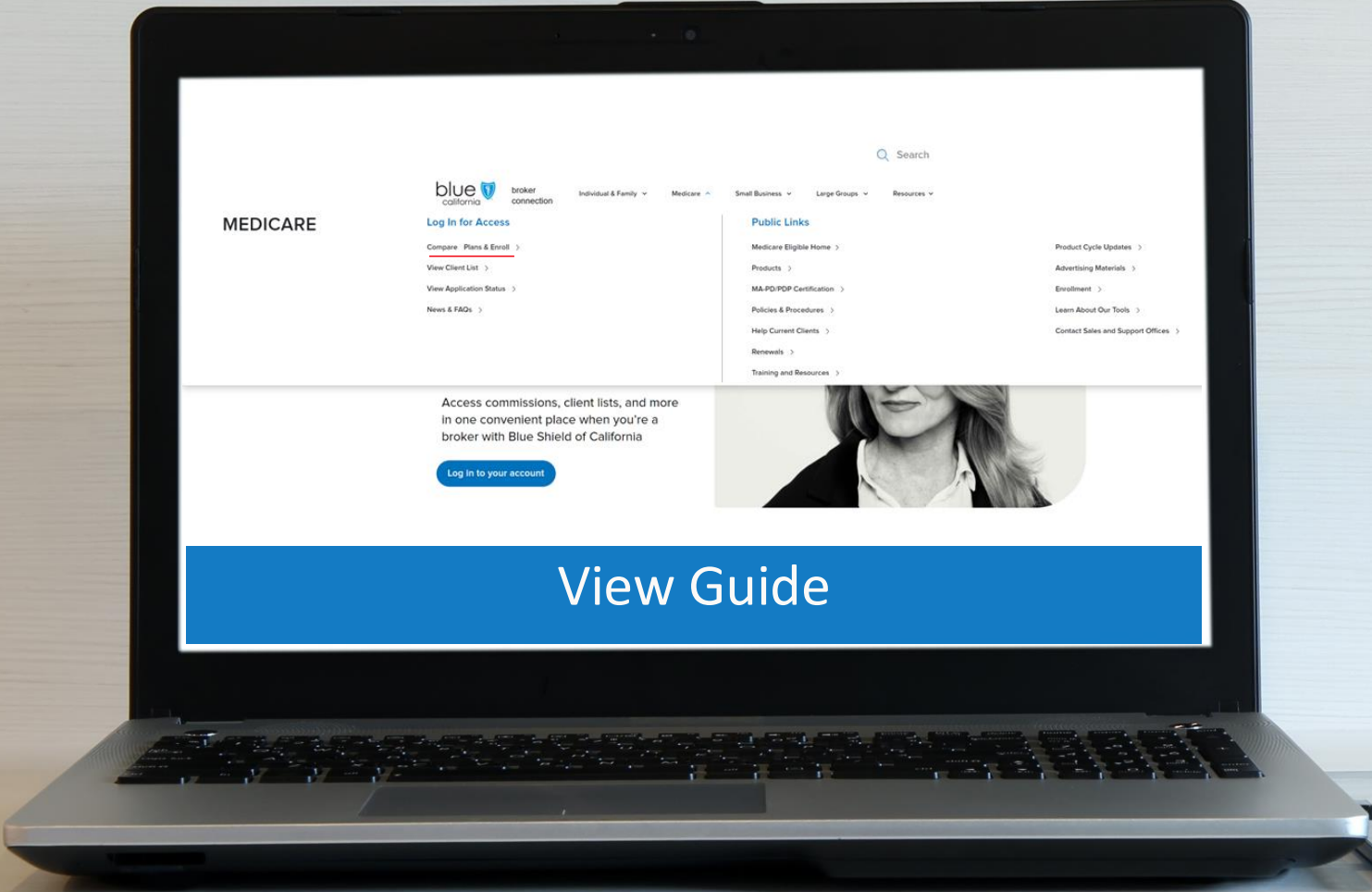


Blue Shield Medicare Enrollment Site

Reference Guide



Y0118_23_718A_C 10042023

H2819_23_718A_C 10042023

Overview

Our Online Enrollment system serves two basic purposes:

- Enrolling beneficiaries in Medicare and Medicare Supplement plans.
- Helping beneficiaries estimate their out-of-pocket expenses for each plan including their health, prescriptions, pharmacy, and the amount of coverage the plan offers.

Using this system, you will be able to enter all the beneficiary's information, compare plans, and enroll.

Medicare Advantage Prescription Drug Plans

6 plans

Medicare Supplement Plans

7 plans

Prescription Drug Plans

2 plans

Medicare Advantage Prescription Drug Plans bundle the benefits of a Medicare Advantage Plan and a Prescription Drug Plan. Benefits include medical expenses and prescriptions.

Effective [January 2024](#)

Preferences

Answer a few questions to estimate your annual cost.

[Get Started](#)

[Prescriptions](#)

[Pharmacy](#)

[Enter info](#)

Filters

[Clear all](#)

Medical out of pocket maximum

under \$1999

\$2000-\$5999

\$6000 and over

Premium

under \$49

\$50-\$99

\$100 and over

Sort: Plan Premium (Low to High)

[Hide all Special Needs Plans \(SNP\)](#)

Blue Shield TotalDual Plan (HMO D-SNP) Add to compare

Plan ID: H2819-001-000

Not available [Medicare Star Rating](#) [DSNP plan](#)

| | | |
|--------------------|-------------------------------|----------------------|
| Medical Deductible | Medical out of pocket maximum | Monthly plan premium |
| \$0 | \$8,850 | \$0.00 |

[Plan details](#) [Add to cart](#)

[Add to quote](#)

✓ Dental Services ✓ Vision Services ✓ Hearing Services ✓ Additional Telehealth [View all](#)

Blue Shield Inspire (HMO) Add to compare

Plan ID: H0504-043-000

★★★★☆ [Medicare Star Rating](#)

| | | |
|--------------------|-------------------------------|----------------------|
| Medical Deductible | Medical out of pocket maximum | Monthly plan premium |
| \$0 | \$699 | \$0.00 |

[Plan details](#) [Add to cart](#)

[Add to quote](#)

✓ Dental Services ✓ Vision Services ✓ Hearing Services ✓ Additional Telehealth [View all](#)

Questions ?

Contact US:

[Blue Shield Producer Services](#)
[Phone Number:](#)

1-800-559-5905



What's New for 2024

- Broker Site: Multi-year site
- Broker: Single link to access the Compare & Enroll site
- Consumer Profile: Addition of mobile phone number field & CA license number
- Consumer Profile: Separate section for MBI, Part A Effective Date, and Part B Effective Date fields
- Consumer Profile: Dedicated Consumer Enrolment history page.
- Quoted history display
- Broker Profile: Addition of extension number (if applicable)
- Plan cards display: Addition of on card benefits, addition of contract ID's
- Personal URL: Single URL for all future sites (Not applicable this year)
- Medicare enrollment form: Change in flow.
- NEW ! Online HRA form

Enrollment Begins

This year Medicare Enrollment Site for Medicare Annual Enrollment Period begins on October 15, 2023.

Broker

Login

[View Section](#)

Broker Login

Search

blue shield of california broker connection Individual & Family Medicare Small Business Large Groups Resources Log In or Register

Broker Connection no longer supports Internet Explorer. We recommend using Microsoft Edge or Google Chrome browsers to access our website for a secure and improved experience.

WELCOME TO
BROKER CONNECTION

Access commissions, client lists, and more in one convenient place when you're a broker with Blue Shield of California

Log In to your account

Welcome to Broker Connection

1

2

Welcome to Broker Connection

Log in

Username

Password Show

Remember my username

Login

[Forgot your password?](#)

[Forgot your username?](#)

Create an account

Already appointed with Blue Shield? It takes about 5 minutes and 6 quick steps to register as an agency owner on Broker Connection.

Register

To register you need:

- The tax ID number for your brokerage or your personal tax ID number
- Your Department of Insurance (DOI) license number
- A National Producer Number (NPN), if you have one

[Who can create an account?](#)

[Get appointed with Blue Shield](#)

Log In Steps

1. Enter your **username** and **password**.
2. Click **Log In** button.

For captive agents, there is an additional link dropdown. Agents must choose the correct link to receive credit for the sale.

Broker Login

MEDICARE

blue shield of california broker connection

Individual & Family Medicare Small Business Large Groups Resources

Log In for Access

- Compare Plans & Enroll
- View Client List
- View Application Status
- News & FAQs

Public Links

- Medicare Eligible Home
- Products
- MA-PD/PDP Certification
- Policies & Procedures
- Help Current Clients
- Renewals
- Training and Resources

- Product Cycle Updates
- Advertising Materials
- Enrollment
- Learn About Our Tools
- Contact Sales and Support Offices

Search

Access commissions, client lists, and more in one convenient place when you're a broker with Blue Shield of California

Log in to your account



Log In Steps

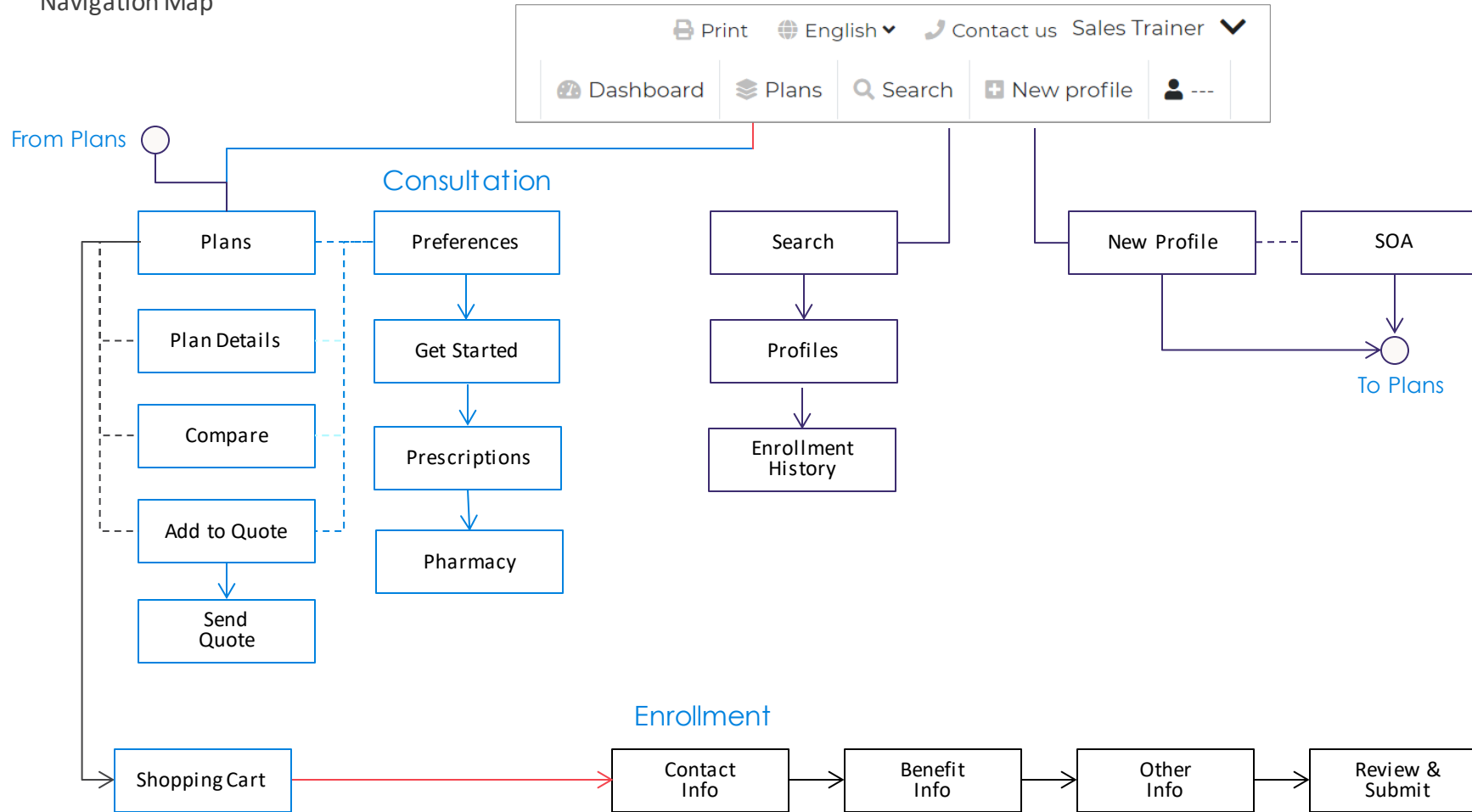
3. Click the **Compare Plans & Enroll** link.

NOTE:

From October 1st onwards there will be just one compare plans & enroll link

Site Navigation

Navigation Map



Use the site flow diagram as a reference guide to navigating through the site

When you login to the site, you will be on the Dashboard page. The Dashboard is your home page that provides a snapshot of your activity.

There are three main areas within the site:

1. Plans
2. Search Profiles & Enrollment
3. New Profile

The diagram shows the associated screens for each area.

NOTE:

- Dotted lines indicate access to supporting site pages for the main screens.
- Solid arrow lines indicate typical process flow a person would follow during an enrollment.

