blue california

Important information

About changes to your Medicare drug and health plan

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

Annual Notice of Changes for 2025

You are currently enrolled as a member of Blue Shield TotalDual Plan. Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at blueshieldca.com/DSNPdocuments2025. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies, will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at the www.medicare.gov/plan-compare website or review the list in the back of your

Medicare & You 2025 handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan
   - If you don't join another plan by December 7, 2024, you will stay in Blue Shield TotalDual Plan.
   - To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025.** This will end your enrollment with Blue Shield TotalDual Plan.
   - Look in section 3.2, page 14 to learn more about your choices.
   - If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Service number at (800) 452-4413 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., seven days a week. This 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 "Electronic Delivery" 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.
- This information may be available in a different format, including Braille, large print, audio cd and data cd. Please call Customer Service at the number listed above if you need plan information in another format.
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Blue Shield TotalDual Plan

- Blue Shield of California is an HMO D-SNP plan with a Medicare contract and a contract with the California State Medi-Cal (Medicaid) Program. Enrollment in Blue Shield of California depends on contract renewal. The plan also has a written agreement with the

California Medi-Cal (Medicaid) program to coordinate your Medi-Cal (Medicaid) benefits.

- Amazon Pharmacy is independent of Blue Shield of California and is contracted with Blue Shield to provide home delivery of prescription medications to Blue Shield members.
- 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.

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Blue Shield TotalDual Plan in several important areas. **Please note this is only a summary of costs**. If you are eligible for Medicare cost-sharing assistance under Medi-Cal (Medicaid), you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Doctor office visits	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit
Inpatient hospital stays	You pay a $0 copay.	You pay a $0 copay.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $545 (except for Tier 1: Preferred Generic Drugs, covered Part D insulin products and most adult Part D vaccines). Copayment during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $0, $1.55 or $4.50 copay • Drug Tier 3: $0, $4.60 or $11.20 copay You pay $0, $4.60 or $11.20 per month supply of each	Deductible: $590 (except for Tier 1: Preferred Generic Drugs, covered Part D insulin products and most adult Part D vaccines). Copayment during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $0, $1.60 or $4.90 copay • Drug Tier 3: $0, $4.80 or $12.15 copay You pay $0, $4.80 or $12.15 per month supply of each

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (cont'd)	covered insulin product on this tier. • Drug Tier 4: $0, $4.60 or $11.20 copay You pay $0, $4.60 or $11.20 per month supply of each covered insulin product on this tier. • Drug Tier 5: $0, $4.60 or $11.20 copay Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	covered insulin product on this tier. • Drug Tier 4: $0, $4.80 or $12.15 copay You pay $0, $4.80 or $12.15 per month supply of each covered insulin product on this tier. • Drug Tier 5: $0, $4.80 or $12.15 copay Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.
Maximum out-of-pocket amount This is the most you will pay out of pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$8,850 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.	$9,350 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.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medi-Cal (Medicaid).)	$0	$0

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

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

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount	$8,850	$9,350
Because our members also get assistance from Medi-Cal (Medicaid), very few members ever reach this out-of-pocket maximum. 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. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.		Once you have paid $9,350 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.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Updated directories are located on our website at blueshieldca.com/medicare/providerdirectories for Provider Directories and blueshieldca.com/medpharmacy2025 for Pharmacy Directories. You may also call Customer Service for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *Provider Directory* at blueshieldca.com/medicare/providerdirectories to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2025 *Pharmacy Directory* at blueshieldca.com/medpharmacy2025 to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are a part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Dental services (non-Medicare covered)	Specific preventive and comprehensive dental services are covered. See the *Routine Dental Benefits Procedure Chart* in Chapter 4, Section 2.1 (below the Medical Benefits Chart) of the *Evidence of Coverage* for more information on covered services and what you pay.	Specific comprehensive dental services are covered. See the *Covered Dental Services Procedure Chart* in Chapter 4, Section 2.1 (below the Medical Benefits Chart) of the *Evidence of Coverage* for more information on covered services and what you pay.

Cost	2024 (this year)	2025 (next year)
Over-the-Counter (OTC) items	You have a $180 allowance per quarter for covered items. You can place two orders per quarter and cannot roll over your unused allowance into the next quarter. Some limitations may apply. Refer to the OTC items catalog for more information.	You have a $170 allowance per quarter for covered items. You can place two orders per quarter and cannot roll over your unused allowance into the next quarter. Some limitations may apply. Refer to the OTC items catalog for more information.
Vision care, non-Medicare covered (obtained from a network provider) Eyeglass frames and eyeglass lenses (including single, lined bifocal, lined trifocal, and lenticular lenses) or contact lenses	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 $295) every 24 months when you use a network provider. If you choose eyeglass frames priced above $295, 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 $295 for contact lens services and materials) every 12 months when you use a network provider. If the service and materials price above $295, you are responsible for the difference.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or Drug List. A copy of our Drug List is provided electronically.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

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

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Customer Service for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Customer Service or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

If you receive "Extra Help" to pay your Medicare prescription drugs, you may qualify for a reduction or elimination of your cost sharing for Part D drugs. Some of the information described in this section may not apply to you. **Note:** If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also called the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug costs. If you receive "Extra Help" and you haven't

received this insert by September 30, 2024, please call Customer Service and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

