January 1, 2020 - December 31, 2020

2020
Summary of Benefits

Blue Shield Promise AdvantageOptimum Plan (HMO)

Stanislaus 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".

blueshieldca.com/promise/medicare

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Promise Health Plan

2020 Summary of Benefits
Blue Shield Promise AdvantageOptimum Plan
Stanislaus County, Plan 051

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."

Blue Shield Promise AdvantageOptimum Plan includes Medicare health care (Part C) and prescription drug (Part D) coverage and may offer supplemental benefits in addition to Part C and Part D benefits, offering you the convenience of having both your medical and prescription drugs covered through one plan.

To join **Blue Shield Promise AdvantageOptimum Plan**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in California: Stanislaus.
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

Summary of Benefits
January 1, 2020 - December 31, 2020

Blue Shield Promise
AdvantageOptimum Plan
Stanislaus County

Premiums and Benefits	Blue Shield Promise AdvantageOptimum Plan
Monthly Plan Premium	$0
Deductible	No deductible
Maximum Out-of-Pocket Responsibility (does not include Part D prescription drugs)	You pay no more than $3,400 annually Includes copays and other costs for covered Medicare Parts A and B services for the year
Inpatient Hospital Care	$150 copay each day for days 1 through 5 $0 copay each day for days 6 and over Benefit Period: Per Admission, Per Stay
Outpatient Hospital Facility	$200 copay for each visit to an outpatient hospital facility
Ambulatory Surgery Center	$50 copay for each visit to an ambulatory surgical center
Doctor Visits	
• Primary Care Physician	$0 copay per visit
• Specialists	$15 copay per visit
Preventive Services (Mammography & influenza vaccines) (No referral needed)	$0 copay Other preventive services are available There are some covered services that have a cost
Emergency Care	$85 copay per visit (waived if admitted)
Urgently Needed Services	$15 copay per visit (waived if admitted)
Diagnostic Services/Labs/Imaging	
• Diagnostic radiology services (such as MRIs, CT scans, PET scans)	$50 copay
• Diagnostic test and procedures	$0 copay
• Outpatient X-rays	$0 copay
• Therapeutic radiology services (such as radiation treatment for cancer)	20% of the cost
Hearing Services	
• Hearing exam (Medicare-covered)	$10 copay for each Medicare-covered visit
• Routine (non-Medicare covered) hearing exam	$0 copay for 1 routine hearing exam every year
• Hearing aid • Hearing exam	$0 copay for 1 fitting/evaluation for hearing aid every year $0 copay for up to 2 hearing aids every year $350 limit every year
Dental Services	
• Unlimited oral exams every year	$0 copay
• Cleaning, one every 6 months	$0 copay
• Fluoride treatment, one every six months	$5 copay per visit
• X-rays, one full set every two years	$0 copay

Summary of Benefits (cont'd)
January 1, 2020 - December 31, 2020

Premiums and Benefits	Blue Shield Promise Advantage Optimum Plan
Vision Services	
• Exam to diagnose and treat diseases and conditions of the eye	$0 copay
• Routine eye exam (one every year)	$0 copay
• Eyewear coverage limit	$150 limit for glasses and contacts every 2 years
• Refraction test (one every 2 years)	$0 copay
Mental Health Services	
• Inpatient mental health care	$200 copay per day for days 1-8 $0 copay per day for days 9-90 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.
• Outpatient group therapy visit	$25 copay per visit
• Outpatient individual therapy visit	$25 copay per visit
Opioid Treatment Program Services	$0 copay
Podiatry	
• Foot exams and treatment	$15 copay per visit
• Routine (non-Medicare covered) foot care	$15 copay per visit
Medical Supplies	20% of the Medicare-allowed amount
Skilled Nursing Facility Care	$0 copay per day for days 1 through 20 $100 copay per day for days 21 through 100 No prior hospital stay required There is a limit for 100 days for each benefit period if your condition requires additional rehabilitation services, other types of daily skilled nursing, or other skilled care. If you go over the 100 day limit, you will be responsible for all costs.
Rehabilitation Services	
• Occupational therapy visit	$20 copay per visit
• Physical therapy and speech and language therapy visit	$20 copay per visit
Ambulance Services	$200 copay per trip (each way) (waived if admitted)
Transportation Services	$0 copay 12 one-way trips to plan-approved health-related locations Transportation must be arranged 24 hours in advance
Medicare Part B Drugs	20% of the cost for chemotherapy drugs 20% of the cost for other Part B drugs

Prescription drug coverage

You pay the following:

Part D Prescription Drug Benefit	Blue Shield Promise AdvantageOptimum Plan			
Stage 1: Annual Deductible	**$0** This stage does not apply because there is no deductible.			
Stage 2: Initial Coverage	**Preferred retail cost-sharing (in-network)**		**Standard retail cost-sharing (in-network)**	
	30-day supply	**90-day supply[MO]**	**30-day supply**	**90-day supply[MO]**
Tier 1: Preferred Generic Drugs	$0 copay	$0 copay	$3 copay	$3 copay
Tier 2: Generic Drugs	$10 copay	$25 copay	$17 copay	$42.50 copay
Tier 3: Preferred Brand Drugs	$40 copay	$100 copay	$47 copay	$117.50 copay
Tier 4: Non-Preferred Drugs	$90 copay	$225 copay	$100 copay	$250 copay
Tier 5: Specialty Tier Drugs	33% coinsurance	Not covered	33% coinsurance	Not covered
Coverage Gap Phase (After the total drug costs paid by you and the plan reach $4,020, up to the out-of-pocket threshold of $6,350)	Tier 1: Preferred Generic Drugs and Tier 2: Generic Drugs are covered at the copays described above. For all other tiers, you pay 25% of the 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			

If you reside in a long-term care facility, you pay the same as at a standard retail cost-sharing pharmacy. There are limited situations where you may get drugs from an out-of-network pharmacy at the same cost as an in network standard retail cost sharing pharmacy. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please refer to the plan EOC.

***90-day supply preferred retail cost-sharing also applies to Blue Shield Promise's mail order pharmacy. Tier 5 drugs are limited to a 30-day supply for mail order.**

MO A long-term (up to a 90-day) supply is only available for select drugs. The drugs that are available for a long-term supply are marked with the symbol MO in our Drug List. Drugs that are not marked with this symbol are not available for a long-term supply. For your protection, we limit the amount of select drugs that can be filled at one time.

Supplemental plan benefits
You pay the following:

Supplemental Plan Benefits	Blue Shield Promise AdvantageOptimum Plan
Nurse Advice Line	$0 copay
Worldwide Emergency Care/ Urgently Needed Services	$85 copay per visit Coverage up to $25,000 per year (waived if admitted)
Over-the-Counter Items	You have $50 per quarter to spend on covered items. You can place one order per quarter and cannot roll over your unused allowance into the next quarter
Telehealth	$0 copay
SilverSneakers Fitness	$0 copay

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.

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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

- ☐ 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).

We’re here to help

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.

Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association OMR15775-PHP-ST (02/20)