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2020

Summary of Benefits

January 1, 2020 - December 31, 2020

Blue Shield Promise TotalDual Plan (HMO D-SNP)

Fresno, Los Angeles, *Orange, *San Bernardino, San Diego, San Joaquin, and Stanislaus Counties (*partial county)

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage".

Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association

Promise Health Plan

2020 Summary of Benefits

Blue Shield Promise TotalDual Plan

Los Angeles County (H5928-001), *Orange and *San Bernardino Counties (H5928-005), San Diego County (H5928-009), and Fresno, San Joaquin, and Stanislaus Counties (H5928-054)

This is a summary of drug and health services covered by Blue Shield Promise TotalDual Plan from January 1, 2020 - December 31, 2020.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage."

To join **Blue Shield Promise TotalDual Plan**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, have full or partial Medi-Cal (Medicaid) coverage and live in one of our covered service areas. If you live in Los Angeles, San Diego, Orange or San Bernardino counties, you must also not qualify for a Cal MediConnect Plan. Our service area includes the following counties in California: Fresno, Los Angeles, *Orange, *San Bernardino, San Diego, San Joaquin, and Stanislaus.

The service area for Orange County includes **only the ZIP codes listed below**. You must live in one of these ZIP codes to join the plan:
90620 90621 90622 90623 90624 90630 90631 90632 90633 90638 90680 90720 90740 90742 90743 92609 92610 92617 92619 92620 92626 92637 92646 92647 92648 92649 92655 92657 92673 92683 92685 92694 92697 92698 92701 92702 92703 92704 92705 92706 92707 92708 92725 92735 92801 92802 92803 92804 92805 92806 92807 92808 92809 92812 92814 92815 92816 92817 92821 92822 92823 92825 92831 92832 92833 92834 92835 92836 92837 92838 92840 92841 92842 92843 92844 92845 92846 92850 92868 92870 92871 92885 92886 92887 92899

The service area for San Bernardino County includes **only the ZIP codes listed below**. You must live in one of these ZIP codes to join the plan:
91701 91708 91709 91710 91730 91737 91739 91761 91762 91763 91764 91784 91786 92301 92307 92308 92313 92316 92318 92324 92334 92335 92336 92337 92344 92345 92346 92350 92354 92357 92359 92368 92369 92371 92373 92374 92376 92377 92392 92394 92395 92399 92401 92402 92403 92404 92405 92406 92407 92408 92410 92411 92412 92413 92414 92415 92418 92420 92423 92424 92427

*partial county

If you use the providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print or audio.

For more information, please call us at (800) 847-1222 (TTY: 711), 8 a.m. – 8 p.m., seven days a week, from October 1 to March 31 and 8 a.m. – 6 p.m. weekdays, from April 1 to September 30, or visit us at blueshieldca.com/promise/medicare

Premiums and Benefits	Blue Shield Promise TotalDual Plan
Monthly Plan Premium	You pay $32 for Part D services. You must continue to pay your Medicare Part B premium.
Medical Deductible	No deductible
Maximum Out-of-Pocket Responsibility (does not include Part D prescription drugs)	You pay no more than $6,700 annually. Includes copays and other costs for covered Medicare Part A and B services for the year.
Inpatient Hospital Care	2019 Medicare-defined cost-sharing amounts; these amounts may change for 2020. Days 1-60: $1,364 deductible Days 61-90: $341 copay per day Days 91-150: $682 copay per lifetime reserve day (up to 60 days over your lifetime) Cost-sharing amounts apply per benefit period. A benefit period starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins.
Outpatient Hospital Services	You pay 20% of the cost
Doctor Visits • Primary Care Physician • Specialists	 You pay nothing You pay nothing
Preventive Services (Mammography & influenza vaccines) (No referral needed)	You pay nothing Other preventive services are available. There are some covered services that have a cost.
Emergency Care	You pay 20% of the cost
Urgently Needed Services	You pay 20% of the cost
Outpatient Diagnostic Services/Labs/ Imaging • Diagnostic Tests • Lab services • Therapeutic radiology services (such as radiation treatment for cancer) • Outpatient X-rays	 You pay 20% of the cost You pay nothing You pay 20% of the cost You pay 20% of the cost
Hearing Services • Hearing exam (Medicare-covered) • Routine (non-Medicare covered) hearing exam • Hearing aid	 You pay 20% of the cost You pay nothing for routine hearing exam (1 every year) You pay nothing for up to 2 hearing aids every year; $2,000 limit every year
Dental Services • Unlimited oral exams every year • Cleaning, one every 6 months • X-rays, one full set every two years	 You pay nothing You pay nothing You pay $0-5

