	$8,300 Once you have paid $8,300 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year. If you are eligible for Medicare and Medi-Cal (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$8,850 Once you have paid $8,850 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year. If you are eligible for Medicare and Medi-Cal (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.
Acupuncture services (non-Medicare covered)	You pay a $0 copay per visit for up to 12 visits per year.	Acupuncture services (non-Medicare covered) is not covered
Transportation Services (non-Medicare covered)	You pay a $0 copay each one way trip to plan-approved health-related locations (Unlimited one way trips per year)	You pay a $0 copay each one way trip to plan-approved health-related locations (limited to 48 one way trips per year)

Vision care, non-Medicare covered (obtained from a network provider)*	You pay $0 for eyeglass frames (priced up to a regular retail value of $350) every 24 months when you use a network provider. If you choose eyeglass frames priced above $350, you are responsible for the difference. You pay $0 for either one pair of prescription eyeglass lenses (regardless of size or power) OR for contact lenses (priced up to $350 for contact lens services and materials) every 12 months when you use a network provider. If the service and materials price above $350, you are responsible for the difference.	You pay $0 for eyeglass frames (priced up to a regular retail value of $375) every 24 months when you use a network provider. If you choose eyeglass frames priced above $375, you are responsible for the difference. You pay $0 for either one pair of prescription eyeglass lenses (regardless of size or power) OR for contact lenses (priced up to $375 for contact lens services and materials) every 12 months when you use a network provider. If the service and materials price above $375, you are responsible for the difference.

D2. Changes to prescription drug coverage

Changes to our Drug List

An updated *List of Covered Drugs* is located on our website at blueshieldca.com/medpharmacy2024. You may also call Customer Care at the numbers at the bottom of the page for updated drug information or to ask us to mail you a *List of Covered Drugs*.

The *List of Covered Drugs* is also called the “Drug List.”

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs.

Review the Drug List to **make sure your drugs will be covered next year** and to find out if there are any restrictions.

If you are affected by a change in drug coverage, we encourage you to:

- Work with your doctor (or other prescriber) to find a different drug that we cover.

  - You can call Customer Care at the numbers at the bottom of the page or contact your care coordinator to ask for a list of covered drugs that treat the same condition.
  - This list can help your provider find a covered drug that might work for you.
- Work with your doctor (or other prescriber) and ask us to make an exception to cover the drug.
  - You can ask for an exception before next year, and we'll give you an answer within 72 hours after we get your request (or your prescriber's supporting statement).
  - To learn what you must do to ask for an exception, refer to **Chapter 9** of your *Member Handbook* or call Customer Care at the numbers at the bottom of the page.
  - If you need help asking for an exception, contact Customer Care or your care coordinator. Refer to **Chapters 2 and 3** of your *Member Handbook* to learn more about how to contact your care coordinator.
- Ask us to cover a temporary supply of the drug.
  - In some situations, we cover a **temporary** supply of the drug during the first 90 days of the calendar year.
  - This temporary supply is for up to 30 days. (To learn more about when you can get a temporary supply and how to ask for one, refer to **Chapter 5** of your *Member Handbook*.)
  - When you get a temporary supply of a drug, talk with your doctor about what to do when your temporary supply runs out. You can either switch to a different drug our plan covers or ask us to make an exception for you and cover your current drug.
  - Requests for formulary exceptions must be submitted each year to the plan.

Changes to prescription drug costs

There are two payment stages for your Medicare Part D prescription drug coverage under our plan. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

Stage 1 Initial Coverage Stage	Stage 2 Catastrophic Coverage Stage
During this stage, our plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin this stage when you fill your first prescription of the year.	During this stage, the plan pays all of the costs of your drugs through December 31, 2024. You begin this stage after you pay a certain amount of out-of-pocket costs.

The Initial Coverage Stage ends when your total out-of-pocket costs for prescription drugs reaches **$**8,000. At that point, the Catastrophic Coverage Stage begins. Our plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information on how much you will pay for prescription drugs.

D3. Stage 1: "Initial Coverage Stage"

During the Initial Coverage Stage, our plan pays a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it. You pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

We moved some of the drugs on our Drug List to a lower or higher drug tier. If your drugs move from tier to tier, this could affect your copay. To find out if your drugs are in a different tier, look them up in our Drug List.

The following table shows your costs for drugs in each of our five drug tiers. These amounts apply **only** during the time when you're in the Initial Coverage Stage.

	2023 (this year)	2024 (next year)
Drugs in Tier 1 (*Preferred Generic Drugs*) Cost for a one-month supply of a drug in Tier 1 that is filled at a network pharmacy	Your copay for a one-month (30-day) supply is **$0 per prescription**.	Your copay for a one-month (30-day) supply is **$0 per prescription**.

