Effective January 1, 2021 – December 31, 2021

# 2021 Summary of Benefits

## Blue Shield Inspire (PPO)

**Medicare Advantage Prescription Drug Plan**

Alameda County

blue california

blueshieldca.com/medicare

H4937_20_376A_001_M Accepted 08252020

# 2021 Summary of Benefits
# Blue Shield Inspire
# Alameda County

## Effective January 1, 2021 – December 31, 2021

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 refer to the ***Evidence of Coverage* (EOC) at blueshieldca.com/MAPDdocuments or by calling** Member Services at **(800) 776-4466** [TTY: **711**], 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., weekdays (8 a.m. to 5 p.m., Saturday and Sunday), from April 1 through September 30. **Note: The EOC will be available on our website by October 15.**

**Blue Shield Inspire** includes Part D coverage, which provides prescription drug coverage, offering you the convenience of having both your medical and prescription drugs covered through one plan.

To join **Blue Shield Inspire**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. **Our service area includes: Alameda County.**

If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Our plan Provider Directory is located on our website at **blueshieldca.com/find-a-doctor**.

Our plan Pharmacy Directory is located on our website at **blueshieldca.com/medpharmacy2021**.

To get the most complete and current information about which drugs are covered, you can visit our website at **blueshieldca.com/medformulary2021**.

# Summary of benefits

Effective January 1, 2021 - December 31, 2021



| Premiums and benefits | In-Network You pay | Out-of-Network You pay | What you should know |
|---|---|---|---|
| **Monthly plan premium** | $98 | | You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable. |
| **Deductible** | $0 | $750 | |
| **Annual out-of-pocket maximum amount** | $6,700 | $10,000 (combined in-network and out-of-network) | Does not include Part D prescription drugs. This is the most you would pay for the year for covered Medicare Part A and Part B services. |
| **Inpatient hospital care** | $175 per day for days 1-7<br>$0 per day for days 8 and over | 40% coinsurance per stay after you pay your plan deductible | Our plan covers an unlimited number of days for each Medicare-covered inpatient hospital stay in a network hospital. |
| **Outpatient hospital services**<br>• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery | $250 copay for each visit to an outpatient hospital facility<br>$10 copay for observation services | 40% coinsurance for each visit after you pay your plan deductible.<br>40% coinsurance for observation services after you pay your plan deductible. | Our plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.<br>Prior authorization may be required and is the responsibility of your provider. |
| **Outpatient surgery** | $100 copay for each visit to an ambulatory surgical center<br>$250 copay for each visit to an outpatient hospital facility | 40% coinsurance for Medicare-covered outpatient surgery after you pay your plan deductible. | Prior authorization may be required and is the responsibility of your provider. |
| **Doctor visits** | | | |
| • Primary care physician | $10 copay per visit | 40% coinsurance after you pay your plan deductible | |
| • Specialists | $35 copay per visit | 40% coinsurance after you pay your plan deductible | |

# Summary of benefits (cont'd)

Effective January 1, 2021 - December 31, 2021

| Premiums and benefits | In-Network You pay | Out-of-Network You pay | What you should know |
|---|---|---|---|
| **Preventive care** | $0 copay | 40% coinsurance | Any additional preventive services approved by Medicare during the contract year will be covered. |
| **Emergency care** | $90 copay per visit<br>No combined annual limit for covered emergency care and urgently needed services outside the United States and its territories | $90 copay per visit<br>No combined annual limit for covered emergency care and urgently needed services outside the United States and its territories | This copay is waived if you are admitted to a hospital within one day for the same condition.<br>Worldwide coverage. |
| **Urgently needed services** | $30 copay for each visit to a network urgent care center within your plan service area<br>$30 copay for each visit to an urgent care center or physician office outside your plan service area but within the United States and its territories<br>$90 copay for each visit to an emergency room outside of your plan service area but within the United States and its territories<br>$90 copay for each visit to an emergency room, urgent care center, or physician office that is outside of the United States and its territories<br>No combined annual limit for covered emergency care and urgently needed services outside the United States and its territories | $30 copay for each visit to a network urgent care center within your plan service area<br>$30 copay for each visit to an urgent care center or physician office outside your plan service area but within the United States and its territories<br>$90 copay for each visit to an emergency room outside of your plan service area but within the United States and its territories<br>$90 copay for each visit to an emergency room, urgent care center, or physician office that is outside of the United States and its territories<br>No combined annual limit for covered emergency care and urgently needed services outside the United States and its territories | |