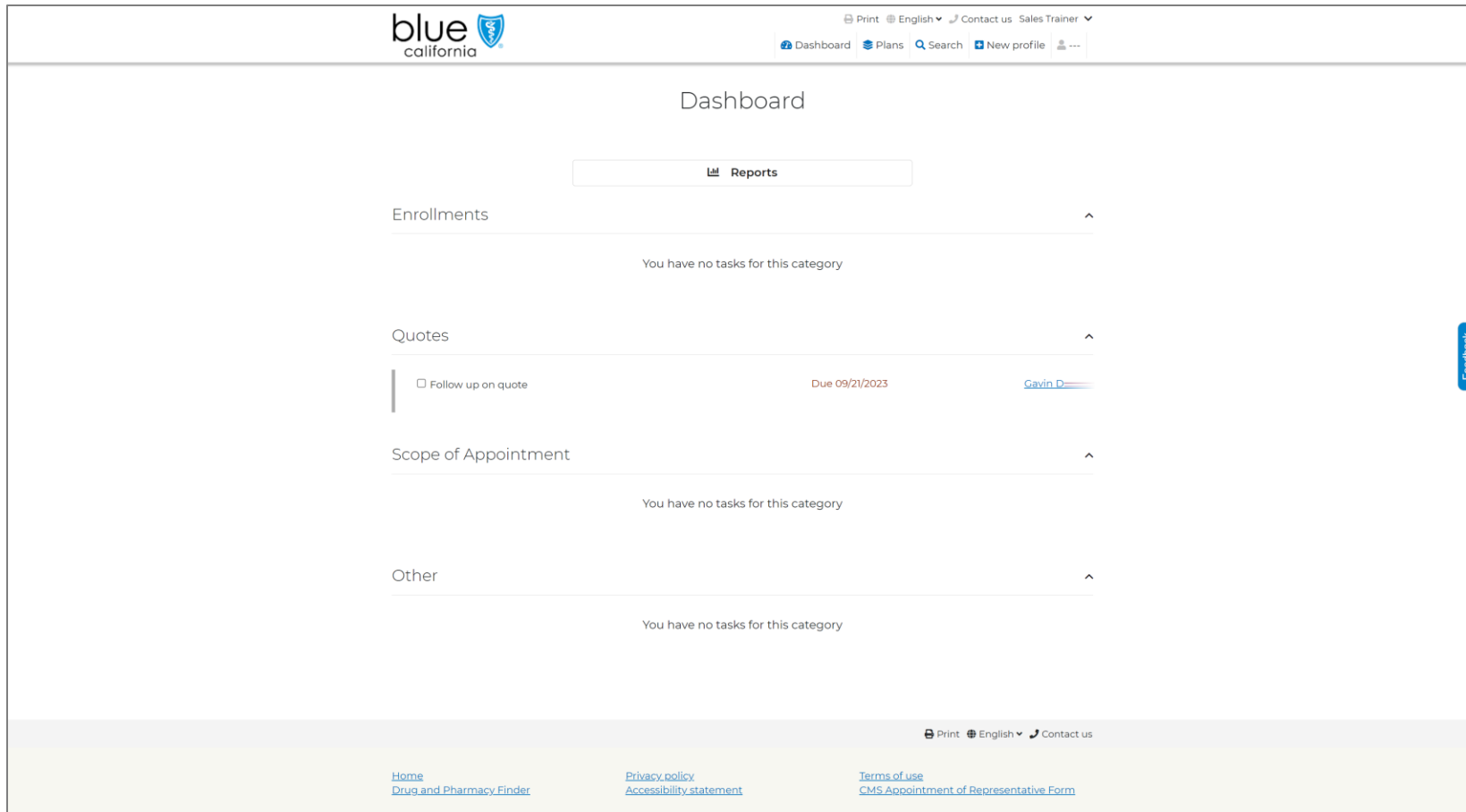


When you login to the site, you will be on the Dashboard Screen

Dashboard Overview

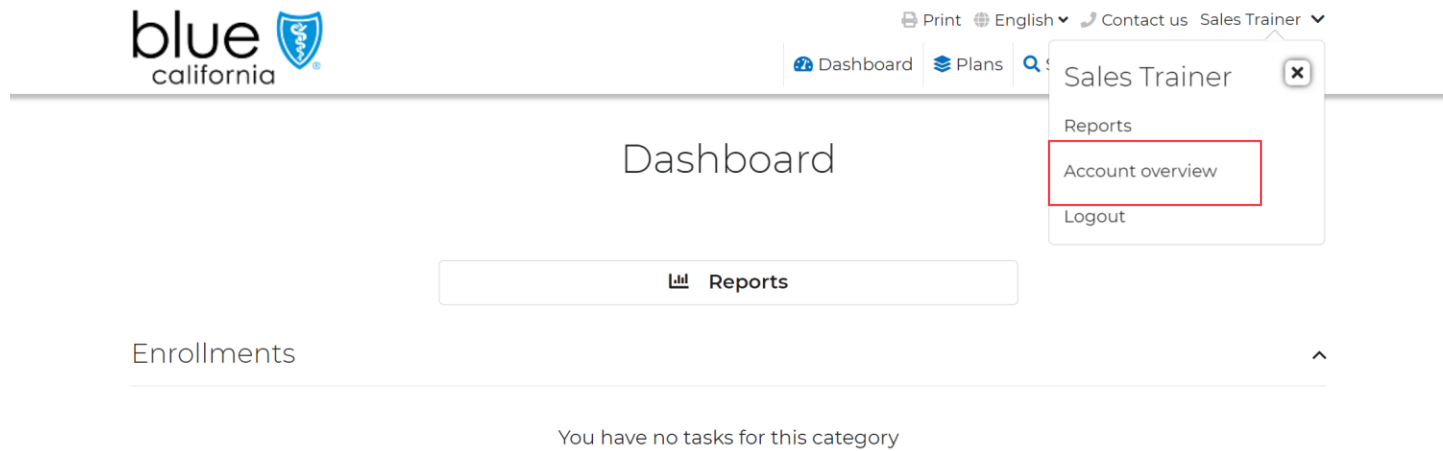
The dashboard provides an overview of your sales activities including:

- In process enrollments
- Completed applications
- Quotes to follow up on



Feedback

Account Overview



Personal Sales Link

The **Account Overview** screen provides your personalized link.

Share this link with your clients to get them started shopping for plans.

You will get credit for the sale if your client enrolls in any of the plans you are authorized to sell.

Account Overview



Print English Contact us Sales Trainer

Dashboard Plans Search New profile

Account overview

My shopping link

Send your personalized link to the client to get them started with shopping for plans. Don't worry, you will get credit if the consumer enrolls in any of these plans.

Copy 2024 link

[Copy 2023 link](#)

My picture

This image will be used on the consumer shopping site and email signatures.



Please upload a .png, or .jpg, less than 5 MB.

Upload

Personal information

* First name

Sales

* Last name

Trainer

Email address

S_trainer@email.com

Phone number

(888) 321-5555

Ext.

Address

123 Main Street

City

San Francisco

State

CA

ZIP code

94102

Save

Personal Sales Link

It's important to confirm your information including the NPN to ensure that you get credit for the sale.

You can make changes to the some of the fields and click the **Save** button to update the information.

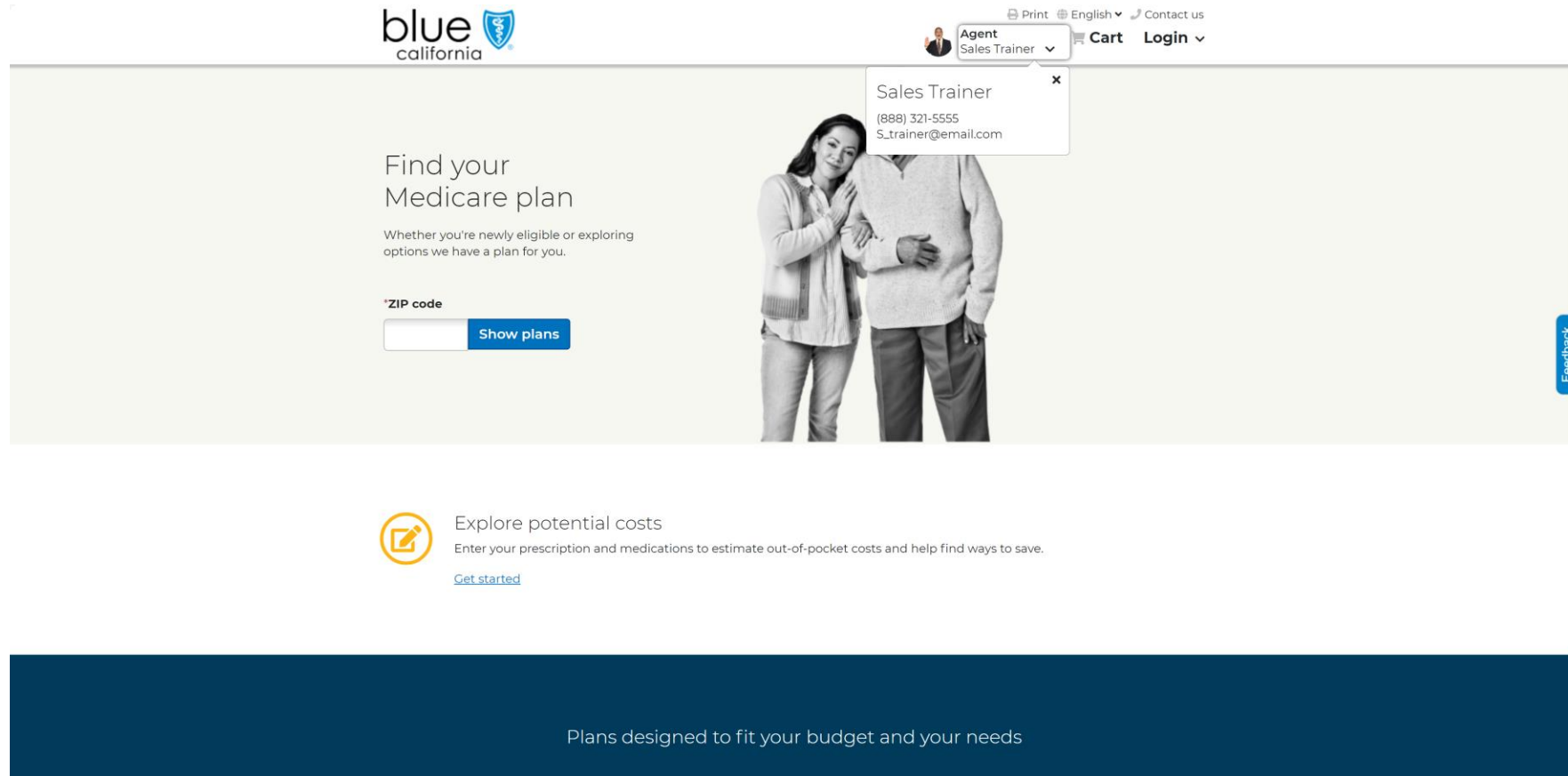
Fields you can edit include:

- Name
- Email
- Phone number
- Address
- Agency ID
- Agency name
- CA License number

Note:

In 2024 the Personal Shopping links are going to be one link only.

Site Navigation



Personal Link Page

When the prospect clicks your personal link, they will see your name, email, and image at the top of the page.

Start a New Consultation

[View Section](#)



Add Client



Print English Contact us Sales Trainer

Dashboard Plans Search **New profile** ---

Dashboard

Create a Profile

Select **New Profile** to create a new beneficiary profile. Creating a profile will allow you to search and return to view all information related to this beneficiary record in the future.

Profile

Add Client

Personal information

***ZIP code**

*** First name** *** Last name** **Date of birth**

Email address **Primary phone number** **Mobile phone number**

Same as primary

Home address

Address 1 **Address 2**

City **State**

Sales information

Is the sales contact different from the beneficiary?

Save

SOA

You have no SOAs for this profile

Notes

You have no notes for this profile

[Add note](#)

Tasks

You have no tasks for this profile

[Add task](#)

Eligibility

Medicare Number [Show](#)

Hospital (Part A) effective date

*** Medical (Part B) effective date**

[Add/Edit subsidy](#)

[Add/Edit subsidy](#)

Does beneficiary receive extra help paying for prescription drugs? (Optional)

[Previous](#)

[Enter info](#)

Continue to SOA

Continue to plans

1

2

3

4

Create a Profile

1. Begin by entering the beneficiary information sections:
 - Personal Information
 - Home Address
 - Sales Information
 - Eligibility
2. Add **Notes or Tasks** to the profile.
3. Click **Save**.
4. Click **SOA** to move to the Scope of Appointment screen.

NOTE:
Fields with an asterisk are required.
The new fields will only validate the correct format, **NOT** the accuracy of the MBI or the effective dates.

New Fields

- Medicare Number
- Hospital (Part A) effective Date
- Medical (Part B) effective date

Scope of Appointment

Scope of Appointment

A Scope of Appointment (SOA) is needed for all sales appointments and required 48-hours in advance with limited exceptions. Submit the SOA once you have received it from the beneficiary.

SOAs

You have no SOAs for this profile

[Complete SOA form in-person](#) | [Print consumer form](#) | [Upload](#)

Email address

Phone number

5

6

[← Previous](#)

Enter info

Continue to plans

SOA - Email

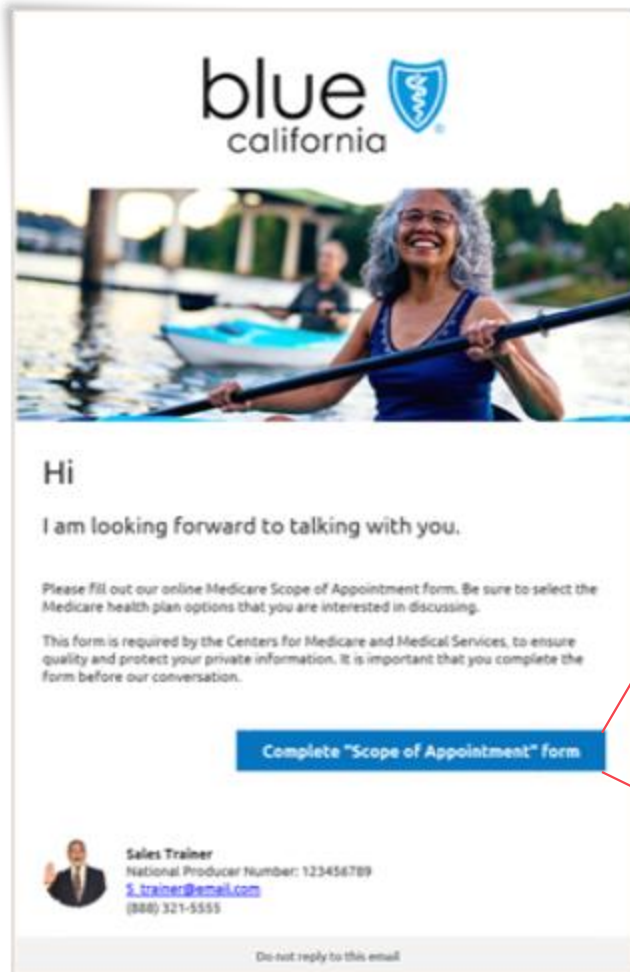
Electronically capture & store Scope of Appointment (SOA) confirmation.

5. Complete the **Email or Text option** to send the SOA to yourself or the beneficiary.
6. Click **Continue to plans**.

NOTE:

- The agent receives confirmation that beneficiary has signed their SOA.
- The beneficiary receives confirmation SOA has been submitted.
- You can upload a copy of the SOA using the upload button.

Prospect SOA Email



blue shield of california English Agent Sales Trainer

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative. Fields marked with an asterisk (*) are required.

Please check one or ALL the product(s) below that you want the agent to discuss.*

- Stand-alone Medicare Prescription Drug Plans (Part D)
- Medicare Advantage Plans (Part C) and Cost Plans
- Medicare Supplement (Medigap) Products
- Ancillary Products

[View](#) complete Medicare product descriptions.

Beneficiary or Authorized Representative Information

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary's First Name*

Beneficiary's Last Name*

***Address (Line 1)**

Address (Line 2)

***City**

***State**

***Zip Code**

Phone Number

Are you the authorized representative acting on behalf of the beneficiary?

Yes No

By checking this box, I have read and understand the contents of the Scope of Appointment form, and that I confirm that the information I have provided is accurate. If submitted by an authorized individual (as described above), this submission certifies that 1) this person is authorized under State law to complete the Scope of Appointment form, and 2) documentation of this authority is available upon request by Medicare.

SOA - Email

The beneficiary will receive an email or text with a link.

When they click the link, they are taken to the Scope of Appointment form.

When they complete form, you will receive an email notification.

NOTE:

Brokers will receive a notification when the SOA is received, and can click on the notification to be taken directly to Blue Shield of California Medicare Enrollment Site, if they are already logged in.

Start Consultation

7

15 plans available in **90002** for **2024**
for Los Angeles county, CA
Licensed to sell 1 Medicare organizations with 8 plans for 2024

| | | |
|---|--------------------------------------|------------------------------------|
| Medicare Advantage Prescription Drug Plans 6 plans | Medicare Supplement Plans 7 plans | Prescription Drug Plans 2 plans |
|---|--------------------------------------|------------------------------------|

Medicare Advantage Prescription Drug Plans bundle the benefits of a Medicare Advantage Plan and a Prescription Drug Plan. Benefits include medical expenses and prescriptions.

Sort: Plan Premium (Low to High)

Hide all Special Needs Plans (SNP)

Effective [January 2024](#)

Preferences

Answer a few questions to estimate your annual cost.

