January 1, 2020 - December 31, 2020

2020 Summary of Benefits

Blue Shield Promise Coordinated Choice Plan (HMO)

Los Angeles, *Orange, *San Bernardino, *Riverside, San Diego, Fresno, Santa Clara, *Merced, San Joaquin, and Stanislaus Counties (*partial)

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

H5928_19_540A_037_M Accepted 09102019

blue california

Promise Health Plan

2020 Summary of Benefits
Blue Shield Promise Coordinated Choice Plan
Los Angeles, *Orange, *San Bernardino, *Riverside, San Diego, Fresno, Santa Clara, *Merced, San Joaquin, and Stanislaus Counties, Plan 037

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 Coordinated Choice 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: Los Angeles, *Orange, *San Bernardino, *Riverside, San Diego, Fresno, Santa Clara, *Merced, San Joaquin, and Stanislaus Counties.

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

The service area for Riverside County includes **only the ZIP codes listed below**. You must live in one of these ZIP codes to join the plan:
91718 91719 91720 91752 91760 92028 92201 92202 92203 92210 92211 92220 92223 92230 92234
92235 92236 92240 92241 92247 92248 92253 92254 92255 92258 92260 92261 92262 92263 92264
92270 92274 92276 92282 92292 92320 92324 92373 92399 92501 92502 92503 92504 92505 92506
92507 92508 92509 92513 92514 92515 92516 92517 92518 92519 92521 92522 92530 92531 92532
92536 92539 92543 92544 92545 92546 92548 92549 92551 92552 92553 92554 92555 92556 92557
92561 92562 92563 92564 92567 92570 92571 92572 92581 92582 92583 92584 92585 92586 92587
92589 92590 92591 92592 92593 92595 92596 92599 92860 92877 92878 92879 92880 92881 92882
92883

The service area for Merced County includes **only the ZIP codes listed below**. You must live in one of these ZIP codes to join the plan:
93610 93620 93661 93665 95301 95303 95312 95315 95317 95322 95324 95333 95334 95340 95341
95343 95344 95348 95365 95369 95374 95380 95388

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

*Partial

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

Blue Shield Promise Coordinated Choice Plan Los Angeles, *Orange, *San Bernardino, *Riverside, San Diego, Fresno, Santa Clara, *Merced, San Joaquin, and Stanislaus Counties (*partial)

Premiums and Benefits	Blue Shield Promise Coordinated Choice Plan
Monthly Plan Premium	You pay $32 You must continue to pay your Medicare Part B premium
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 Parts A and B services for the year
Inpatient Hospital Care	Days 1-60: $1,408 deductible Days 61-90: $352 copay per day Days 91-150: $704 copay per lifetime reserve day (up to 60 days over your lifetime) 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 Facility	20% of the cost
Ambulatory Surgery Center	20% of the cost for each Medicare-covered ambulatory surgical center and outpatient hospital facility.
Doctor Visits • Primary Care Physician • Specialists	 $0 copay $0 copay
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	20% of the cost
Urgently Needed Services	20% of the cost
Diagnostic Services/Labs/Imaging • Diagnostic radiology services (such as MRIs, CT scans, PET scans) • Diagnostic test and procedures • Lab services • Outpatient X-rays • Therapeutic radiology services (such as radiation treatment for cancer)	 20% of the cost for Medicare-covered radiology services 20% of the cost for Medicare-covered diagnostic tests $0 copay for Medicare-covered lab services 20% of the cost for Medicare-covered X-ray services 20% of the cost for Medicare-covered therapeutic radiology services
Hearing Services • Hearing exam (Medicare-covered) • Routine (non-Medicare covered) hearing exam • Hearing aid	20% of the cost for Medicare-covered benefits $0 copay for one routine hearing exam $0 copay for fitting/evaluation for hearing aid (1 every year) $0 copay for up to 2 hearing aids every year $2,000 limit every year

Summary of Benefits (cont'd)
January 1, 2020 - December31, 2020

Premiums and Benefits	Blue Shield Promise Coordinated Choice Plan
Dental Services	
• Unlimited oral exams every year	$0 copay
• Cleaning, one every 6 months	$0 copay
• Fluoride treatment, one every 6 months	$0 copay per visit
• X-rays, one full set every 2 years	$0 copay
Vision Services	
• Exam to diagnose and treat diseases and conditions of the eye	20% of the cost
• Routine eye exam (one every year)	$0 copay
• Eyewear coverage limit	$500 limit for glasses and contacts every two years
• Refraction test (one every 2 years)	$0 copay
Mental Health Services	
• Inpatient mental health care	Days 1-60: $1,408 deductible Days 61-90: $352 copay per day Days 91-150: $704 copay per lifetime reserve day (up to 60 days over your lifetime) 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	20% of the cost per visit
• Outpatient individual therapy visit	20% of the cost per visit
Opioid Treatment Program Services	$0 copay
Podiatry	
• Foot exams and treatment	20% of the cost for Medicare-covered podiatry services
• Routine foot care	$0 copay for routine visits, 1 routine visit per month
Medical Supplies	20% of the Medicare-allowed amount
Skilled Nursing Facility Care	$0 copay per day for days 1-20 $176 copay per day for days 21-100 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.
Rehabilitation Services • Occupational therapy visit • Physical therapy and speech and language therapy visit	20% of the cost per visit
Ambulance Services	20% of the cost (each way)
Transportation Services	$0 copay 48 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 Coordinated Choice Plan	
Stage 1: Annual Deductible	**$435, Tier 1 excluded**	
Stage 2: Initial Coverage (After you pay your deductible, if applicable, up to the initial coverage limit of $4,020)	**Standard retail**	
	30-day supply cost-sharing (in-network)MO	**90-day supply cost-sharing (in-network)MO**
Tier 1: Preferred Generic Drugs	$0 copay	$0 copay
Tier 2: Generic Drugs	25% coinsurance	25% coinsurance
Tier 3: Preferred Brand Drugs	25% coinsurance	25% coinsurance
Tier 4: Non-Preferred Drugs	25% coinsurance	25% coinsurance
Tier 5: Specialty Tier Drugs	25% 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 are covered at the copays described above. For all other tiers, 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.	
Catastrophic Coverage (When your annual out-of-pocket 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 Coordinated Choice Plan
SilverSneakers Fitness	$0 copay
Nurse Advice Line	$0 copay
Worldwide Emergency Care/ Urgently Needed Services	$100 copay per visit Coverage up to $25,000 per year (waived if admitted)
Acupuncture	$0 copay 24 visits per year
Personal Emergency Response System	$0 copay
Over-the-Counter Items	You have $200 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

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.

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.