	2023 (this year)	2024 (next year)
Drugs in Tier 2 (*Generic Drugs*) Cost for a one-month supply of a drug in Tier 2 that is filled at a network pharmacy	Your copay for a one-month (30-day) supply is **$0, $1.45, or $4.15 per prescription**.	Your copay for a one-month (30-day) supply is **$0, $1.55, or $4.50 per prescription**.
Drugs in Tier 3 *(Preferred Brand Drugs)* Cost for a one-month supply of a drug in Tier 3 that is filled at a network pharmacy	Your copay for a one-month (30-day) supply is **$0, $4.30, or $10.35 per prescription**.	Your copay for a one-month (30-day) supply is **$0, $4.60, or $11.20 per prescription**.
Drugs in Tier 4 *(Non-Preferred Drugs)* Cost for a one-month supply of a drug in Tier 4 that is filled at a network pharmacy	Your copay for a one-month (30-day) supply is **$0, $4.30, or $10.35 per prescription**.	Your copay for a one-month (30-day) supply is **$0, $4.60, or $11.20 per prescription**.
Drugs in Tier 5 *(Specialty Tier Drugs)* Cost for a one-month supply of a drug in Tier 5 that is filled at a network pharmacy	Your copay for a one-month (30-day) supply is **$0, $4.30, or $10.35 per prescription**.	Your copay for a one-month (30-day) supply is **$0, $4.60, or $11.20 per prescription**.

The Initial Coverage Stage ends when your total out-of-pocket costs reach **$**8,000. At that point the Catastrophic Coverage Stage begins. Refer to **Chapter 6** of your *Member Handbook* for more information about how much you pay for prescription drugs.

D4. Stage 2: "Catastrophic Coverage Stage"

When you reach the out-of-pocket limit $8,000 for your prescription drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year.

E. Administrative changes

	2023 (this year)	2024 (next year)
Your Blue Shield TotalDual Plan Contract and Plan Benefit Package (PBP) number will change next year. This does not impact your coverage and there is nothing you need to do to keep your plan.	H5928-005	H2819-001

F. Choosing a plan

F1. Staying in our plan

We hope to keep you as a plan member. You do not have to do anything to stay in our plan. If you do **not** change to another Medicare plan or change to Original Medicare, you automatically stay enrolled as a member of our plan for 2024.

F2. Changing plans

Most people with Medicare can end their membership during certain times of the year. Because you have Medi-Cal, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- you moved out of our service area,
- your eligibility for Medi-Cal or Extra Help changed, **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your Medicare services

You have three options for getting your Medicare services. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to:	Here is what to do:
Another Medicare health plan, including another Medicare Medi-Cal Plan	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. For Program of All-inclusive Care for the Elderly (PACE) inquiries, call 1-855-921-PACE (7223). If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/. **OR** Enroll in a new Medicare plan. You will automatically be disenrolled from our plan when your new plan's coverage begins. Your Medi-Cal plan may change.

2. You can change to:	**Here is what to do:**
Original Medicare with a separate Medicare prescription drug plan	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/. **OR** Enroll in a new Medicare prescription drug plan. You will automatically be disenrolled from our plan when your Original Medicare coverage begins. Your Medi-Cal plan will not change.

3. You can change to: **Original Medicare without a separate Medicare prescription drug plan** **NOTE**: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/. You will automatically be disenrolled from our plan when your Original Medicare coverage begins. Your Medi-Cal plan will not change.

Your Medi-Cal services

For questions about how to choose a Medi-Cal plan or get your Medi-Cal services after you leave our plan, contact Health Care Options at 1-800-430-4263, Monday – Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

G. Getting help

G1. Our plan

We're here to help if you have any questions. Call Customer Care at the numbers at the bottom of the page during the days and hours of operation listed. These calls are toll-free.

Read your *Member Handbook*

Your *Member Handbook* is a legal, detailed description of our plan's benefits. It has details about benefits and costs for 2024. It explains your rights and the rules to follow to get services and prescription drugs we cover.

The *Member Handbook* for 2024 will be available by October 15. An up-to-date copy of the *Member Handbook* is available on our website at blueshieldca.com/MAPDdocuments2024. You may also call Customer Care at the numbers at the bottom of the page to ask us to mail you a *Member Handbook* for 2024.

Our website

You can visit our website at blueshieldca.com/medicare. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our Drug List (*List of Covered Drugs*).

G2. Health Insurance Counseling and Advocacy Program (HICAP)

You can also call the State Health Insurance Assistance Program (SHIP). In California, the SHIP is called the Health Insurance Counseling and Advocacy Program (HICAP). HICAP counselors can help you understand your plan choices and answer questions about switching plans. HICAP is not connected with us or with any insurance company or health plan. HICAP has trained counselors in every county, and services are free. HICAP's phone number is 1-800-434-0222. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/.

G3. Ombuds Program

The Medicare Medi-Cal Ombuds Program can help you if you have a problem with our plan. The ombudsman's services are free and available in all languages. The Medicare Medi-Cal Ombuds Program:

- works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do.
- makes sure you have information related to your rights and protections and how you can get your concerns resolved.
- is not connected with us or with any insurance company or health plan. The phone number for the Medicare Medi-Cal Ombuds Program is 1-888-804-3536.

G4. Medicare

To get information directly from Medicare, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Medicare's Website

You can visit the Medicare website (www.medicare.gov). If you choose to disenroll from our plan and enroll in another Medicare plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare plans.

You can find information about Medicare plans available in your area by using Medicare Plan Finder on Medicare's website. (For information about plans, refer to www.medicare.gov and click on "Find plans.")

Medicare & You 2024

You can read the *Medicare & You 2024* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. This handbook is also available in Spanish, Chinese, and Vietnamese.

If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1--800--MEDICARE (1--800--633--4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

G5. California Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. The DMHC Help Center can help you with appeals and complaints about Medi-Cal services. If you have a grievance against your health plan, you should first telephone your health plan at 1-800-452-4413 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week 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 **(1-888-466-2219)** and a TDD line **(1877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.