- Get Started
- Prescriptions
- Pharmacy

Enter info

Filters

Clear all

Medical out of pocket maximum

- under \$1999
- \$2000-\$5999
- \$6000 and over

Premium

- under \$49
- \$50-\$99
- \$100 and over

Add-on coverage

- Dental

Additional benefits

- Transportation

Special Needs Plans (SNP)

- Medicare and Medicaid

Blue Shield TotalDual Plan (HMO D-SNP)
Plan ID: H2819-001-000
Not available [Medicare Star Rating](#) [DSNP plan](#)

| | | |
|--------------------|-------------------------------|----------------------|
| Medical Deductible | Medical out of pocket maximum | Monthly plan premium |
| \$0 | \$8,850 | \$0.00 |

Plan details **Add to cart** **Add to quote**

Add to compare

Dental Services Vision Services Hearing Services Additional Telehealth [View all](#)

Blue Shield Inspire (HMO)
Plan ID: H0504-043-000
★★★★☆ [Medicare Star Rating](#)

| | | |
|--------------------|-------------------------------|----------------------|
| Medical Deductible | Medical out of pocket maximum | Monthly plan premium |
| \$0 | \$699 | \$0.00 |

Plan details **Add to cart** **Add to quote**

Add to compare

Add-on coverage: [View all](#)

Dental Services Vision Services Hearing Services Additional Telehealth [View all](#)

Blue Shield 65 Plus (HMO)
Plan ID: H0504-015-000
★★★★☆ [Medicare Star Rating](#)

| | | |
|--------------------|-------------------------------|----------------------|
| Medical Deductible | Medical out of pocket maximum | Monthly plan premium |
| \$0 | \$999 | \$0.00 |

Plan details **Add to cart** **Add to quote**

Add to compare

Add-on coverage: [View all](#)

Dental Services Vision Services Hearing Services Additional Telehealth [View all](#)

Preferences

Guided Help gives agents and beneficiaries the option of adding preferences for a more personalized shopping experience, along with the ability to see the most accurate cost estimates for every plan option.

From the **Get Started** page, the following can be added:

- Prescriptions
- Pharmacy

7. Select the **Enter Info** option to start the consultation.

NOTE: This section is optional.

Start Consultation



Get Started

Prescriptions

Pharmacy

[Go to plans >](#)

*ZIP code

County
Los Angeles, CA

These optional questions help us estimate your potential costs.

What coverage type are you interested in? (Optional)

| | | | |
|--------------|-------------------|--------------------------------------|--------------|
| Medical only | Prescription drug | Medical and prescription drug | I don't know |
|--------------|-------------------|--------------------------------------|--------------|

8

Do you receive extra help paying for prescription drugs?(Optional)

| |
|--|
| I receive help from Medicaid |
| I get supplemental security income |
| I belong to a Medicare Savings Program (MSP) |
| I applied and got full help through social security |
| I applied for and got partial help through social security |
| No, I am not eligible for special assistance |
| I don't know |

[< Previous](#) [Skip >](#) **Continue**

9

Get Started

- Add what type of coverage the beneficiary is interested in.
- Click **Continue**.

NOTE: This section is optional.

Start Consultation

✔ Get Started

● Prescriptions

○ Pharmacy

[Go to plans >](#)



Prescriptions

Add your prescriptions to see how each plan provides coverage.

- Lipitor
- Lipofen
- Locoid Lipocream
- paliperidone er
- Qulipta
- Declinsen

12

[← Previous](#) [Skip >](#) [Continue](#)

13

Prescription

- 12. Add prescriptions to see how each plan provides coverage.
- 13. Click **Continue**.

NOTE: This section is optional.

Start Consultation

- ✔ Get Started
 - Prescriptions
 - Pharmacy
- [Go to plans >](#)



Prescriptions

Add your prescriptions to see how each plan provides coverage.

Lipitor

Select your dosage and enter the amount you use below. The most common dosage and quantity is prefilled.

Select dose and form

- Lipitor TAB 10MG
- Lipitor TAB 20MG
- Lipitor TAB 40MG
- Lipitor TAB 80MG

Enter quantity and frequency

14

Would you like to use a Generic (atorvastatin calcium) for Lipitor

According to the FDA, this generic drug has the same quality, strength, safety and active ingredient as the brand name drug.

15

[< Previous](#)

[Skip >](#)

Prescription

14. Select the dose, form, and quantity. Indicate the generic preference, if available.
15. Click **Add** to continue.

NOTE: This section is optional.

Start Consultation

- Get Started
 - Prescriptions
 - Pharmacy
- [Go to plans >](#)

16

Pharmacy

Drug costs vary based on the pharmacy you use. Select multiple pharmacies to compare estimated drug costs for all available plans.

ZIP code: 90002 Pharmacy name:

Retail pharmacy Digital pharmacy

Pharmacy & Medical Supply
1422 E Florence Ave
Los Angeles, CA 90001

Medishack Pharmacy
1350 E Florence Ave Ste B & C
Los Angeles, CA 90001

Rite Aid Pharmacy 05423
1534 East Florence Avenue
Los Angeles, CA 90001

Viewing 1 - 10 of 24

Your pharmacies

| | | | |
|--------------------------------|--|---|---|
| AMAZON PHARMACY #001 | Digital pharmacy | ★ Primary pharmacy | ✕ |
| CVS Pharmacy #08853 | 1645 East 103rd Street Los Angeles, CA 90002 | Set as primary pharmacy | ✕ |
| Rite Aid Pharmacy 05423 | 1534 East Florence Avenue Los Angeles, CA 90001 | Set as primary pharmacy | ✕ |

17

Pharmacy

16. Add the beneficiary pharmacy preference.

You may add both retail and digital pharmacies to your list.
17. Click **Continue**.

NOTE: This section is optional.

Start Consultation

15 plans available in [90002](#) for [2024](#) for Los Angeles county, CA

Licensed to sell 1 Medicare organizations with 8 plans for 2024

19

Medicare Advantage Prescription Drug Plans
6 plans

Medicare Supplement Plans
7 plans

Prescription Drug Plans
2 plans

Medicare Advantage Prescription Drug Plans bundle the benefits of a Medicare Advantage Plan and a Prescription Drug Plan. Benefits include medical expenses and prescriptions.

Sort: Plan Premium (Low to High)

20

Blue Shield TotalDual Plan (HMO D-SNP)
Plan ID: H2819-001-000
Not available. [Medicare Star Rating](#) [DSNP plan](#)

| | | |
|--------------------|-------------------------------|----------------------|
| Medical Deductible | Medical out of pocket maximum | Monthly plan premium |
| \$0 | \$8,850 | \$0.00 |

[Plan details](#) [Add to cart](#) [Add to quote](#)

Prescriptions 0 of 1 on formulary **Pharmacy** Amazon Pharmacy #001 **Est. drug cost** \$5,333 **Total est. annual cost** \$5,333
Savings might be available. Standard in-network. Effective Jan 2024

✓ Dental Services ✓ Vision Services ✓ Hearing Services Additional Telehealth [View all](#)

Blue Shield Inspire (HMO)
Plan ID: H0504-043-000
★★★★☆ [Medicare Star Rating](#)

| | | |
|--------------------|-------------------------------|----------------------|
| Medical Deductible | Medical out of pocket maximum | Monthly plan premium |
| \$0 | \$699 | \$0.00 |

[Plan details](#) [Add to cart](#) [Add to quote](#)

Add-on coverage

Prescriptions 0 of 1 on formulary **Pharmacy** Amazon Pharmacy #001 **Est. drug cost** \$5,333 **Total est. annual cost** \$5,333
Savings might be available. Standard in-network. Effective Jan 2024

✓ Dental Services ✓ Vision Services ✓ Hearing Services Additional Telehealth [View all](#)

Select Plan Year [X]

Select the year you want coverage for

Plan Year

2023 2024

Cancel Continue

Plans

- Available plans are shown for the beneficiary's zip code.
- Select the plan year you want coverage for.
 - Select the tab to view available plans by type
 - Medicare Advantage Prescription Drug Plans
 - Prescription Drug Plans
 - Medicare Supplement Plans
 - Sort the plans by:
 - Plan Premium (low to high)
 - Total Estimated Cost
 - Estimated Drug Costs (Low to High)
 - Medicare Star Ratings
 - Plan Name (A -Z)
 - Max Out of Pocket (Low to High)

Start Consultation

Costs are based on

- AMAZON PHARMACY #001
- CVS Pharmacy #08853
- Rite Aid Pharmacy 05423
- Mail order

Effective [January 2024](#)

Filters

Medical out of pocket maximum

- under \$1999
- \$2000-\$5999
- \$6000 and over

Premium

- under \$49
- \$50-\$99
- \$100 and over

Add-on coverage

- Dental

Additional benefits

- Transportation

Special Needs Plans (SNP)

- Medicare and Medicaid

Preferences

- Get Started**
 - Extra help: No, I am not eligible for special assistance
- Prescriptions**
 - Lipitor TAB 10MG
- Pharmacy**
 - AMAZON PHARMAC... (primary)
 - CVS Pharmacy #...
 - Rite Aid Pharm...

Hide all Special Needs Plans (SNP) Plan Premium (Low to High)

Blue Shield TotalDual Plan (HMO D-SNP) Compare now

Plan ID: H2819-001-000

Not available [Medicare Star Rating](#) [DSNP plan](#)

| | | |
|--------------------|-------------------------------|----------------------|
| Medical Deductible | Medical out of pocket maximum | Monthly plan premium |
| \$0 | \$8,850 | \$0.00 |

Plan details Add to cart Add to quote

Prescriptions 0 of 1 on formulary [Savings might be available](#)

Pharmacy Amazon Pharmacy #001 Standard In-network

Est. drug cost \$5,333

Total est. annual cost \$5,333 Effective Jan 2024

Dental Services Vision Services Hearing Services Additional Telehealth [View all](#)

Blue Shield Inspire (HMO) Compare now

Plan ID: H0504-043-000

★★★★☆ [Medicare Star Rating](#)

| | | |
|--------------------|-------------------------------|----------------------|
| Medical Deductible | Medical out of pocket maximum | Monthly plan premium |
| \$0 | \$699 | \$0.00 |

Plan details Add to cart Add to quote

Add-on coverage

Prescriptions 0 of 1 on formulary [Savings might be available](#)

Pharmacy Amazon Pharmacy #001 Standard In-network

Est. drug cost \$5,333

Total est. annual cost \$5,333 Effective Jan 2024

Dental Services Vision Services Hearing Services Additional Telehealth [View all](#)

Blue Shield 65 Plus (HMO) Compare now

Plan ID: H0504-015-000

★★★★☆ [Medicare Star Rating](#)

| | | |
|--------------------|-------------------------------|----------------------|
| Medical Deductible | Medical out of pocket maximum | Monthly plan premium |
| \$0 | \$999 | \$0.00 |

Plan details Add to cart Add to quote

Add-on coverage

Prescriptions 0 of 1 on formulary [Savings might be available](#)

Pharmacy Amazon Pharmacy #001 Standard In-network

Est. drug cost \$5,333

Total est. annual cost \$5,333 Effective Jan 2024

21

Compare Plans

Select up to three plans to compare side-by-side.

- 21. Check the box for each plan that you want to compare and click **Compare Now** to view the results.

Start Consultation

22

Show plan differences

Send quote

Costs are based on

AMAZON PHARMACY #001

CVS Pharmacy #08853

Rite Aid Pharmacy 05423

Mail order

Effective January 2024

| | Blue Shield Inspire (HMO) | Blue Shield 65 Plus (HMO) | Blue Shield TotalDual Plan (HMO D-SNP) |
|----------------------|---------------------------|---------------------------|--|
| Medicare Star Rating | ★★★★☆ | ★★★★☆ | Not available |
| Monthly plan premium | \$0.00 | \$0.00 | \$0.00 |
| Plan details | Plan details | Plan details | Plan details |
| Add to cart | Add to cart | Add to cart | Add to cart |

Costs

| | Blue Shield Inspire (HMO) | Blue Shield 65 Plus (HMO) | Blue Shield TotalDual Plan (HMO D-SNP) |
|---|---------------------------|---------------------------|--|
| Est. drug cost Based on 1 drugs Add/edit | \$5,333 annually | \$5,333 annually | \$5,333 annually |
| Total est. annual cost Based on plan premium and drug costs. (Effective Jan 2024) | \$5,333 annually | \$5,333 annually | \$5,333 annually |

Benefits

| | Blue Shield Inspire (HMO) | Blue Shield 65 Plus (HMO) | Blue Shield TotalDual Plan (HMO D-SNP) |
|-------------------------------|---------------------------|---------------------------|--|
| Medical coverage | Medical coverage | | |
| Medical Deductible | \$0.00 | \$0.00 | \$0.00 |
| Medical out of pocket maximum | \$699.00 | \$999.00 | \$8,850.00 |

Preferences

Provider

Search Provider [Provider directory](#) [Provider directory](#) [Provider directory](#)

Prescriptions

Search Prescriptions [Prescription directory](#) [Prescription directory](#) [Prescription directory](#)

Pharmacy

Search Pharmacy [Pharmacy directory](#) [Pharmacy directory](#) [Pharmacy directory](#)

| | | | |
|--------------------------------|--|--|--|
| AMAZON PHARMACY #001 (primary) | ✔ In-network pharmacy with standard pricing | ✔ In-network pharmacy with standard pricing | ✔ In-network pharmacy with standard pricing |
| Mail order | ✔ Covered | ✔ Covered | ✔ Covered |

Optional add-on coverage (available in cart)

23

Plans

Expand each section to view the information for each plan side-by-side.

In the Preferences section, you can search for:

- Provider
- Prescriptions
- Pharmacy's

From this page, you can:

22. Send a quote.
23. Add a plan to the shopping cart.

NOTE:

Differences between plans are highlighted in orange.



Send a Quick Quote

View & Compare plans

[View Section](#)

Quick Quote



Pr **1** English Contact us Sales Trainer

Dashboard Plans Search New profile

Plans

Available plans are shown for the beneficiary's zip code.

1. Select **Plans** from the menu bar.
2. Select the **Edit Zip Code** button.
3. Enter the zip code and click **Shop for Plans** to continue.

NOTE: This section is optional.

0 plans available in [edit]

Enter ZIP code [X]

Please enter your ZIP code to see plans.

*ZIP code **2**

3 Shop for plans

Cancel

No plan results

There are no plans found based on the information provided. Please try your search again.

For more information contact Producer Services at (800) 559-5905.

Quick Quote

15 plans available in [90026](#) for [2024](#)

4

for Los Angeles county, CA

Licensed to sell 1 Medicare organizations with 8 plans for 2024

| | | |
|--|---|---|
| Medicare Advantage Prescription Drug Plans 6 plans | Medicare Supplement Plans 7 plans | Prescription Drug Plans 2 plans |
|--|---|---|

Medicare Advantage Prescription Drug Plans bundle the benefits of a Medicare Advantage Plan and a Prescription Drug Plan. Benefits include medical expenses and prescriptions.

5

Select Plan Year ✕

Select the year you want coverage for

Plan Year

2023 **2024**

Cancel Continue

Effective [January 2024](#)

Preferences

Answer a few questions to estimate your annual cost.

- Get Started
- Prescriptions
- Pharmacy

Enter info

Filters

[Clear all](#)

Medical out of pocket maximum

- under \$1999
- \$2000-\$5999
- \$6000 and over

Premium

- under \$49
- \$50-\$99
- \$100 and over

Sort: Plan Premium (Low to High)

Blue Shield TotalDual Plan (HMO D-SNP) Add to compare

Plan ID: H2819-001-000

Not available [Medicare Star Rating](#) [DSNP plan](#)

| | | |
|--------------------|-------------------------------|----------------------|
| Medical Deductible | Medical out of pocket maximum | Monthly plan premium |
| \$0 | \$8,850 | \$0.00 |

Plan details
Add to cart

Add to quote

✓ Dental Services
 ✓ Vision Services
 ✓ Hearing Services
 ✓ Additional Telehealth
 [View all](#)

6

Blue Shield Inspire (HMO) Add to compare

Plan ID: H0504-043-000

★★★★☆ [Medicare Star Rating](#)

| | | |
|--------------------|-------------------------------|----------------------|
| Medical Deductible | Medical out of pocket maximum | Monthly plan premium |
| \$0 | \$699 | \$0.00 |

Plan details
Add to cart

Add to quote

Add-on coverage

✓ Dental Services
 ✓ Vision Services
 ✓ Hearing Services
 ✓ Additional Telehealth
 [View all](#)

Plans

Available plans are shown for the beneficiary's zip code.

4. Select the year you want coverage for.
5. You can hide or show Special Needs Plans (SNP) by clicking the show/hide button.
6. Send a quote with up to three plans (of the same type) at a time.
 - Click **Add to quote** button for each plan.