| Premiums and benefits | In-Network You pay | Out-of-Network You pay | What you should know |
|---|---|---|---|
| **Diagnostic services, labs, and imaging** | | | **Prior authorization may be required for diagnostic services and is the responsibility of your provider.** |
| • Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.) | $100 copay for each diagnostic radiology service | 40% coinsurance after you have paid your plan deductible | Covered according to Medicare guidelines; prior authorization is required. |
| • Lab services | $40 copay | 40% coinsurance after you have paid your plan deductible | |
| • Diagnostic tests and procedures | $40 copay | 40% coinsurance after you have paid your plan deductible | |
| • Outpatient X-rays | $40 copay | 40% coinsurance after you have paid your plan deductible | |
| • Therapeutic radiology services (such as radiation treatment for cancer) | 20% coinsurance for each therapeutic radiology service | 40% coinsurance after you have paid your plan deductible | |
| **Hearing services**<br>• Hearing exam (Medicare-covered)<br>• Routine (non-Medicare covered) hearing exam | $0 copay per visit | 40% coinsurance after you have paid your plan deductible | |
| **Dental services (Medicare-covered)** | $10 copay per visit if performed by your PCP<br>$35 copay per visit if performed by a specialist | 40% coinsurance | See optional supplemental dental PPO plan for more information about dental services for an extra plan premium. |

| Premiums and benefits | In-Network You pay | Out-of-Network You pay | What you should know |
|---|---|---|---|
| **Vision services** | | | |
| • Exam to diagnose and treat diseases and conditions of the eye | $35 copay for each Medicare-covered visit | 40% coinsurance after you have paid your plan deductible | **A referral from your doctor may be required for an exam to diagnose and treat diseases and conditions of the eye.** |
| • Routine eye exam and refraction | $20 copay | You are reimbursed up to $30 for one exam every 12 months | One visit every 12 months with network provider. Some coverage at non-network providers included; see the plan EOC for details. |
| • Eyeglass frames | $20 copay | You are reimbursed up to $35 for one pair of eyeglass frames every 24 months | Our plan pays up to $75 for one pair of eyeglass frames every 24 months. Some coverage at non-network providers included; see the plan EOC for details. |
| • Eyeglass lenses or contact lenses | $20 copay | You are reimbursed up to $35 for either one pair of prescription eyeglass lenses or contact lenses every 12 months | Our plan pays for either one pair of prescription eyeglass lenses or up to $75 for contact lenses every 12 months. Some coverage at non-network providers included; see the plan EOC for details. |

| Premiums and benefits | In-Network You pay | Out-of-Network You pay | What you should know |
|---|---|---|---|
| **Mental health services** | | | **Prior authorization may be required and is the responsibility of your provider.**<br>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.<br>If you go into the hospital after one benefit period has ended, a new benefit period begins. |
| • Inpatient mental health care | $1,600 copay per Medicare-covered stay | 40% coinsurance after you have paid your plan deductible | |
| • Outpatient group therapy visit | $20 copay per visit | 40% coinsurance after you have paid your plan deductible | |
| • Outpatient individual therapy visit | $20 copay per visit | 40% coinsurance after you have paid your plan deductible | |
| **Skilled nursing facility (SNF) care** | $0 copay per day for days 1 – 20<br>$178 copay per day for days 21 - 100 | 40% coinsurance per stay after you have paid your plan deductible | **Prior authorization may be required and is the responsibility of your provider.**<br>100 days per benefit period; no prior hospitalization required with network provider.<br>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<br>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 | $25 copay per visit | 40% coinsurance after you have paid your plan deductible | |
| • Physical therapy and speech and language therapy | $25 copay per visit | 40% coinsurance after you have paid your plan deductible | |

| Premiums and benefits | In-Network You pay | Out-of-Network You pay | What you should know |
|---|---|---|---|
| **Ambulance** | $225 copay per trip (each way) | $225 copay per trip (each way) | **Prior authorization is required for non-emergency transportation by fixed-wing aircraft.** |
| **Transportation** | Not covered | Not covered | |
| **Medicare Part B Drugs** | 20% coinsurance for chemotherapy/ radiation drugs and other Part B drugs | 40% coinsurance after you have paid your plan deductible | Some Part B drugs may require prior authorizations from your provider. |

## Additional benefits included in your plan

| Premiums and benefits | In-Network You pay | Out-of-Network You pay | What you should know |
|---|---|---|---|
| **Annual Physical Exam** | $0 copay | 40% coinsurance after you have paid your plan deductible | One every 12 months. |
| **Special Supplemental Benefits for the Chronically Ill: Independence and Safe Mobility with AAA** | $0 copay | | This is a Special Supplemental Benefit for the Chronically Ill (SSBCI) which requires eligibility determination. You must meet one or more qualifying chronic conditions to receive this benefit. Please see the plan EOC for additional details. |
| **Opioid Treatment Program Services** | $0 copay | 40% coinsurance after you have paid your plan deductible | Referral and prior authorization may be required and is the responsibility of your provider. |
| **Foot care (podiatry services)** | | | |
| • Foot exams and treatment | $35 copay for each Medicare-covered visit | 40% coinsurance after you have paid your plan deductible | |
| **Diabetic Supplies & Services** | | | **A referral from your doctor may be required for diabetic supplies & services.** |
| •Blood glucose monitors | $0 copay for ACCU-CHEK blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers | 40% coinsurance after you have paid your plan deductible | Prior authorization from the plan may be required for durable medical equipment, blood glucose monitors and test strips. |
| • Diabetes self-management training, diabetic services and supplies | $0 copay for all training, services and supplies except blood glucose monitors (see "Blood glucose monitors" above) | 40% coinsurance for diabetic self-management training and 20% coinsurance for diabetic supplies and services except blood glucose monitors (see "Blood glucose monitors" above) | See the plan EOC for more information. |