Premiums and Benefits	Blue Shield Promise TotalDual Plan
Vision Services • Exam to diagnose and treat diseases and conditions of the eye • Routine (non-Medicare covered) eye exam (one every year) • Eyewear coverage limit	You pay 20% of the cost You pay nothing $300 limit for frames, lenses, lens enhancements, contact lens exam and contact lenses every year
Mental Health Services • Outpatient group therapy/ individual therapy visit • Inpatient Mental Health Care	You pay 20% of the cost for Medicare-covered visits 2019 Medicare-defined cost-sharing amounts; these amounts may change for 2020. Days 1-60: $1,364 deductible Days 61-90: $341 copay per day Days 91-150: $682 copay per lifetime reserve day (up to 60 days over your lifetime) You are covered for 90 days each benefit period, up to the 190-day lifetime limit. A benefit period starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins.
Skilled Nursing Facility Care	2019 Medicare-defined cost-sharing amounts; these amounts may change for 2020. $0 copay per day for days 1-20 $170.50 copay per day for days 21-100 100 days per benefit period; no prior hospital stay required A benefit period starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins.
Physical Therapy	You pay 20% of the cost
Ambulance Services	You pay 20% of the cost (each way)
Transportation Services	You pay nothing 48 one-way trips to plan-approved health-related locations per year. Transportation must be arranged 24 hours in advance.
Medicare Part B Drugs	20% of the cost for Medicare Part B covered drugs

Supplemental Plan Benefits	Blue Shield Promise TotalDual Plan
Health Club/Fitness	You pay nothing
Nurse Advice Line	You pay nothing
Worldwide Emergency Care/ Urgently Needed Services	20% of the cost for worldwide emergency care/urgently needed services (not waived if admitted) $25,000 annual coverage limit for covered emergency care or urgently needed services outside the U.S. every year
Acupuncture	You pay nothing for up to 24 visits per year
Over-the-Counter Items	You are entitled to a quarterly allowance for OTC drugs and supplies: • $160 quarterly allowance if you reside in Fresno, Orange, San Bernardino, San Diego, San Joaquin, and Stanislaus Counties • $155 quarterly allowance if you reside in Los Angeles County You can place one order per quarter and cannot roll over your unused allowance into the next quarter.

Outpatient Prescription Drugs	Blue Shield Promise TotalDual Plan	
Annual Deductible	You pay $435 (excludes Tier 1 drugs)	
Initial Coverage Phase (After you pay your deductible, if applicable, up to the initial coverage limit of $4,020)	Standard Retail cost-sharing 30-day supply	Standard Retail or Mail-Order cost-sharing 90-day supply
Tier 1: Preferred Generic	You pay nothing	You pay nothing
Tier 2: Non-Preferred Generic	25% coinsurance	25% coinsurance
Tier 3: Preferred Brand	25% coinsurance	25% coinsurance
Tier 4: Non-Preferred Brand	25% coinsurance	25% coinsurance
Tier 5: Specialty Tier	25% coinsurance	25% coinsurance
Coverage Gap Phase	Tier 1: $0 copay Tiers 2-5: you pay 25% of the negotiated price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs until your costs total $6,350, which is the end of the coverage gap.	
Catastrophic Coverage (When your annual out-of-pocket costs exceed $6,350)	After your yearly out-of-pocket drug costs (including drugs you bought through your retail pharmacy and through mail order) reach $6,350, you pay the greater of: • 5% of the cost, or • $3.60 copay for a generic drug (including brand drugs treated as generic) and an $8.95 copay for all other drugs	

IMPORTANT NOTE: To view information on non-discrimination requirements, you can go to our website at https://www.blueshieldca.com/promise/affordable-care-act.asp.

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

Blue Shield of California Promise Health Plan complies with applicable State and Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

Promise Health Plan

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Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **(800) 847-1222 (TTY: 711)**.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit **blueshieldca.com/promise/medicare** or call **(800) 847-1222 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2021.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

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For enrollment inquiries please call the Sales Department (800) 847-1222 (TTY: 711)

8 a.m. – 8 p.m., seven days a week, from October 1 to March 31 and 8 a.m. – 6 p.m. weekdays, from April 1 to September 30.

601 Potrero Grande Dr.,
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