NOTE: This section is optional.

Quick Quote

14 plans available in [90026](#) for [2024](#)
for Los Angeles county, CA

Licensed to sell 1 Medicare organizations with 8 plans for 2024

| | | |
|---|--------------------------------------|------------------------------------|
| Medicare Advantage Prescription Drug Plans 5 plans | Medicare Supplement Plans 7 plans | Prescription Drug Plans 2 plans |
|---|--------------------------------------|------------------------------------|

Medicare Advantage Prescription Drug Plans bundle the benefits of a Medicare Advantage Plan and a Prescription Drug Plan. Benefits include medical expenses and prescriptions.

[Blue Shield Inspire \(HMO\)](#) \$0.00 × [Blue Shield 65 Plus \(HMO\)](#) \$0.00 × [Blue Shield 65 Plus Plan 2 \(HMO\)](#) \$0.00 × [Send quote](#) **7**

Sort: Plan Premium (Low to High)

Effective [January 2024](#)

Preferences

Answer a few questions to estimate your annual cost.

- [Get Started](#)
- [Prescriptions](#)
- [Pharmacy](#)

[Enter info](#)

Blue Shield Inspire (HMO) Add to compare
Plan ID: H0504-043-000
★★★★☆ [Medicare Star Rating](#)

| | | |
|--------------------|-------------------------------|----------------------|
| Medical Deductible | Medical out of pocket maximum | Monthly plan premium |
| \$0 | \$699 | \$0.00 |

[Plan details](#) [Add to cart](#) [Remove from quote](#)

Add-on coverage

✓ Dental Services ✓ Vision Services ✓ Hearing Services ✓ Additional Telehealth [View all](#)

Plans

The plans that you selected are shown at the top.

7. Click **Send quote** button.

NOTE: This section is optional.

Quick Quote

The screenshot shows the 'Send quote' modal form on the Blue Shield of California Medicare Enrollment Site. The form is titled 'Send quote' and has a close button (X) in the top right corner. It contains the following fields and sections:

- * First name** and *** Last name**: Text input fields.
- How would the beneficiary like to receive the quote information?**: A section with two radio button options:
 - Email: Includes an *** Email address** text input field.
 - Text: Includes an *** Primary phone number** text input field.
- Additional message**: A text area with the placeholder text: "This will show when the user logs back into the site. Please review this quote at your earliest convenience. Let me know if you have any questions." A blue circle with the number '8' is overlaid on this section.
- Buttons**: 'Cancel' and 'Send quote' buttons at the bottom.

To the right of the main form, a confirmation window is shown with a green checkmark and the text: "We've successfully sent the quote to Bob Bark". It also displays an authorization code (6AIN3E7K), a link to "View Bob profile", a "Due date" of 09/28/2023, and a "Create a task" section with the text "Follow up on quote" and an "Add task" button. A "Close" button is at the bottom of the confirmation window.

Send Quote

Complete the form and select how you want to send the quote via email or text by checking the box.

8. Click **Send quote** button.
You will receive a confirmation that the quote was sent.

You can also create a task to follow up with beneficiary.

To dismiss the confirmation window, click the close button to return to the plans list.

NOTE: This section is optional.

blue shield of california Print English 9 Sales Trainer Gavin

Quote History

Profile

Personal information

ZIP code: 90210 County: Los Angeles, CA
Licensed to sell 1 Medicare organizations with 8 plans for 2024

* First name: Gavin * Last name: D Date of birth: 01/01/1954

Email address: Gavin.D@email.com Primary phone number: (510) 963-0000 Mobile phone number: (510) 963-0000
 Same as primary

Home address

[Save](#)

Agent of record

Sales Trainer

SOA

You have no SOAs for this profile

Notes

You have no notes for this profile

[Add note](#)

Eligibility

Medicare Number: [Show](#) Hospital (Part A) effective date: January 2023 * Medical (Part B) effective date: January 2023

[Add/Edit subsidy](#)

Quote history

Quote sent 09/19/2023 4:18 pm PST to Gavin.Dsouza@blueshieldca.com 2024

Blue Shield TotalDual Plan (HMO D-SNP)
 Blue Shield 65 Plus (HMO)
 Blue Shield AdvantageOptimum Plan (HMO)

Plan type MAPD Authorization code: 7U7H3W7A Please review this quote at your earliest convenience. Let me know if you have any questions.
 Sales Trainer
 BSC_Test_Sales_trainer_2024

Enrollment History

You have no enrollments for this beneficiary

Quote History

The **Quote history** allows you to see all quotes that have been sent to the beneficiary. The Quote history will display:

- The plan quoted
- The date and time the quote was sent
- The email/phone number the quote was sent to
- The authorization code

9. Click the **Search** button to find the beneficiary profile.
10. At the bottom of the Profile screen is the Quote and Enrollment history.

NOTE: This section is optional.



Medicare Supplement Plans

[View Section](#)

Quick Quote



Pr **1** English Contact us Sales Trainer

Dashboard Plans Search New profile

Plans

Available plans are shown for the beneficiary's zip code.

1. Select **Plans** from the menu bar.
2. Select the **Edit Zip Code** button.
3. Enter the zip code and click **Shop for Plans** to continue.

NOTE: This section is optional.

0 plans available in

Enter ZIP code

Please enter your ZIP code to see plans.

*ZIP code **2**

Cancel Shop for plans **3**

No plan results

There are no plans found based on the information provided. Please try your search again.

For more information contact Producer Services at (800) 559-5905.

Quick Quote



14 plans available in 90026 for 2024

for Los Angeles county, CA

Licensed to sell 1 M organizations with 8 plans for 2024

Medicare Advantage Prescription Drug Plans 5 plans

Medicare Supplement Plans 7 plans

Prescription Drug Plans 2 plans

Select Plan Year

Select the year you want coverage for

Plan Year

2023 2024

Cancel Continue

Medicare Supplement Plans cover gaps in Medicare Part A and B. You also have the option to enroll your client in a Prescription Drug Plan.

Click [get a personalized quote](#) to see premiums for plans available in your area

Sort: Plan Premium (Low to High)

Preferences

Answer a few questions to estimate your annual cost.

Get Started Prescriptions Pharmacy

Enter info

Filters

Clear all

Additional benefits

Fitness benefit

Plan subtypes

Plan A Plan C Plan C Innovative Plan N

Medicare Supplement Plan A

Attained Age Add to compare

Monthly plan premium [Get a personalized quote](#)

Add-on coverage Plan details

Medicare Supplement Plan A with \$25 Welcome to Medicare Savings*

Attained Age Add to compare

Monthly plan premium [Get a personalized quote](#)

Add-on coverage Plan details

Medicare Supplement Plan C

Attained Age Add to compare

Monthly plan premium [Get a personalized quote](#)

Add-on coverage Plan details

Plans

Available plans are shown for the beneficiary's zip code.

4. Select the year you want coverage for.
5. Click the **Medicare Supplement Plans** tab to view plans.
6. Click **get a personalized quote** to see premiums for plans available.

NOTE: This section is optional.

Quick Quote

| | | |
|---|--------------------------------------|------------------------------------|
| Medicare Advantage Prescription Drug Plans 5 plans | Medicare Supplement Plans 7 plans | Prescription Drug Plans 2 plans |
|---|--------------------------------------|------------------------------------|

Medicare Supplement Information

The information you provide below will be used to calculate your Medicare Supplement plan premium. Rates are determined based on your age at the time of your plan effective date.

To qualify for the \$25 monthly savings for the first 12 months of enrollment, you must be 65 years or older and Blue Shield must receive your application no later than six months from your original Medicare Part B effective date.

7

| | | | |
|---|---|--|--|
| * Date of birth | * Effective date | * Hospital (Part A) effective date | * Medical (Part B) effective date |
| <input type="text" value="mm/dd/yyyy"/> | <input type="text" value="Select an option"/> | <input type="text" value="Month"/> <input type="text" value="Year"/> | <input type="text" value="Month"/> <input type="text" value="Year"/> |

[← Previous](#) [Continue to plans](#)

Medicare Supplement Information

The information you provide below is used to calculate the beneficiaries Medicare Supplement plan premium.

Rates are determined based on beneficiaries age at the time of their plan effective date.

7. Complete the form and click **Continue to plans**.

NOTE: This section is optional.

Quick Quote

| | | |
|---|---------------------------------------|------------------------------------|
| Medicare Advantage Prescription Drug Plans 5 plans | Medicare Supplement Plans 10 plans | Prescription Drug Plans 2 plans |
|---|---------------------------------------|------------------------------------|

Medicare Supplement Plans cover gaps in Medicare Part A and B. You also have the option to enroll your client in a Prescription Drug Plan.

[Edit your answers](#)

[Medicare Supplement Plan F Extra](#) \$228.00 ×
 [Medicare Supplement Plan G](#) \$176.00 ×
 [Medicare Supplement Plan G Extra](#) \$191.00 ×

9

Sort: Plan Premium (Low to High)

Preferences

Answer a few questions to estimate your annual cost.

- [Get Started](#)
- [Prescriptions](#)
- [Pharmacy](#)

Filters

[Clear all](#)

Add-on coverage

- Dental

Additional benefits

- Fitness benefit

Plan subtypes

- Plan A
- Plan F Innovative
- Plan G
- Plan G Innovative
- Plan N

Medicare Supplement Plan G Add to compare

[Attained Age](#)

Monthly plan premium **\$176.00**

Add-on coverage

8

Medicare Supplement Plan G Extra Add to compare

[Attained Age](#)

Monthly plan premium **\$191.00**

Add-on coverage

Medicare Supplement Plan F Extra Add to compare

[Attained Age](#)

Monthly plan premium **\$228.00**

Add-on coverage

Plans

Available plans are shown for the beneficiary's zip code with their monthly plan premium.

8. Click the **Add to quote** button.

The quotes are shown at the top of the screen.

9. Click **Send a Quote** button.

NOTE: This section is optional.

Quick Quote

Medicare Advantage Prescription Drug Plans
5 plans

Medicare Supplement Plans
10 plans

Prescription Drug Plans
2 plans

Medicare Supplement Plans cover gaps in Medicare Part A and B. You also have the option to enroll your client in a Prescription Drug Plan.

[Edit your answers](#)

Medicare Supplement Plan F Extra \$228.00

Preferences

Answer a few questions to estimate your annual cost.

- Get Started
- Prescriptions
- Pharmacy

[Enter info](#)

Filters

[Clear all](#)

Add-on coverage

- Dental

Additional benefits

- Fitness benefit

Plan subtypes

Send quote

* First name: gavin

* Last name: g.

How would the beneficiary like to receive the quote information?

Email

* Email address

Text

* Primary phone number

Additional message

This will show when the user logs back into the site.

Please review this quote at your earliest convenience. Let me know if you have any questions.

Plan(s) included

- Medicare Supplement Plan F Extra
- Medicare Supplement Plan G
- Medicare Supplement Plan G Extra

Cancel **Send quote**

Send Quote

Complete the form and select how you want to send the quote via email or text by checking the box.

10. Click **Send quote** button.

You will receive a confirmation that the quote was sent.

You can also create a task to follow up with beneficiary.

To dismiss the confirmation window, click the close button to return to the plans list.

NOTE: This section is optional.

10

Quote History

blue shield of california

Print English 11 Sales Trainer

Dashboard Plans Search

Profile

Personal information

*ZIP code: 90026 County: Los Angeles, CA
Licensed to sell 1 Medicare organizations with 8 plans for 2024

* First name: gavin * Last name: g. Date of birth: MM/DD/YYYY

Email address: Primary phone number: Mobile phone number: Same as primary

Home address: [Save](#)

Agent of record

Sales Trainer

SOA

You have no SOAs for this profile

Notes

You have no notes for this profile [Add note](#)

Eligibility

Medicare Number: [Show](#) Hospital (Part A) effective date: September 2011 * Medical (Part B) effective date: September 2011 [Add/Edit subsidy](#)

Quote history

Quote sent 09/26/2023 11:41 am PST to vincent.vigliotti@blueshieldca.com

Medicare Supplement Plan F Extra
Medicare Supplement Plan G
Medicare Supplement Plan G Extra

Plan type MEDIGAP Requested effective date: 01/01/2024 Authorization code: HBU4N5T3

Please review this quote at your earliest convenience. Let me know if you have any questions.
Sales Trainer
BSC_Test_Sales_trainer_2024

Enrollment History

You have no enrollments for this beneficiary

Quote History

The **Quote history** allows you to see all quotes that have been sent to the beneficiary. The Quote history will display:

- The plan quoted
- The date and time the quote was sent
- The email/phone number the quote was sent to
- The authorization code

11. Click the Search button to find the beneficiary profile.
12. At the bottom of the Profile screen is the Quote and Enrollment history.

NOTE: This section is optional.



Start New Enrollment

Annual Enrollment Period (AEP)

[View Section](#)

Shopping Cart

15 plans available in [90026](#) for [2024](#)

for Los Angeles county, CA

Licensed to sell 1 Medicare organizations with 8 plans for 2024

2

- Medicare Advantage Prescription Drug Plans (6 plans)
- Medicare Supplement Plans (7 plans)
- Prescription Drug Plans (2 plans)

Medicare Advantage Prescription Drug Plans bundle the benefits of a Medicare Advantage Plan and a Prescription Drug Plan. Benefits include medical expenses and prescriptions.

1

Select Plan Year

Select the year you want coverage for

Plan Year

2023 2024

Cancel Continue

Sort: Plan Premium (Low to High)

3

Hide all Special Needs Plans (SNP)

Effective [January 2024](#)

Preferences

- Get Started
- Prescriptions
- Pharmacy
- Enter info

Filters

Medical out of pocket maximum

- under \$1999
- \$2000-\$5999
- \$6000 and over

Premium

- under \$49
- \$50-\$99
- \$100 and over

Blue Shield TotalDual Plan (HMO D-SNP)

Plan ID: H2819-001-000

Not available [Medicare Star Rating](#) [DSNP plan](#)

| | | |
|--------------------|-------------------------------|----------------------|
| Medical Deductible | Medical out of pocket maximum | Monthly plan premium |
| \$0 | \$8,850 | \$0.00 |

Plan details Add to cart Add to quote

✓ Dental Services ✓ Vision Services ✓ Hearing Services ✓ Additional Telehealth [View all](#)

Blue Shield Inspire (HMO)

Plan ID: H0504-043-000

★★★★☆ [Medicare Star Rating](#)

| | | |
|--------------------|-------------------------------|----------------------|
| Medical Deductible | Medical out of pocket maximum | Monthly plan premium |
| \$0 | \$699 | \$0.00 |

Plan details Add to cart Add to quote

Add-on coverage

✓ Dental Services ✓ Vision Services ✓ Hearing Services ✓ Additional Telehealth [View all](#)

4

Plans

Available plans are shown for the beneficiary's zip code.

1. Select the year you want coverage for.
2. Select the tab to view available plans by type
 - Medicare Advantage Prescription Drug Plans
 - Prescription Drug Plans
 - Medicare Supplement Plans
3. Sort the plans by:
 - Plan Premium (low to high)
 - Total Estimated Annual Cost
 - Medicare Star Ratings
 - Plan Name (A -Z)
4. Add plan to cart

Shopping Cart



[Back to plans](#)

Cart

Medicare Advantage Prescription Drug Plan

Blue Shield Inspire (HMO) Monthly plan premium **\$0.00**

[View details](#) [Change plan](#) [Remove plan](#)

Optional add-on coverage

Dental

| | | | |
|---------------------------------------|------------------------------|---------|------------|
| Optional Supplemental Dental HMO plan | View details | \$15.00 | Add Dental |
| Optional Supplemental Dental PPO plan | View details | \$45.00 | Add Dental |

*** In order to process this application Blue Shield of California requires agreement from the beneficiary, How will you be completing this form?**

| |
|--|
| <input type="radio"/> Send to beneficiary to sign and submit |
| <input type="radio"/> Complete and submit form myself |

Continue to apply

5

6

7

You may [clear the cart](#) if you have completed all enrollments.