| Premiums and benefits | In-Network You pay | Out-of-Network You pay | What you should know |
|---|---|---|---|
| **Durable Medical Equipment (DME) and Related Supplies**<br>• Durable medical equipment (e.g., wheelchairs, oxygen | 20% coinsurance | 40% coinsurance after you have paid your plan deductible | **A referral from your doctor may be required for DME and related supplies.**<br>Prior authorization from the plan may be required for DME.<br>See the plan EOC for more information. |
| **Prosthetics/Medical Supplies**<br>• Prosthetics (e.g., braces, artificial limbs)<br>• Medical supplies (e.g., splints, casts) | 20% coinsurance<br>20% coinsurance | 40% coinsurance after you have paid your plan deductible<br>40% coinsurance after you have paid your plan deductible | **A referral from your doctor may be required for prosthetics/medical supplies.** |
| **Health and Wellness programs**<br>• Basic gym access through SilverSneakers Fitness<br>• NurseHelp 24/7℠ (telephone and online support) | $0 copay<br>$0 copay | $0 copay<br>$0 copay | |
| **Acupuncture (non-Medicare covered)** | $0 copay per visit<br>Up to 12 visits per year | 40% coinsurance after you have paid your plan deductible | |
| **Over-the-Counter Items** | You have an $80 allowance per quarter to spend on covered items | You have an $80 allowance 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. |
| **Routine chiropractic services (non-Medicare covered)** | $0 copay per visit<br>Up to 12 visits per year | 40% coinsurance after you have paid your plan deductible | |

# Prescription drug coverage

Effective January 1, 2021 - December 31, 2021

## You pay the following:

| Part D prescription drug benefit | | | | | | |
|---|---|---|---|---|---|---|
| **Stage 1: Annual Deductible Stage** | $400 deductible (Tier 1 and Tier 2 excluded) | | | | | |
| **Stage 2: Initial Coverage Stage** | **Preferred retail cost-sharing (in-network)** | | | **Standard retail cost-sharing (in-network)^** | | |
| | **30-day supply** | **90-day supply*NDS** | **100-day supplyNDS** | **30-day supply** | **90-day supplyNDS** | **100-day supplyNDS** |
| **Tier 1: Preferred Generic Drugs** | $0 copay | See 100-day supply | $0 copay | $5 copay | See 100-day supply | $5 copay |
| **Tier 2: Generic Drugs** | $15 copay | $22.50 copay | Not Covered | $20 copay | $60 copay | Not Covered |
| **Tier 3: Preferred Brand Drugs** | $40 copay | $100 copay | Not Covered | $47 copay | $141 copay | Not Covered |
| **Tier 4: Non-Preferred Drugs** | $95 copay | $237.50 copay | Not Covered | $100 copay | $300 copay | Not Covered |
| **Tier 5: Specialty Tier Drugs** | 25% coinsurance | Not Covered | Not Covered | 25% coinsurance | Not Covered | Not Covered |

^If you reside in a long-term care facility, you pay the same as at an in-network standard retail cost-sharing pharmacy. There are limited situations where you may be able to 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- and 100-day supply cost-sharing also applies to Blue Shield's mail service pharmacy.**

**NDS** A long-term (up to a 90- or 100-day) supply is not available for select drugs. The drugs that are not available for a long-term supply are marked with the symbol NDS in our Drug List.

# Prescription drug coverage (cont'd)

Effective January 1, 2021 - December 31, 2021

| Part D prescription drug benefit | | |
|---|---|---|
| **Stage 3: Coverage Gap Stage** | Coverage for outpatient prescription drugs after the total yearly drug costs paid by both you and Blue Shield reaches $4,130, until your yearly out-of-pocket drug costs reach $6,550 | Tier 1: Preferred 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 year-to-date out-of-pocket drug costs total $6,550, which is the end of the coverage gap stage. Whether a drug is considered generic or brand can be determined using the plan formulary |
| **Stage 4: Catastrophic Coverage** | After your yearly out-of-pocket drug costs (including drugs you bought through your retail pharmacy and through mail service) reach $6,550, you pay the greater of:<br>• 5% of the cost, or<br>• $3.70 copay for a generic drug (including brand-name drugs treated as generic) and a $9.20 copay for all other drugs<br>(This stage **protects** you from any additional costs once you have paid your yearly out-of-pocket drug costs.) | |

## Mail Service Pharmacy

CVS Caremark is our network mail service pharmacy where you may obtain a 90- or 100-day supply of maintenance drugs at a lower cost. They will be delivered to your home or office with no charge for shipping or delivery. Sign up at caremark.com or call (866) 346-7200 [TTY: 711].