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

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 2: Generic Drugs, Tier 3: Preferred Brand Drugs, Tier 4: Non-Preferred Drugs and Tier 5: Specialty Tier Drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.	The deductible is $545. During this stage, you pay $0 cost sharing for drugs on Tier 1 and the full cost of drugs on Tier 2: Generic Drugs, Tier 3: Preferred Brand Drugs, Tier 4: Non-Preferred Drugs and Tier 5: Specialty Tier Drugs until you have reached the yearly deductible.	The deductible is $590. During this stage, you pay $0 cost sharing for drugs on Tier 1 and the full cost of drugs on Tier 2: Generic Drugs, Tier 3: Preferred Brand Drugs, Tier 4: Non-Preferred Drugs and Tier 5: Specialty Tier Drugs until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost**. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is: **Tier 1 Preferred Generic Drugs:** You pay $0 per prescription. **Tier 2 Generic Drugs:** You pay $0, $1.55 or $4.50 per prescription. **Tier 3 Preferred Brand Drugs:** You pay $0, $4.60 or $11.20 per prescription. You pay $0, $4.60 or $11.20 per month supply of each covered insulin product on this tier. **Tier 4 Non-Preferred Drugs:** You pay $0, $4.60 or $11.20 per prescription. You pay $0, $4.60 or $11.20 per month supply of each covered insulin product on this tier. **Tier 5 Specialty Tier Drugs:** You pay $0, $4.60 or $11.20 per prescription. Your cost for a one-month mail service prescription is $0, $4.60, or $11.20. Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is: **Tier 1 Preferred Generic Drugs:** You pay $0 per prescription. **Tier 2 Generic Drugs:** You pay $0, $1.60 or $4.90 per prescription. **Tier 3 Preferred Brand Drugs:** You pay $0, $4.80 or $12.15 per prescription. You pay $0, $4.80 or $12.15 per month supply of each covered insulin product on this tier. **Tier 4 Non-Preferred Drugs:** You pay $0, $4.80 or $12.15 per prescription. You pay $0, $4.80 or $12.15 per month supply of each covered insulin product on this tier. **Tier 5 Specialty Tier Drugs:** You pay $0, $4.80 or $12.15 per prescription. Your cost for a one-month home delivery prescription is $0, $4.80 or $12.15. Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

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

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). To learn more about this payment option, please contact us at (833) 696-2087 or visit Medicare.gov.
Part D Prescription Drug Claims Processing Mailing Address	Blue Shield of California P.O. Box 52066 Phoenix, AZ. 85072-2066	Claims Processing 1606 Ave. Ponce de Leon San Juan, PR. 00909-4830
Mail Service Pharmacy Provider Change	CVS Caremark® Mail Service Pharmacy	Amazon Pharmacy
Terminology Change	mail service	home delivery

Description	2024 (this year)	2025 (next year)
Change to the Long-Term Supply for Tier 2: Generic Drugs, Tier 3: Preferred Brand Drugs and Tier 4: Non-Preferred Drugs	You can obtain up to a 90-day supply of covered Tier 2, 3 and 4 drugs at an in-network standard retail cost sharing pharmacy or through the network mail service pharmacy.	You can obtain up to a 100-day supply of covered Tier 2, 3 and 4 drugs at an in-network standard retail cost sharing pharmacy or through the network home delivery pharmacy.
Timeline requirement to request an appeal	You must make your appeal request within 60 calendar days from the date on the written notice of the coverage decision.	You must make your appeal request within 65 calendar days from the date on the written notice of the coverage decision.
Delivery change for Over-the-Counter (OTC) items	Please allow approximately 14 business days for delivery.	Please allow approximately 7 business days for delivery.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Blue Shield TotalDual Plan

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in Blue Shield TotalDual Plan.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR* – You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, California Physicians' Service (dba Blue Shield of California) offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Blue Shield TotalDual Plan.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Blue Shield TotalDual Plan.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do so.
    - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

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 have opted out of automatic enrollment.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2025.

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

In certain situations, changes are also allowed at other times of the year. Examples include people with Medi-Cal (Medicaid), those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

Because you have Medi-Cal (Medicaid), you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or

- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medi-Cal (Medicaid) benefits and services in one plan.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can also switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer Free Counseling about Medicare and Medi-Cal (Medicaid)

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In California, the SHIP is called Health Insurance Counseling and Advocacy Program (HICAP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. HICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call HICAP at 1-800-434-0222. You can learn more about HICAP by visiting their website (http://www.cahealthadvocates.org/hicap/).

For questions about your Medi-Cal (Medicaid) benefits, contact the California Department of Health Care Services/Health Care Options at 1-800-430-4263 (TTY users should call 1-800-430-7077), 8:00 am to 6:00 pm, Monday through Friday, except holidays. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal (Medicaid) coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** Because you have Medi-Cal (Medicaid), you are already enrolled in "Extra Help," also called the Low-Income Subsidy. "Extra Help" pays some of your prescription drug premiums, yearly deductibles, and coinsurance. Because you qualify, you do not have a late enrollment penalty. If you have questions about "Extra Help," call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;

- The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
- Your State Medi-Cal (Medicaid) Office.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the ADAP in California. For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call California ADAP Call Center at (844) 421-7050, 8 a.m. to 5 p.m., Monday through Friday (excluding holidays), or visit their website at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_eligibility.aspx. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at (833) 696-2087 (TTY users should call 711) or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from Blue Shield TotalDual Plan

Questions? We're here to help. Please call Customer Service at (800) 452-4413. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m., seven days a week. Calls to these numbers are free.

Read your *2025 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the *2025 Evidence of Coverage* for Blue Shield TotalDual Plan. The

Evidence of Coverage is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at blueshieldca.com/DSNPdocuments2025. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

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

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document 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. If you don't have a copy of this document, you can get it at the Medicare website (https://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.

Section 7.3 – Getting Help from Medi-Cal (Medicaid)

To get information from Medi-Cal (Medicaid), you can call the California Department of Health Care Services/Medi-Cal Managed Care at 1-888-452-8609. TTY users should call 711.

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