Total monthly plan premium **\$0.00**

Add to Cart

5. Add any optional add-on coverage.

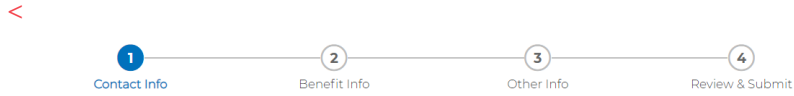
You can only add optional coverage in the Cart screen.

6. Select how you will complete this form:

- Send to beneficiary to sign and submit
- Complete and submit form yourself

7. Click the **Continue to apply** button.

Shopping Cart



Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

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

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

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

When do I use this form?

You can join a plan:

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

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

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

Note: You must complete all fields that are marked with an asterisk (*). Some items are optional. You cannot be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
• Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit. For more information, see Paying Your Plan Premium section on the Review & Submit page of this application.

Individuals experiencing homelessness

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

Shopping cart summary for Blue Shield Inspire (HMO) with Total monthly plan premium of \$0.00.

Sales Trainer
123 Main Street
San Francisco CA 94102
(888) 321-5555
Blue Shield of California Address
6300 Canoga Avenue
Woodland Hills, CA 91367
Phone (800) 776-4466
Hours 8am-8pm, seven days a week

8 Contact Information

Personal Information

*First Name

Middle Initial

*Last Name

*Birth Date

*Gender

Male Female

*Phone Number

Please enter your 10 digit phone number with no hyphen or spaces (e.g., 2125551212).

Phone Number Type

Landline Cell

Alternate Phone Number

Please enter your 10 digit phone number with no hyphen or spaces (e.g., 2125551212).

Alternate Phone Number Type

Landline Cell

I agree that Blue Shield and its affiliated entities and agents may communicate with me about my account and various health and wellness programs available to me, and other promotional information that may benefit me and my dependents, including by phone or text to the numbers I have listed on this form, using an auto-dialer or artificial or prerecorded voice; standard data rates apply.

Yes No

Participation is voluntary and you can opt-out at any time, for more information visit blueshieldca.com/terms

9 Communication Preference

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

Email address

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

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

Preferred Communications Channel

Select

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

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

Spanish Chinese

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

Braille Large Print Audio CD

Please contact Blue Shield Customer Care at (800) 776-4466 (TTY: 711) if you need information in an accessible format or language other than what is listed above. For members enrolled in D-SNP plans, please contact D-SNP Customer Care (800) 452-4413 (TTY: 711). For Medicare Prescription Drug plans call (888) 239-6469 (TTY: 711). Our office hours are 8 a.m. to 8 p.m., seven days a week.

Permanent Residence

*Street Address 1

Street Address 2

*City

Los Angeles

*State

CA

*ZIP Code

90026 Edit

Mailing Address

Do you have a mailing address that is different than your permanent address?

Yes No



Continue

Contact Information

There is a 4-step process to completing the enrollment.

Step 1- Contact Info

8. Complete the Contact Information sections:

- Personal Information
• Permanent Residence

9. Continue down the page to complete the Contact Information sections:

- Mailing Address
• Email Consent

Option Fields:

- Ethnicity & Race
• Language options
• Accessible format materials

10. Click Continue to go to Step 2.

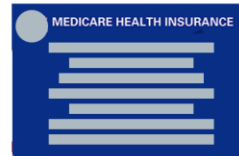
Shopping Cart



Benefits Information

* Indicates Required Fields

Medicare Information



*Medicare Number

11

Special Enrollment Period

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

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

I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me.
I moved on

I recently was released from incarceration.
I was released on

I recently returned to the United States after living permanently outside of the U.S.
I returned to the U.S. on

I recently obtained lawful presence status in the United States.
I got this status on

Shopping cart

Blue Shield Inspire (HMO)
Medicare Advantage
Prescription Drug Plan

\$0.00

Total monthly plan premium

\$0.00

[Blue Shield Inspire \(HMO\)](#)
[Los Angeles Counties & Orange County SOB](#)
[Blue Shield Inspire \(HMO\)](#)
[Los Angeles Counties & Orange County ANOC](#)
[Multi Language Insert](#)

Sales Trainer
123 Main Street
San Francisco, CA 94102
(888) 321-5555

Blue Shield of California
Address
6300 Canoga Avenue
Woodland Hills, CA 91367
Phone
(800) 776-4466
Hours
8am-8pm, seven days a week

I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on

I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on

I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change

I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility).
I moved/will move into/out of the facility on

I recently left a PACE program.
I left the program on

I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
I lost my drug coverage on

I am leaving employer or union coverage on

I belong to a pharmacy assistance program provided by my state

My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan

I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan.
My enrollment in that plan started on

I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualifications required to be in the plan.
I was disenrolled from the SNP on

I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

I'm in a plan that was recently taken over by the state or territorial regulatory authority because of financial issues. I want to switch to another plan.

I'm in a plan that had a star-rating less than 3 stars for the last 3 years. I want to join a plan with a star rating 3 stars or higher.

I am new to Medicare AND Medicare entitlement was made retroactively so I was notified about getting Medicare after my Part A and/or B effective date.

If none of these statements applies to you or you're not sure, please contact Blue Shield of California at (888) 534-4263 (TTY: 711) or Authorized Agent, to see if you are eligible to enroll. For Medicare Prescription Drug plans please call (888) 292-7591 (TTY: 711).

We are open 8 a.m. to 8 p.m., seven days a week from October 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday, from April 1 to September 30.

Prescription Drug Coverage

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Blue Shield Inspire (HMO)?

Medicaid Enrollment

Are you enrolled in your State Medicaid (Medi-Cal) program?

Special Supplemental Benefits for the Chronically Ill (SSBCI)

Blue Shield Inspire (HMO) in the counties of Alameda, Fresno, Madera, Merced, Sacramento, San Joaquin, San Mateo, Santa Clara, and Stanislaus; Blue Shield Inspire (HMO D-SNP) in San Joaquin, Merced and Stanislaus; and Blue Shield Balance (HMO) in the county of Los Angeles includes one or more Special Supplemental Benefits for the Chronically Ill (SSBCI).

SSBCI are part of special supplemental benefits available in select plans. Not all plan members will qualify. Refer to the Evidence of Coverage for details and eligibility requirements. To be eligible for each SSBCI benefit, you must have at least one of the required qualifying chronic conditions which can vary by plan. Please refer to the "Attestation for Special Supplemental Benefit" for the Chronically Ill (SSBCI) form included in the enrollment kit, online or contact Customer Care (800) 776-4466 (TTY: 711) for a copy. For members enrolled in D-SNP plans, please contact D-SNP Customer Care (800) 452-4413 (TTY: 711)

[Previous](#)

[Continue](#)

12

Benefit Information

There is a 4-step process to completing the enrollment.

Step 2- Benefit Info

11. Complete the Benefits Information sections:

- Medicare Number
- Prescription Drug Coverage
- Medicaid Enrollment

12. Click **Continue** to go to Step 3.

Shopping Cart

13

Other Information

Please see the additional questions below. Answering these questions is your choice. You can't be denied coverage for not answering any of them.

Employment Information

Do you work?

Does your spouse work?

Ethnicity and Race

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

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

What's your race? Select all that apply.

- American Indian or Alaska Native
- Asian Indian
- Black or African American
- Chinese
- Filipino
- Guamanian or Chamorro
- Japanese
- Korean
- Native Hawaiian
- Other Asian
- Other Pacific Islander
- Samoan
- Vietnamese
- White
- I choose not to answer

2024 Print English Contact us Sales Trainer
 Dashboard Plans Search New profile Bob



Shopping cart

Blue Shield Inspire (HMO)
 Medicare Advantage Prescription Drug Plan

\$0.00

Total monthly plan premium

\$0.00

[Blue Shield Inspire \(HMO\)](#)
[Los Angeles Counties & Orange County SOB](#)
[Blue Shield Inspire \(HMO\)](#)
[Los Angeles Counties & Orange County ANOC](#)
[Multi Language Insert](#)

Sales Trainer
 123 Main Street
 San Francisco CA 94102
 (888) 321-5555

Blue Shield of California
Address
 6300 Canoga Avenue
 Woodland Hills, CA 91367
Phone
 (800) 776-4466
Hours
 8am-8pm, seven days a week

Physician Selection

Use [Find A Doctor](#) to locate your primary care physician. Once you've made your selection, click on the "Make PCP" button under your chosen doctor's name and then confirm your selection by clicking the "Choose for primary care" button.

The doctor's name and ID number will automatically be populated in the fields below

*Physician Name or Clinic Name:

*Physician ID #

Physician Group Name:

*Current Patient?

Producer Information (Broker Use Only)

FMO/Agency Name

FMO/Agency ID

This info has been hidden for security purposes.

Producer First Name

Producer Last Name

Producer ID

This info has been hidden for security purposes.

National Producer Number

For auditing, Brokers please retain copy of the paper application.

[Previous](#)

[Continue](#)

14

Other Information

Step 3- Benefit Info

13. Complete the Other Information sections:

- Employment Information
- Physician Selection
- Producer Information
- Special Supplemental benefits for the Chronically III (SSBCI) – Blue Shield Inspire (HMO) and Blue Shield Inspire (HMO D-SNP)

14. Click **Continue** to go to Step 4.

NOTE: Physician information can be added manually.

Shopping Cart



15

Review and Submit

Review your application

You may review your answers to the application by expanding each section below and make updates if needed. After you review, in the Important Information section below, check the acknowledgement that you have reviewed the information. Then indicate who is submitting this form and click the Submit button at the bottom of the page.

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

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

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

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

When do I use this form?

You can join a plan:

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

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

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

Note: You must complete all fields that are marked with an asterisk (*). Some items are optional. You cannot be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit. For more information, see Paying Your Plan Premium section on the Review & Submit page of this application.

Individuals experiencing homelessness

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

Shopping cart

Blue Shield Inspire (HMO)
Medicare Advantage Prescription Drug Plan

\$0.00

Total monthly plan premium

\$0.00

[Blue Shield Inspire \(HMO\) Los Angeles Counties & Orange County SOR](#)
[Blue Shield Inspire \(HMO\) Los Angeles Counties & Orange County ANOC Multi Language Insert](#)

Sales Trainer
123 Main Street
San Francisco CA 94102
(888) 321-5555

Blue Shield of California Address
6300 Canoga Avenue
Woodland Hills, CA 91367
Phone
(800) 776-4466
Hours
8am-8pm, seven days a week

Contact Information

* Indicates Required Fields

Personal Information

*First Name

Bob

Middle Initial

*Last Name

B

*Birth Date

09/04/1956

*Gender

Male Female

*Phone Number

(800) 555-1212

Please enter your 10 digit phone number with no hyphen or spaces (e.g., 2125551212).

Phone Number Type

Landline Cell

Alternate Phone Number

Please enter your 10 digit phone number with no hyphen or spaces (e.g., 2125551212).

Alternate Phone Number Type

Landline Cell

I agree that Blue Shield and its affiliated entities and agents may communicate with me about my account and various health and wellness programs available to me, and other promotional information that may benefit me and my dependents, including by phone or text to the numbers I have listed on this form, using an auto-dialer or artificial prerecorded voice; standard data rates apply.

Yes No

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

Communication Preference

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

Email address

vincent.vigliotti@blueshieldca.com

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

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

Preferred Communications Channel

Email

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

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

Spanish Chinese

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

Braille Large Print Audio CD

Please contact Blue Shield Customer Care at (800) 776-4466 (TTY: 711) if you need information in an accessible format or language other than what is listed above. For members enrolled in D-SNP plans, please contact D-SNP Customer Care (800) 452-4413 (TTY: 711). For Medicare Prescription Drug plans call (888) 239-6469 (TTY: 711). Our office hours are 8 a.m. to 8 p.m., seven days a week.

Permanent Residence

*Street Address 1

123 main street

Street Address 2

*City

Los Angeles

*State

CA

*ZIP Code

90026 [Edit](#)

Mailing Address

Do you have a mailing address that is different than your permanent residence address?

Yes No

Benefits Information

Other Information

Review & Submit

Complete the application.

Step 4 - Review & Submit

15. Complete the Review and Submit sections:

- Expand each section to view and verify the information.
- Correct or complete any fields that require revision.
- Scroll down the page to complete the Review and Submit sections.



Shopping Cart

IMPORTANT: Read and sign below:

I Bob Bark understand(s) that:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Blue Shield Inspire (HMO).
- By joining this Medicare Advantage Plan, I acknowledge that Blue Shield Inspire (HMO) will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA or Part D plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that when my Blue Shield Inspire (HMO) coverage begins, I must get all of my medical and prescription drug benefits from Blue Shield Inspire (HMO). Benefits and services provided by Blue Shield Inspire (HMO) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Blue Shield Inspire (HMO) will pay for benefits or services that are not covered.

*What is your relationship to the person enrolling in this plan?

- I am (or am helping) the person enrolling
- I am an agent or authorized person

16

- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
 - This person is authorized under State law to complete this enrollment, and
 - Documentation of this authority is available upon request by Medicare.

Volunteer / Authorized Individual

If you have been authorized to fill out this form on behalf of another individual, under the laws of the State where that individual resides, you must provide the following information. Upon request, you must be able to present Blue Shield of California and/or Medicare with documentation of your authority to represent the individual listed on this application

*Name

*Address

*City

*State

*ZIP

*Phone Number

Please enter your 10 digit phone number with no hyphen or spaces (e.g., 2125551212).

*Relationship to Enrollee

Authorized Individual Signature

*Please sign your name in the space below using your mouse, stylus, or finger.

- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
 - This person is authorized under State law to complete this enrollment, and
 - Documentation of this authority is available upon request by Medicare.

Paying Your Plan Premium

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

To learn more about your payment options, visit us at blueshieldca.com/medicarewaystopay or call Customer Care at 800-776-4466 (TTY: 711). For members enrolled in D-SNP plans, please contact D-SNP Customer Care 800-452-4413 (TTY: 711). For Medicare Prescription drug plans 888-239-6469.

Electronic funds transfer (EFT) from your bank account each month

Credit Card

Get Monthly Bill

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

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

PRIVACY ACT STATEMENT

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

Previous

Send to beneficiary

17

Send enrollment

How would the beneficiary like to receive the application to finish enrolling?

Email *Email address

Text *Phone number

Plan included [Select all](#)

Blue Shield Inspire (HMO)

Blue Shield Inspire (HMO) Los Angeles Counties & Orange County SOB

Blue Shield Inspire (HMO) Los Angeles Counties & Orange County ANOC

Multi Language Insert

Cancel Send application

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Review & Submit

Step 4 - Review & Submit

16. For the question: "What is your relationship to the person enrolling in this plan?"




- Select "I am (or am helping) the person enrolling" if you have the Power of Attorney (POA).
- Select "I am an agent or authorized person" if you are the Broker/Agent.

17. Click **Send to Beneficiary** to sign.

18. Complete the form and select the method of sending the application to the beneficiary by selecting a check box (you can select multiple boxes). Click **Send Application**.



Shopping Cart



Hi Bob,

To view the plan information we discussed, please enter your authorization code in the box below. The authorization code was sent to you via your email or text messages for the code.

*** Authorization code**

[Continue](#)

20


Hi Bob,

Here is the plan we discussed...

Thank you for meeting with me. Per our discussion, here is the plan that should fit your needs. Once you receive your verification code, which should arrive in an email shortly, you will be able to enroll in this plan.

[View application](#)

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 **Sales Trainer**
BSC_TEST_Agency
sales_training@blueshieldca.com
(415) 355-1212

Beneficiary Review & Submit

- 19. The beneficiary will receive an email or text with a link. When they click the link, they are taken to application to sign and submit.
- 20. The beneficiary will also receive a second email with the authorization code to access the application.