Tier 5 drugs are limited to a 30-day supply by mail service.

## Network pharmacies that offer preferred cost-sharing

You may pay less when you visit one of our network pharmacies that offer preferred cost- sharing. Here's just a few:

| | | |
|---|---|---|
| • CVS/pharmacy‡ (including CVS pharmacy at Target) | (888) 607-4287 [TTY: 711] | CVS/pharmacy |
| • Safeway and Vons pharmacies‡ | (877) 723-3929 [TTY: 711] | VONS Pharmacy |
| • Albertsons/Sav-on/Osco pharmacies‡ | (877) 932-7948 [TTY: 711] | Albertsons Savon |
| • Costco‡ | (800) 955-2292 [TTY: 711] | COSTCO PHARMACY |

• Ralphs‡, Walmart‡ and many more.

You do not have to be a Costco member to use Costco Pharmacies.
‡Accepts e-prescribing

# Optional supplemental dental PPO plan



Optional supplemental dental HMO plan is not available to H4937-001 members.
Effective January 1, 2021 - December 31, 2021

## You pay the following:

| Network access | Optional supplemental dental PPO | |
|---|---|---|
| | **Participating dentists** | **Non-participating dentists** |
| **Monthly optional supplemental dental plan premium** | $40.50 | |
| **Calendar year deductible per member (not applicable to diagnostic and preventive services)** | You pay $50 before major services begin | |
| **Calendar year benefit maximum per member*** | $1,500 for covered preventive and comprehensive dental services combined, no matter if the services are performed by a participating general dentist or a dental specialist. Up to $1,000 of this maximum amount may be used for covered preventive and comprehensive dental services performed by non-participating dentists in a calendar year. You pay any amount above the $1,500 calendar year benefit maximum. | |
| **Waiting Period** | No waiting period | |

*All services must be performed, prescribed or authorized by your network dentist. If you need to see a specialist, you must get a referral from your primary dentist to receive covered specialist services. Plan pays a maximum of $1,000 per calendar year for covered specialist services. You are responsible for amounts above $1,000. If you are enrolled in the optional supplemental dental PPO plan and you need to see a specialist, you may go directly to the specialist.

# Optional supplemental dental PPO plan (cont'd)



Effective January 1, 2021 - December 31, 2021

| Network access | Optional supplemental dental PPO | |
|---|---|---|
| | Participating dentists | Non-participating dentists |
| **Summary list of services covered (ADA code)†** | | |
| | **You pay** | **You pay** |
| **Diagnostic services** | | |
| **Comprehensive oral exam (D0150)** | 0%<br>(2 visits in 12 months) | 20%<br>(2 visits in 12 months) |
| **Complete X-rays (D0210)** | 0%<br>(1 series every 36 months) | 20%<br>(1 series every 36 months) |
| **Preventive care** | | |
| **Prophylaxis – adult (D1110)** | 0%<br>(1 cleaning every 6 months) | 20%<br>(1 cleaning every 6 months) |
| **Restorative services** | | |
| **One surface composite resin restoration – anterior (D2330)** | 20% | 30% |
| **Crown (porcelain fused to noble metal) (D2750)** | 50% | 50% |
| **Periodontics** | | |
| **Periodontal scaling & root planing/four or more teeth per quadrant (D4341)** | 50% | 50% |
| **Endodontics** | | |
| **Anterior root canal therapy (D3310)** | 50% | 50% |
| **Molar tooth therapy (D3330)** | 50% | 50% |

† ADA codes are procedure codes established by the American Dental Association for efficient processing and reporting of dental claims.

‡ You pay the copayment plus the cost of precious or semi-precious metals. Porcelain on molar crowns is not a covered benefit.

# We're here to help

Contact Blue Shield at **(888) 534-4263** [TTY: **711**]

**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., weekdays, from April 1 through September 30.**

Blue Shield of California is a PPO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal.



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Blue Shield of California cumple con las leyes estatales y las leyes federales de derechos civiles vigentes, y no discrimina por motivos de raza, color, país de origen, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad ni discapacidad.

Blue Shield of California 遵循適用的州法律和聯邦公民權利法律，並且不以種族、膚色、原國籍、血統、宗教、性別、婚姻狀況、性別認同、性取向、年齡或殘障為由而進行歧視。

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