Meet with Sales Trainer

(888) 321-5555
S_trainer@email.com

Shopping Cart



Review and Submit

Review your application. You may review your answers to the application by expanding each section below and make updates if needed. After you review, in the Important Information section below, check the acknowledgement that you have reviewed the information. Then indicate who is submitting this form and click the Submit button at the bottom of the page.

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

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

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

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

When do I use this form?

You can join a plan:

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

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

What do I need to complete this form?

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

Note: You must complete all fields that are marked with an asterisk (*). Some items are optional. You cannot be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit. For more information, see Paying Your Plan Premium section on the Review & Submit page of this application.

Shopping cart

Blue Shield Inspire (HMO)
Medicare Advantage
Prescription Drug Plan

\$0.00

Total monthly plan premium \$0.00

[Blue Shield Inspire \(HMO\) Los Angeles Counties & Orange County S.O.B.](#)
[Blue Shield Inspire \(HMO\) Los Angeles Counties & Orange County J.N.O.C.](#)
[Multi Language Insert](#)

Sales Trainer
123 Main Street
San Francisco CA 94102
(888) 321-5555

Blue Shield of California Address
6300 Canoga Avenue
Woodland Hills, CA 91367
Phone
(800) 776-4466
Hours
8am-8pm, seven days a week

*What is your relationship to the person enrolling in this plan?

I am (or am helping) the person enrolling

I am an agent or authorized person



Beneficiary Signature

Due to physical limitations, I am unable to sign

*Please sign your name in the space below using your

Electronic funds transfer (EFT) from your bank account each month

Credit Card

Get Monthly Bill

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

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

PRIVACY ACT STATEMENT

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

Bob B

I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:

- This person is authorized under State law to complete this enrollment, and
- Documentation of this authority is available upon request by Medicare.

Paying Your Plan Premium

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

To learn more about your payment options, visit us at blueshieldca.com/medicarewaystopyay or call Customer Care at **800-776-4466** (TTY: 711). For members enrolled in D-SNP plans, please contact D-SNP Customer Care **800-452-4413** (TTY: 711). For Medicare Prescription drug plans **888-239-6469**.

Electronic funds transfer (EFT) from your bank account each month

Credit Card

Get Monthly Bill

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

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

PRIVACY ACT STATEMENT

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

[Previous](#)

[Submit](#)



Beneficiary Review & Submit

Step 4 - Review & Submit

21. For the question: "What is your relationship to the person enrolling in this plan?"

- Select "I am (or am helping) the person enrolling" if you have the Power of Attorney (POA) or **the beneficiary**.

- Select "I am an agent or authorized person" if you are the Broker/Agent.

22. Click **Submit**.

Shopping Cart

Application submitted

Your application has been submitted and is pending approval.
This confirmation is not proof of membership.

You may have other coverage in your cart you still need to enroll in.
You may clear your cart if you have completed all enrollments. [Continue applying for coverage](#)

[Email](#) [Print](#)

What to expect

- Confirmation**
Within 10 days of enrollment, you will receive a confirmation enrollment letter in the mail. It is also confirmation that Medicare has approved your enrollment
- Member ID card**
You will also receive your member ID card. Keep this with you for all your doctor, hospital, and pharmacy visits.
- Welcome package**
You will receive a package containing important plan documents. This includes instructions about how to access the Evidence of Coverage, drug list, and provider directory.
- Premium assistance**
If you qualify for help, you will receive a Low-Income Subsidy (LIS) letter. Depending on your level of coverage, receiving US means lower prescription drug costs and financial assistance to cover your Part D premium.
- Complete your Health Risk Assessment HMO, D-SNP members only**

If you have enrolled in a D-SNP plan, Blue Shield Care Coordinators will call you within 90 days of enrollment to complete your Health Risk Assessment (HRA) and Care Plan. Completing these tools helps our Care Coordinators individualize your care to meet your needs. You can also complete your HRA by mail or call 1-888-548-5765.

Blue Shield of California
6300 Canoga Avenue Woodland Hills, CA 91367
8am-8pm, seven days a week
(800) 776-4466
<https://www.blueshieldca.com/medicare>

Application details

Member name
Bob Bark

Member address
123 main street Los Angeles, CA 90026

Submitted on
September 26, 2023

Confirmation number
A54262644Z73464M

[View application](#)

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Your pending coverage

Medicare Advantage Prescription Drug Plan

blue Blue Shield Inspire (HMO) **california** Monthly plan premium **\$0.00**

Total monthly plan premium \$0.00

[Continue applying for coverage](#)

What's Next:
This confirmation number can be used to help track the online enrollment, but it is not proof of membership. Please wait at least 10 days before calling the plan to ask about the status of your enrollment. Please keep this information in case you have any questions about your enrollment and need to contact your selected plan.

If any of the required information on your enrollment form was missing or does not match your Medicare record, the plan may contact you to get the missing or correct information. This could delay the plan's ability to process your enrollment.

Here are some important things to expect when your coverage is first effective if the plan determines that your enrollment meets all of the Medicare requirements and is complete. This information is especially important if you enrolled late in the month and you have not received a letter, or your membership card, by the day your coverage starts.

- After the plan has processed your application, you should get a letter from the plan you joined. This may take several days. If you do not receive correspondence from the plan in about 10 calendar days, you should contact the plan to check on the status of the enrollment.
- Enrollment can be effective as early as the first of the next month depending on your circumstances. The plan you have selected will inform you of your effective date of enrollment.
- If you need to fill a prescription before you get your plan membership card, let your pharmacist know your plan name and show any of the following materials as proof of membership:
 - Take your acknowledgement, welcome, or confirmation letter that you receive from the plan with you to the pharmacy.
 - Please note: The confirmation number listed on this website cannot be used at your local pharmacy as proof of plan membership.**
 - If you haven't gotten a letter yet, you might have a copy of an enrollment application signed by a plan representative.
 - If you have both Medicare and Medicaid, you should bring proof of enrollment in both programs such as your Medicare and Medicaid cards, a copy of a Medicare Summary Notice, a recent Medicaid bill, or a copy of your current Medicaid award letter. If you qualify for extra help (the low-income subsidy) you can also bring proof that you qualify such as a copy of your yellow or green automatic enrollment letter from Medicare (if you automatically qualify) or your approval letter from Social Security (if you applied and qualify).
 - As a last resort, if you pay out of pocket for your prescription, save your receipts and work with your plan to be reimbursed.
- If you have questions, call the plan's toll-free number.

Beneficiary Confirmation

23. Ask the beneficiary to copy the confirmation number for your records.

The beneficiary can also view and download a copy of the application.



Medicare Supplement Plans

[View Section](#)

Shopping Cart

2024 Print English Contact us Sales Trainer

Dashboard Plans Search New profile

14 plans available in 90026 for 2024 for Los Angeles county, CA

Licensed to sell 11 Medicare organizations with 8 plans for 2024

2 Medicare Advantage Prescription Drug Plans 5 plans

3 Medicare Supplement Plans 7 plans

4 Prescription Drug Plans 2 plans

Select Plan Year

Select the year you want coverage for

Plan Year

2023 2024

Cancel Continue

3 Click [get a personalized quote](#) to see premiums for plans available in your area

Sort: Plan Premium (Low to High)

Preferences

Answer a few questions to estimate your annual cost.

Get Started Prescriptions Pharmacy

Enter info

Filters

Clear all

Additional benefits

Fitness benefit

Plan subtypes

Plan A Plan C Plan C Innovative Plan N

Medicare Supplement Plan A

Attained Age

Monthly plan premium [Get a personalized quote](#)

Add-on coverage

Plan details

Medicare Supplement Plan A with \$25 Welcome to Medicare Savings*

Attained Age

Monthly plan premium [Get a personalized quote](#)

Add-on coverage

Plan details

Medicare Supplement Plan C

Attained Age

Monthly plan premium [Get a personalized quote](#)

Add-on coverage

Plan details

Plans

Available plans are shown for the beneficiary's zip code.

1. Select the year you want coverage for.
2. Click the **Medicare Supplement Plans** tab to view plans.
3. Click **get a personalized quote** to see premiums for plans available.
4. **Add plan to cart**



Quick Quote

| | | |
|--|---|---|
| <p>Medicare Advantage Prescription Drug Plans</p> <p>5 plans</p> | <p>Medicare Supplement Plans</p> <p>7 plans</p> | <p>Prescription Drug Plans</p> <p>2 plans</p> |
|--|---|---|

Medicare Supplement Information

The information you provide below will be used to calculate your Medicare Supplement plan premium. Rates are determined based on your age at the time of your plan effective date.

To qualify for the \$25 monthly savings for the first 12 months of enrollment, you must be 65 years or older and Blue Shield must receive your application no later than six months from your original Medicare Part B effective date.

5

* Date of birth

* Effective date

* Hospital (Part A) effective date

* Medical (Part B) effective date

[← Previous](#)

[Continue to plans](#)

Medicare Supplement Information

The information you provide below is used to calculate the beneficiaries Medicare Supplement plan premium.

Rates are determined based on beneficiaries age at the time of their plan effective date.

- Complete the form and click **Continue to plans**.

Quick Quote

17 plans available in 90026 for 2024

for Los Angeles county, CA

Licensed to sell 1 Medicare organizations with 8 plans for 2024

Medicare Advantage Prescription Drug Plans 5 plans

Medicare Supplement Plans 10 plans

Prescription Drug Plans 2 plans

Medicare Supplement Plans cover gaps in Medicare Part A and B. You also have the option to enroll your client in a Prescription Drug Plan.

[Edit your answers](#)

Sort: Plan Premium (Low to High)

Preferences

Answer a few questions to estimate your annual cost.

- Get Started
- Prescriptions
- Pharmacy

[Enter info](#)

Filters

[Clear all](#)

Add-on coverage

- Dental

Additional benefits

- Fitness benefit

Plan subtypes

- Plan A
- Plan F Innovative
- Plan G
- Plan G Innovative
- Plan N

Medicare Supplement Plan G Add to compare

[Attained Age](#)

Monthly plan premium **\$176.00**

[Plan details](#) [Add to cart](#) [Remove from quote](#)

Add-on coverage

Medicare Supplement Plan G Extra Add to compare

[Attained Age](#)

Monthly plan premium **\$191.00**

[Plan details](#) [Add to cart](#) [Remove from quote](#)

Add-on coverage

Medicare Supplement Plan F Extra Add to compare

[Attained Age](#)

Monthly plan premium **\$228.00**

[Plan details](#) [Add to cart](#) [Remove from quote](#)

Add-on coverage

6

Plans

Available plans are shown for the beneficiary's zip code with their monthly plan premium.

6. Click the **Add to cart** button.

Shopping Cart

Add to Cart

7. Add any optional add-on coverage.

You can only add optional coverage in the Cart screen.
8. Select how you will complete this form:
 - Send to beneficiary to sign and submit
 - Complete and submit form yourself
9. Click the **Continue to apply** button.

[Back to plans](#)

Cart

Add a Prescription Drug Plan

Adding a Prescription Drug Plan can help save money on your prescription costs.

[Shop for plans](#)

7

Medicare Supplement Plan

Medicare Supplement Plan G Extra
Requested start date: January 1, 2024

Monthly plan premium
\$191.00

[View details](#) [Change plan](#) [Remove plan](#)

Optional add-on coverage

Dental

| | | | |
|-----------------|------------------------------|---------|----------------------------|
| Dental PPO 1000 | View details | \$36.10 | Add Dental |
| Dental PPO 1500 | View details | \$52.80 | Add Dental |

* In order to process this application Blue Shield of California requires agreement from the beneficiary. How will you be completing this form?

- Send to beneficiary to sign and submit
- Complete and submit form myself

[Continue to apply](#)

9

8

You may [clear the cart](#) if you have completed all enrollments.

Total monthly plan premium **\$191.00**

[Previous](#)





Shopping Cart



Print English Contact us Sales Trainer

Dashboard Plans Search New profile

Each of these links contain important information about Medicare Supplement and this plan.

Medicare Supplement Plan G Extra

[Choosing a Medigap Policy](#)

[Evidence of Coverage](#)

[Multi-Lanugage Notice](#)

[Notice of New or Innovative Benefits Form](#)

[Summary of Benefits](#)

Please be advised that if the information you provide on the enrollment form differs from the information you provided for a rate quote, then your premium may change.

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*I acknowledge I have read the above documents and fully understand their contents.

[Previous](#)

Continue

11

Important Information

10. Check the checkbox to acknowledge that you have read the above documents and fully understand their contents.

11. Click the **Continue** button.

Shopping Cart



12 **1** Applicant Info **2** Additional Info **3** Guaranteed Acceptance **4** Current Insurance Coverage **5** Producer Info **6** Payment & Conditions of Membership

Application for Blue Shield of California Medicare Supplement Plans

Here's how to apply

1. Please make sure you answer all questions completely and accurately
2. Sign and date in all places indicated.

If you are a current member interested in transferring to a Medicare Supplement plan of equal or lesser value outside your enrollment period or to a richer benefit plan at any time, you must complete this application.

Plan F Extra will only be available to applicants who attained age 65 before January 1, 2020 or first became eligible for Medicare benefits due to disability before January 1, 2020.

Fields marked with an asterisk (*) are required

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Medicare Supplement Plan G Extra
Medicare Supplement Plan

\$191.00

Total monthly plan premium

\$191.00

Sales Trainer
123 Main Street

13

Personal Information

Please enter your personal information in the spaces provided.

First Name*

Middle Initial

Last Name*

Gender*

Male Female Non-binary

Date of Birth*

Language Preference*

Phone Number*

Please enter your 10 digit phone number with no hyphen or spaces (e.g., 2125551212).

Phone Number Type

Alternate Phone Number

Please enter your 10 digit phone number with no hyphen or spaces (e.g., 2125551212).

Alternate Phone Number Type

I agree that Blue Shield and its affiliated entities and agents may communicate with me about my account and various health and wellness programs available to me, and other promotional information that may benefit me and my dependents, including by phone or text to the numbers I have listed on this form, using an auto-dialer or artificial or prerecorded voice; standard data rates apply.

Yes No

Participation is voluntary and you can opt-out at any time, for more information visit blueshieldca.com/terms

Communication Preference

Email Address

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

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

Communication Preference

Home Address

Home Address (NO PO BOX)*

Apt

City*

State*

Zip* [Edit](#)

Mailing Address

Is your Mailing address different than your home address?

Yes No

Billing Address

Is your Billing address different than your home address?

Yes No

Medicare Information

Please take out your red, white and blue Medicare card to complete this section. In the spaces provided, enter your Medicare Number (do not enter dashes) and the Effective Dates for your Part A and Part B coverage.

You must have Medicare Part A and Part B to join a Medicare Supplement plan.

Medicare Beneficiary Identification (MBI) number*

I am entitled to:

Hospital (Part A) Effective Date*

Medical (Part B) Effective Date*

Requested Effective Date*

Are you currently a Blue Shield of California member? Yes No

[Continue](#)

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Applicant Information

There is a 6-step process to completing the enrollment.

Step 1- Applicant Info

12. Complete the Personal Information sections:

- Home Address
- Mailing Address
- Billing Address
- Communication Preferences

13. Continue down the page to complete the Contact Information sections:

- Medicare Information
- Medicare Prescription Drug Plan Information

14. Click **Next** to continue.

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Dashboard Plans Search New profile Bob

1 Applicant Info 2 Additional Info 3 Guaranteed Acceptance 4 Current Insurance Coverage 5 Producer Info 6 Payment & Conditions of Membership

Household Savings Program

Each individual must complete their own application if not already an active member:

If you and the other member of your household are age 65 or older and both members have, or are applying for the same plan (including any dental plans), you may be eligible for a 7% monthly savings on your combined medical plan dues when both members are enrolled in the same eligible plan. Both members must share the same home and mailing addresses. Tobacco users are not eligible for the Household Savings Program.

15

Is the other member of your household is enrolled in, or applying for, the **same** Blue Shield Medicare Supplement plan that you are applying for and share both addresses? please check this box:
If "Yes," Please provide the following information for the other household member:

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Continue

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Shopping cart

Medicare Supplement Plan C Extra
Medicare Supplement Plan

\$191.00

Total monthly plan premium
\$191.00

Sales Trainer
123 Main Street
San Francisco CA 94102
(888) 321-5555

Blue Shield of California Medicare Supplement Plan.
Address
P.O. Box 3008
Lodi, CA 95241
Phone
(888) 713-0000

Additional Information

Step 2- Additional Info

- 15. Check the box to acknowledge to indicate any other members of the beneficiary's household is enrolled in or applying for the same Blue Shield Medicare Supplement plan.
- 16. Click the **Continue** button.

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blue shield of california

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1 Applicant Info 2 Additional Info 3 **Guaranteed Acceptance** 4 Current Insurance Coverage 5 Producer Info 6 Payment & Conditions of Membership

Guaranteed Acceptance

17 Do you believe you qualify for Guaranteed Acceptance?*

Yes No

Continue

18

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Medicare Supplement Plan G Extra
Medicare Supplement Plan

\$191.00

Total monthly plan premium
\$191.00

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Address
P.O. Box 3008
Lodi, CA 95241

Phone
(888) 713-0000

Guaranteed Acceptance

Step 3- Guaranteed Acceptance

17. Indicate if the beneficiary qualifies for Guaranteed Acceptance.

Depending on how you answer the question, additional fields will appear, and you must complete the form to move the next part of the application.

18. Click the **Continue** button.

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Applicant Info Additional Info Guaranteed Acceptance **Current Insurance Coverage** Producer Info Payment & Conditions of Membership

Current Insurance Coverage

Step 4- Current Insurance Coverage

- 19. Complete the Current Insurance Coverage section.
- 20. Click Continue to go to Step 5.

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 eligible for guaranteed acceptance in one or more of our Medicare Supplements 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 fax or mail a copy of the front and back of your current carrier ID card. And please also include a copy of the notice from you prior insurer. Please fax the documents to (844) 266-1850 or mail to: Blue Shield of California, P.O. Box 3008, Lodi, Ca 95241-1912.

Please answer all questions to the best of your knowledge. (Please check Yes or No below.)

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Medicare Supplement Plan G Extra

Medicare Supplement Plan

\$191.00

Total monthly plan premium

\$191.00

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123 Main Street
San Francisco CA 94102
(888) 321-5555

Blue Shield of California Medicare Supplement Plan.

- a. Did you turn 65 years of age in the last 6 months?*

Yes No
- a. Are you covered for medical assistance through California's Medi-Cal program?

NOTE TO APPLICANT: if you have a share cost under the Medi-Cal program, please answer No to this question.*

Yes No
- a. Have 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)? If yes fill in your start and end dates below. If you are still covered under this plan, leave the "End" blank.*

Yes No
- 4a. Do you have any another Medicare Supplement plan policy or certificate or contract in force?*

Yes No
5. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?*

Yes No
6. Are you under age 65?*

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 (1-888-466-2219), 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 Internet website (www.dmhc.ca.gov).

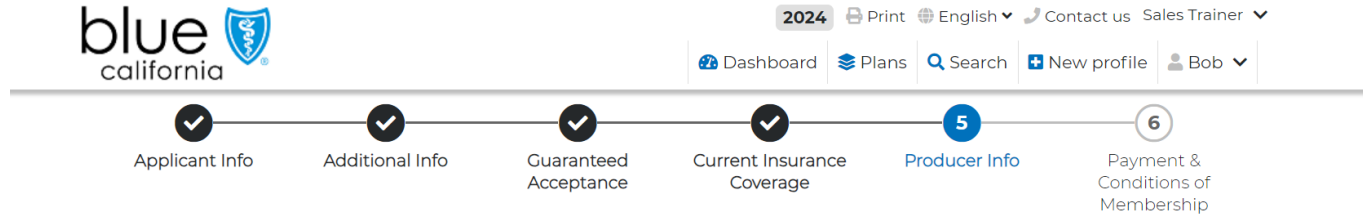
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Continue

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Shopping Cart



21 Optional - Agent Confirmation, for verification purposes only - please select continue

National Producer Number

Producer First Name (writing agent)

Producer Last Name (writing agent)

FMO/Agency name

FMO/Agency ID

Print Name

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Medicare Supplement Plan G Extra
Medicare Supplement Plan

\$191.00

Total monthly plan premium
\$191.00

Sales Trainer
123 Main Street
San Francisco CA 94102
(888) 321-5555

Blue Shield of California Medicare Supplement Plan.

Address
P.O. Box 3008
Lodi, CA 95241
Phone
(888) 713-0000

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Continue

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Producer Information

Step 5- Producer Information

- 21. Complete the Agent information section.
- 22. Click the **Continue** button.

>

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Payment Information
 To determine the monthly dues amount, refer to Blue Shield's Medicare Supplement plans rate tables in the enrollment kit or visit blueshieldca.com/medsup02023. 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.

- I agree to choose Monthly billing as the payment option for ongoing billing and payments.

Save \$3 a month by paying dues through automatic monthly debit from your checking or savings account using our AutoPay program. To enroll, after receiving and paying for your first bill, register for and log into your Blue Shield account at blueshieldca.com and access the Payment Center tab. You may also call Customer Service at 800-248-2341 TTY: 711 8 a.m. - 5:30 p.m. Monday through Friday. Requests to enroll in the AutoPay program may take up to two billing cycles for completion. Members should pay all paper bills received until a letter confirming registration in the AutoPay program is received.

1. Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed along to the subscriber.

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Medicare Supplement Plan G Extra
 Medicare Supplement Plan

\$191.00
 Total monthly plan premium
 \$191.00

Sales Trainer
 123 Main Street
 San Francisco, CA 94102
 (888) 52-5555

Blue Shield of California Medicare Supplement Plan
 Address
 P.O. Box 3038
 1101, CA 95241
 Phone
 (888) 715-0000

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.

- You do not need more than one Medicare Supplement plan policy or contract.
- If you purchase this contract, you may want to evaluate your existing health coverage to decide if you need multiple coverage.
- 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 reinstated 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 reinstated 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 reinstated 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 reinstated 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.

7. Receiving materials and communications electronically versus print: You may receive required benefit plan and coverage-related materials and communications via email and/or the [Blue Shield of California Medicare Supplement Plan website](https://blueshieldca.com) blueshieldca.com, as applicable. Obtaining a document electronically will confirm your consent to electronic delivery. You also have the right to obtain printed, mailed materials at any time and at no expense to you. To receive printed materials in the mail, to opt out of email communications, please call 800-248-2341 TTY: 711 8 a.m. - 8 P.m. seven days a week, year-round.

Conditions of Membership

- I understand that this application and the Statement of Health, if applicable, 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.
- 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.
- 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.
- I acknowledge receipt of the:
 - Summary of Benefits
 - Rate table
 - The Guide to Health Insurance for People with Medicare
 - a copy of this application.

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, the Household Savings Program, and the authorizations I have provided. I have read the Summary of Benefits and the terms, conditions, and authorizations set forth above. I certify that I meet the eligibility requirements set forth in the Summary of Benefits. I alone am responsible for the accuracy and completeness of this application and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

Applicant's Signature*

Today's Date*

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Send enrollment [X]

How would the beneficiary like to receive the application to finish enrolling?

Email

Text

Plan Included [Select all](#)

Medicare Supplement Plan G Extra

Choosing a Medigap Policy

Evidence of Coverage

Multi-Language Notice

Notice of New or Innovative Benefits Form

Summary of Benefits

Send enrollment [X]

The application was sent to Vincent.vigliotti@blueshieldca.com
 Authorization code: T9W4V3V6

[View Bob Green's profile](#)

Create a task to follow up with the beneficiary

* Due date

* Create a task
 Follow up on Application for Medicare Supplement Plan G Extra

Payment & Conditions of Membership

Complete the application.

Step 6 - Payment & Conditions of Membership

- Complete the Payment & Conditions of Membership Section.
- Click **send to beneficiary** to send that application to the beneficiary for signing.
- Complete the form and select the method of sending the application to the beneficiary by selecting a check box (you can select multiple boxes). Click **Send Application**.

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Payment Information
 To determine the monthly dues amount, refer to Blue Shield's Medicare Supplement plans rate tables in the enrollment kit or visit blueshieldca.com/medsup02023. 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.

I agree to choose Monthly billing as the payment option for ongoing billing and payments.

Save \$3 a month by paying dues through automatic monthly debit from your checking or savings account using our AutoPay program. To enroll, after receiving and paying for your first bill, register for and log into your Blue Shield account at blueshieldca.com and access the Payment Center tab. You may also call Customer Service at 800-248-2341 TTY: 711 8 a.m. - 5:30 p.m. Monday through Friday. Requests to enroll in the AutoPay program may take up to two billing cycles for completion. Members should pay all paper bills received until a letter confirming registration in the AutoPay program is received.

1. Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed along to the subscriber.

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Medicare Supplement Plan C Extra
 Medicare Supplement Plan

\$191.00
 Total monthly plan premium
 \$191.00

Sales Trainer
 123 Main Street
 San Francisco, CA 94022
 (888) 52-0555

Blue Shield of California Medicare Supplement Plan
 Address
 P.O. Box 3038
 1100, CA 95241
 Phone
 (888) 715-0000

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.

- You do not need more than one Medicare Supplement plan policy or contract.
- If you purchase this contract, you may want to evaluate your existing health coverage to decide if you need multiple coverage.
- 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 reinstated 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 reinstated contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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- I understand that this application and the Statement of Health, if applicable, 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.
- 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.
- 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.
- I acknowledge receipt of the:
 - Summary of Benefits
 - Rate table
 - The Guide to Health Insurance for People with Medicare
 - a copy of this application.

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, the Household Savings Program, and the authorizations I have provided. I have read the Summary of Benefits and the terms, conditions, and authorizations set forth above.

I certify that I meet the eligibility requirements set forth in the Summary of Benefits. I alone am responsible for the accuracy and completeness of this application and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

Applicant's Signature*

Today's Date*

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Payment & Conditions of Membership

- Complete the application.
- Step 6 - Payment & Conditions of Membership
26. Complete the Payment & Conditions of Membership Section.
 27. Beneficiary signs the application.
 28. Beneficiary submits the Application.

Shopping Cart





Hi Bob,

To view the plan information we discussed, please enter your authorization code from your email or text messages for the code.

*** Authorization code**

30 The authorization code was sent to you.

Continue




Hi Bob,

Here is the plan we discussed...

Thank you for meeting with me. Per our discussion, here is the plan that should fit your needs. Once you receive your verification code, which should arrive in an email shortly, you will be able to enroll in this plan.


View application

29

 **Sales Trainer**
BSC_TEST_Agency
sales_training@blueshieldca.com
(415) 355-1212

Beneficiary Review & Submit

- 29. The beneficiary will receive an email or text with a link. When they click the link, they are taken to application to sign and submit.
- 30. The beneficiary will also receive a second email with the authorization code to access the application.

 Meet with Sales Trainer
(888) 321-5555
S_trainer@email.com

Shopping Cart

Review and Submit

Review your application

You may review your answers to the application by expanding each section below and make updates if needed. After you review, in the Important Information section below, check the acknowledgement that you have reviewed the information. Then indicate who is submitting this form and click the Submit button at the bottom of the page.

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

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

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

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

When do I use this form?

You can join a plan:

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

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

What do I need to complete this form?

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

Note: You must complete all fields that are marked with an asterisk (*). Some items are optional. You cannot be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit. For more information, see Paying Your Plan Premium section on the Review & Submit page of this application.

Shopping cart

Blue Shield Inspire (HMO)

Medicare Advantage Prescription Drug Plan

\$0.00

Total monthly plan premium \$0.00

[Blue Shield Inspire \(HMO\)](#)
[Los Angeles Counties & Orange County S.O.B.](#)

[Blue Shield Inspire \(HMO\)](#)
[Los Angeles Counties & Orange County S.O.B.](#)
[Multi Language Insert](#)

Sales Trainer
123 Main Street
San Francisco CA 94102
(888) 321-5555

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

Phone
(800) 776-4466

Hours
8am-8pm, seven days a week

*What is your relationship to the person enrolling in this plan?

I am (or am helping) the person enrolling

I am an agent or authorized person

31

Beneficiary Signature

Due to physical limitations, I am unable to sign

*Please sign your name in the space below using your own handwriting.

Bob B

I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:

- This person is authorized under State law to complete this enrollment, and
- Documentation of this authority is available upon request by Medicare.

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Paying Your Plan Premium

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

To learn more about your payment options, visit us at blueshieldca.com/medicarewaystopyay or call Customer Care at **800-776-4466** (TTY: 711). For members enrolled in D-SNP plans, please contact D-SNP Customer Care **800-452-4413** (TTY: 711). For Medicare Prescription drug plans **888-239-6469**.

| |
|---|
| Electronic funds transfer (EFT) from your bank account each month |
| Credit Card |
| Get Monthly Bill |
| Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. |

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

PRIVACY ACT STATEMENT

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

Previous

Submit

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Beneficiary Review & Submit

Step 4 - Review & Submit

31. For the question: "What is your relationship to the person enrolling in this plan?"

- Select "I am (or am helping) the person enrolling" if you have the Power of Attorney (POA) or **the beneficiary**.

32. The beneficiary signs the form.

33. Click **Submit**.

Shopping Cart

Application submitted

Your application has been submitted and is pending approval.
This confirmation is not proof of membership.

You may have other coverage in your cart you still need to enroll in.
You may clear your cart if you have completed all enrollments.

[Continue applying for coverage](#)

[Email](#) [Print](#)

What to expect

Confirmation
Within 10 days of enrollment, you will receive a confirmation enrollment letter in the mail.

Welcome package including ID card
Within 10 days of your confirmed enrollment, you will receive your welcome package that includes your ID card. This kit gives you a full explanation of how to use your new plan. Be sure to read the plan's *Evidence of Coverage (EOC)*. Present your ID card every time you receive healthcare services.

Blue Shield of California Medicare Supplement Plan.
P.O. Box 3008 Lodi, CA 95241
(888) 713-0000

Application details

Member name
Bob Green

Member address
123 Main Los Angeles, CA 90026

Submitted on
September 27, 2023

Confirmation number
M74587159735145G

[View application](#)

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[Continue applying for coverage](#)

What's Next:

This confirmation number can be used to help track the online enrollment, but it is not proof of membership. Please wait at least 10 days before calling the plan to ask about the status of your enrollment. Please keep this information in case you have any questions about your enrollment and need to contact your selected plan.

If any of the required information on your enrollment form was missing or does not match your Medicare record, the plan may contact you to get the missing or correct information. This could delay the plan's ability to process your enrollment.

Here are some important things to expect when your coverage is first effective if the plan determines that your enrollment meets all of the Medicare requirements and is complete. This information is especially important if you enrolled late in the month and you have not received a letter, or your membership card, by the day your coverage starts.

- After the plan has processed your application, you should get a letter from the plan you joined. This may take several days. If you do not receive correspondence from the plan in about 10 calendar days, you should contact the plan to check on the status of the enrollment.
- Enrollment can be effective as early as the first of the next month depending on your circumstances. The plan you have selected will inform you of your effective date of enrollment.
- If you need to fill a prescription before you get your plan membership card, let your pharmacist know your plan name and show any of the following materials as proof of membership:
 - Take your acknowledgement, welcome, or confirmation letter that you receive from the plan with you to the pharmacy.
 - **Please note: The confirmation number listed on this website cannot be used at your local pharmacy as proof of plan membership.**
 - If you haven't gotten a letter yet, you might have a copy of an enrollment application signed by a plan representative.
 - If you have both Medicare and Medicaid, you should bring proof of enrollment in both programs such as your Medicare and Medicaid cards, a copy of a Medicare Summary Notice, a recent Medicaid bill, or a copy of your current Medicaid award letter. If you qualify for extra help (the low-income subsidy) you can also bring proof that you qualify such as a copy of your yellow or green automatic enrollment letter from Medicare (if you automatically qualify) or your approval letter from Social Security (if you applied and qualify).
 - As a last resort, if you pay out of pocket for your prescription, save your receipts and work with your plan to be reimbursed.
- If you have questions, call the plan's toll-free number.

Beneficiary Confirmation

34. Ask the beneficiary to copy the confirmation number for your records.

The beneficiary can also view and download a copy of the application.

Your pending coverage

Medicare Supplement Plan



Medicare Supplement Plan G Extra

Monthly plan premium
\$191.00

Total monthly plan premium \$191.00





Health Risk Assessment

[View Section](#)



Health Risk Assessment Process Overview

The Health Risk Assessment is available for our Exclusively Aligned Enrollment (EAE) Blue Shield TotalDual Plan (HMO D-SNP) for Los Angeles and San Diego Counties and Non-Exclusively Aligned Enrollment (EAE) Blue Shield Inspire (HMO D-SNP) for San Joaquin/Stanislaus/Merced Counties.

- Enrollment application form must have an app submission date prior to the effective date of the member in the DSNP plan.
- HRA form must have an HRA submission date that is equal to the enrollment app submission date.
- For February through December enrollments, the app submission date must be before the member effective date for the Plan.
 - **Scenario:** May 2024 enrollments must have an app submission date before May 1, 2024.
 - **Definition:** "Enrollments" mean the member effective date/month with the DSNP Plan.

Other Criteria

- Enrollment must be submitted through DRX and/or DocuSign only (paper apps are excluded).
- Eligible for DSNP plans only. Other MAPD and MAPPO plans are excluded.
- Eligible for Individual brokers only. FMOs, Private Exchange and BSC Internal Reps are excluded.

Timing

- Incentives will be paid on the month following the member effective date.
- **Ex. Incentive payout for January 2024 member effectives will occur in February 2024.**

Look-back

There will be a 90-day look-back to check for member late installs and ownership updates only.

Business Rules Scenarios for the HRA Incentive Eligibility

Overview

| | Submission Date | Effective Date | Plan Type | Broker | Pay HRA Incentive? | Comments |
|-------------------|-----------------|----------------|-------------|-----------------|--------------------|--|
| Scenario 1 | 11/4/23 | 1/1/24 | MAPD | Broker A | | |
| | 12/6/23 | 1/1/24 | DSNP | Broker A | Y | |
| Scenario 2 | 11/4/23 | 1/1/24 | DSNP | Broker A | | |
| | 12/6/23 | 1/1/24 | MAPD | Broker A | N | No HRA payment |
| Scenario 3 | 11/4/23 | 1/1/24 | DSNP | Broker A | Y | This broker will be paid both the HRA incentive and the commission |
| | 12/6/23 | 1/1/24 | DSNP | Broker A | N | No duplicate payment due to the same plan type |
| Scenario 4 | 11/4/23 | 1/1/24 | DSNP | Broker A | Y | This broker will be paid both the HRA incentive and the commission |
| | 12/6/23 | 1/1/24 | DSNP | Broker B | N | No duplicate payment due to the same plan type |
| Scenario 5 | 12/7/23 | 1/1/24 | DSNP | Broker A | | Not likely to happen but if it does happen, needs to be flagged and reviewed by SalesOps if payment to incorrect broker needs to be recouped |
| | 3/1/24 | 1/1/24 | DSNP | Broker B | | |

Here are scenarios that you may come across.

- Scenario 1** - The beneficiary moved from a MAPD to the DSNP plan.
- Scenario 2** – The beneficiary moves from a DSNP to a MAPD plan.
- Scenario 3** – The beneficiary is currently enrolled in a DSNP plan and re-enrolls in the DSNP plan for a 1/1/2024 effective date.
- Scenario 4** – The beneficiary is enrolled in the DSNP plan effective 1/1/2024 and submits an enrollment with another broker for the same plan and effective date (aka duplicate enrollment).
- Scenario 5** - the beneficiary is enrolled in the DSNP plan effective 1/1/2024 and dis-enrolls. Submits an enrollment with another broker for the same plan and an effective date with 6 months of the prior date.

Next Steps – Completing the Health Risk Assessment

Application submitted

Your application has been submitted and is pending approval.
This confirmation is not proof of membership.

You may have other coverage in your cart you still need to enroll in.
You may clear your cart if you have completed all enrollments. [Continue applying for coverage](#)

[Email](#) [Print](#)

What to expect

- Confirmation**
Within 10 days of enrollment, you will receive a confirmation enrollment letter in the mail. It is also confirmation that Medicare has approved your enrollment.
- Member ID card**
You will also receive your member ID card. Keep this with you for all your doctor, hospital, and pharmacy visits.
- Welcome package**
You will receive a package containing important plan documents. This includes instructions about how to access the Evidence of Coverage, drug list, and provider directory.
- Premium assistance**
If you qualify for help, you will receive a Low-Income Subsidy (LIS) letter. Depending on your level of coverage, receiving US means lower prescription drug costs and financial assistance to cover your Part D premium.
- Complete your Health Risk Assessment HMO, D-SNP members only**
If you have enrolled in a D-SNP plan, Blue Shield Care Coordinators will call you within 90 days of enrolling to complete your Health Risk Assessment (HRA) and Care Plan. Completing these tools helps our Care Coordinators individualize your care to meet your needs. You can also complete your HRA by mail or call 1-888-548-5765.

Application details

Member name
Bob Green

Member address
123 Main Los Angeles, CA 90026

Submitted on
September 27, 2023

Confirmation number
A54817984979463M

[View application](#)

Next steps

Please complete the plan's optional Health Risk Assessment to gather more information about your health so they may provide health improvement suggestions.

1 [Complete Health Risk Assessment](#)

At the time of Enrollment

When the application is submitted, the broker/agent has the option to complete the Health Risk Assessment.

1. Click the button to open the form.

HRA Form

2

Health Risk Assessment Questionnaire

Blue Shield of California uses this questionnaire to assist in assessing your health status. Please check the appropriate box that answers the questions below and type any additional pertinent information that will help us meet your needs better.

Fields marked with an asterisk (*) are required

1. Did you receive your Blue Shield of California ID Card?
 Yes
 No

2. What is your primary Language?
 English
 Spanish
 Other

3. What is your living situation today?
 I have a steady place to live
 I have a place to live today, but I am worried about losing it in the future
 I do not have a steady place to live

4. Where do you currently live?
 Live in an independent house, apartment, mobile home
 Live in an assisted living apartment, or board & care
 Live in a nursing home
 Other

5. What is your current living arrangement?
 Live alone
 With spouse/significant other
 With children
 With other relative(s)
 With non-relative(s)
 With caregiver

Confirmation

Your Health Risk Assessment has been completed.
Confirmation: 71907583836097

Thank you for completing the Health Risk Assessment. It gives us valuable information that helps cater to your needs.

[View Health Risk Assessment](#)

Health Risk Assessment

Your Health Risk Assessment has been completed.

Thank you for completing the Health Risk Assessment. It gives us valuable information that helps us better serve your needs.

This is a one-time email sent to confirm your enrollment. If you would like to change your communication preferences for Blue Shield of California, please contact Blue Shield of California.

Sales Trainer
 BSCA_Test
 National Producer Number: 123456789
 (888) 321-5555
S_trainer@email.com

Blue Shield of California
 6300 Canoga Avenue Woodland Hills CA 91387
 (800) 452-4413
 8am-8pm, seven days a week
<https://www.blueshieldca.com/medicare>

Assessment details
 Submitted on
 September 27, 2023
 Confirmation number
 71907583836097

Please do not reply to this message

Complete the HRA form

The broker must complete the form in its entirety (all required fields) before submitting.

- Incomplete forms will not qualify for incentive payouts.
- HRA must be completed at the time of enrollment to qualify for incentive payouts.

2. Complete the form.

The beneficiary will receive an email acknowledging the completion of the form.

Search Profiles & Enrollments

Searching for a beneficiary

[View Section](#)

Search



Search beneficiaries

1

| | | | |
|----------------------|----------------------------|------------------------|----------------------|
| First name | Last name | Date of birth | Phone number |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Email address | Confirmation number | Medicare Number | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | |

2

Search profiles

Search

Select **Search** to find and access an existing beneficiary profile. Upon logging in, you will be automatically directed to the “Search Beneficiary” page to avoid creating a duplicate profile.

1. Enter the beneficiary’s information using any of the search criteria available.
2. Click the **Search Profiles** button.

NOTE: The “Personal Code” field has been removed.

Search Results

Search beneficiaries

A registrant is a new beneficiary who has not started the process for an enrollment application. An applicant has started their enrollment application. Completing a Scope of Appointment does not impact a beneficiary's status.

Search results

[Download results](#)

Sort

Last name

3

| | | | |
|---|------------|--------------|--------------------|
| Gavin D 121 N Elm Dr Beverly Hills, CA 90210 | (510) 963— | ● Registrant | Updated 09/19/2023 |
|---|------------|--------------|--------------------|

or [search again](#)

Profile Search Results

The results show all available beneficiaries that match the search results.

Each result shows the beneficiaries' sales stage and the date the record was updated.

3. Click the **hyperlinked name** to view the profile.

View Profile

Licensed to sell 1 Medicare organizations with 8 plans for 2024

| | | |
|--|--|---|
| * First name <input type="text" value="Gavin"/> | * Last name <input type="text" value="D"/> | Date of birth <input type="text" value="01/01/1954"/> |
| Email address <input type="text" value="Gavin.D@email.com"/> | Primary phone number <input type="text" value="(510) 963-0000"/> | Mobile phone number <input type="text" value="(510) 963-0000"/> |
| | | <input checked="" type="checkbox"/> Same as primary |
| Save | | |

SOA
You have no SOAs for this profile

Notes
You have no notes for this profile

Profile

The beneficiaries quotes and enrollment history is shown at the bottom of the page.

4. Click on the quote or application to view.

Eligibility

| | | |
|---|---|--|
| Medicare Number <input type="text" value="....."/> Show | Hospital (Part A) effective date <input type="text" value="January"/> <input type="text" value="2023"/> | * Medical (Part B) effective date <input type="text" value="January"/> <input type="text" value="2023"/> |
| Add/Edit subsidy | | |

Quote history



Quote sent 09/19/2023 4:18 pm PST to Gavin.D 2024

Blue Shield TotalDual Plan (HMO D-SNP)
Blue Shield 65 Plus (HMO)
Blue Shield AdvantageOptimum Plan (HMO)

| | |
|--|---|
| Plan type MAPD Authorization code: 7U7H3W7A | Please review this quote at your earliest convenience. Let me know if you have any questions. Sales Trainer BSC_Test_Sales_trainer_2024 |
|--|---|



View Profile



Print English Contact us Sales Trainer

Dashboard Plans Search New profile Bob

Profile

Personal information

***ZIP code**
90026 County Los Angeles, CA

*** First name** Bob *** Last name** Green **Date of birth** 08/01/1956

Email address **Phone number**

Home address

Address 1 **Address 2**

City **State**

Notes

SOA sent to vincent.vigliotti@ca.com on - Sales Trainer Created 08/31/20

Tasks

You have no tasks for this profile

+ Add task

- Profile
- Scope of Appointment
- Preferences
 - Prescriptions
 - Pharmacy
 - Other Preferences
- Plans
- Cart



Profile

- When you are working with a beneficiary profile, you can easily see the beneficiary's name and use the dropdown navigation bar to access different steps in the workflow.

Drug and Pharmacy

Finder

[View Section](#)





Drug and Pharmacy Finder



Print English Contact us Sales Trainer

Dashboard Plans Search New profile

Dashboard

1

Home
Drug and pharmacy finder

Privacy policy
Accessibility statement

Terms of use

Search

At the bottom of each page's footer, there is a link to the drug and pharmacy finder.

1. Click the link to view the drug and pharmacy finder.



Drug and Pharmacy Finder

0 plans available

Medicare Advantage
Prescription Drug Plans
0 plans

Prescription Drug Plans
0 plans

Please enter your ZIP code to see plans.



***ZIP code**

2. Enter a zip code.

Drug and Pharmacy Finder

10 plans available in [90026](#)
for Los Angeles county, CA

| | |
|---|------------------------------------|
| Medicare Advantage Prescription Drug Plans 8 plans | Prescription Drug Plans 2 plans |
|---|------------------------------------|

Medicare Advantage Prescription Drug Plans bundle the benefits of a Medicare Advantage Plan and a Prescription Drug Plan. Benefits include medical expenses and prescriptions.

- Blue Shield TotalDual Plan (HMO D-SNP)
[Find providers](#) [Find prescriptions](#) [Find pharmacy](#)
- Blue Shield AdvantageOptimum Plan (HMO)
[Find providers](#) [Find prescriptions](#) [Find pharmacy](#)



Search Results

3. Click on:
- Find Prescriptions
 - Find Pharmacy

To see if the drug or pharmacy is covered by the plan.

Drug and Pharmacy Finder

Blue Shield Balance (HMO)

Prescriptions Pharmacy

Add your prescription to see how this plan provides coverage. Formularies may change on January 1.

Search prescriptions

Lipitor

We defaulted the most common dosage so you have a better idea of what you might take.

Select dose and form

Lipitor TAB 10MG

Lipitor TAB 20MG

Lipitor TAB 40MG

Lipitor TAB 80MG

Enter quantity and frequency

30 per month

Would you like to use a Generic (atorvastatin calcium) for Lipitor

Yes No

Cancel See if this drug is covered

4

Blue Shield Balance (HMO)

Prescriptions Pharmacy

*ZIP code 90026 Pharmacy name Search

Rite Aid Pharmacy #05434
1433 Glendale Boulevard
Los Angeles, CA 90026
Standard In-network
30+ days supply.

Echo Park Pharmacy
1634 W Sunset Blvd
Los Angeles, CA 90026
Preferred In-network
30+ days supply and long term care.

Walgreens #9136
1625 W Sunset Blvd
Los Angeles, CA 90026
Standard In-network
30+ days supply.

CVS Pharmacy #17816
330 N Westlake Ave Apt 500

Viewing 1 - 10 of 25

Enter Information

4. For Prescriptions:
- Enter the information.
 - Click the button to see if drug is covered by the plan.
- For Pharmacy:
- Enter the Pharmacy name.
 - Check to see if it is a Preferred in-network pharmacy.

Drug and Pharmacy Finder

Results

5. Review the results

Add your prescription to see how this plan provides coverage. Formularies may change on January 1.

Search prescriptions

✓ Covered prescriptions

Preferred Generic

| | | | | |
|---|------------------|-----------------|-----------------|----------------|
| atorvastatin calcium TAB 10MG ⁷ | | | | |
| 30 tablets per month Generic | | | | |
| Retail cost | Retail Cost ⓘ | Before Gap ⓘ | During Gap ⓘ | After Gap ⓘ |
| | \$2.69 | \$0.00 | \$0.00 | \$2.69 |
| Restrictions | PA No | QL No | ST No | |

5



Resources

- **Broker Connection Site:** <https://www.blueshieldca.com/producer>
- **Consumer Application Status Site:** <https://www.blueshieldca.com/brokerwebapp/medicareProspectAppStatus>



Print

English

Contact us

Sales Trainer

Dashboard

Plans

Search

New profile

Contact us

We're here to help. Contact Producer Services, our contact information is below.

Phone: (800) 559-5905
Email: ProducerServices@blueshieldca.com

Close

Contact Us

Blue Shield Producer Services

Phone Number:

1-800-559-5905