Effective January 1, 2021 – December 31, 2021

2021 Summary of Benefits

Blue Shield Inspire (HMO D-SNP)

Medicare Advantage Prescription Drug Plan

Fresno, San Joaquin and Stanislaus Counties

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Fresno, San Joaquin and Stanislaus Counties

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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** Customer Care 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.

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 have both Medicare Part A and Medicare Part B, be eligible for Medi-Cal (Medicaid), and live in our service area. **Our service area includes Fresno, San Joaquin and Stanislaus Counties.**

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

January 1, 2021 - December 31, 2021

Blue Shield Inspire (HMO D-SNP)
Fresno, San Joaquin and
Stanislaus Counties

Premiums and benefits	You pay	What you should know
Monthly plan premium	$31.50	You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.
Deductible	$0	
Annual out-of-pocket maximum amount	$6,700	Does not include Part D prescription drugs. This is the most you would pay for the year for in-network covered Medicare Part A and Part B services.
Inpatient hospital care	Days 1-60: $1,484 deductible Days 61-90: $371 copay per day Days 91-150: $742 copay per lifetime reserve day (up to 60 days over your lifetime	Our plan covers an unlimited number of days for a Medicare-covered inpatient hospital stay in a network hospital.
Outpatient hospital services • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	20% coinsurance for each visit to an outpatient hospital facility or an emergency room $0 copay for observation services	Our plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.
Outpatient surgery	20% coinsurance for each visit to an ambulatory surgical center or outpatient hospital facility	
Doctor visits • Primary care physician • Specialists	 $0 copay per visit $0 copay per visit	 **A referral from your doctor may be required for Specialist visits.**
Preventive care	$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.

Premiums and benefits	You pay	What you should know
Emergency care	20% coinsurance $25,000 combined annual limit for emergency care and urgently needed services outside the United States and its territories every year. Services outside the United States and its territories do not apply to the plan's maximum out-of-pocket limit.	Worldwide coverage (coinsurance for worldwide emergency coverage is waived if you are admitted to a hospital within one day of the same condition).
Urgently needed services	20% coinsurance $25,000 combined annual limit for emergency care and urgently needed services outside the United States and its territories every year. Services outside the United States and its territories do not apply to the plan's maximum out-of pocket limit.	Worldwide coverage (coinsurance for worldwide urgent coverage is waived if you are admitted to a hospital within one day of the same condition).
Diagnostic services, labs, and imaging		**A referral from your doctor may be required for diagnostic services, labs and imaging services.**
• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)	20% coinsurance for each diagnostic radiology service	Covered according to Medicare guidelines
• Lab services	$0 copay	
• Diagnostic tests and procedures	20% coinsurance	
• Outpatient X-rays	20% coinsurance	
• Therapeutic radiology services (such as radiation treatment for cancer)	20% coinsurance for each therapeutic radiology service	While you pay 20% coinsurance for therapeutic radiology services, you will never pay more than your $6,700 total out-of-pocket maximum for the year.
Hearing services		**A referral from your doctor may be required for hearing services.**
• Hearing exam (Medicare-covered)	20% coinsurance per visit	
• Routine (non-Medicare covered) hearing exam	$0 copay	Routine hearing exams are limited to one exam every year.
• Hearing aids	$0 copay	Our plan pays up to $2,000 for up to 2 hearing aids every year (both ears combined) when obtained from a network provider.

Premiums and benefits	You pay	What you should know
Dental services		
• Prophylaxis (cleaning)	$0 copay	One visit every 6 months.
• Dental X-rays	$0 copay	One series of bitewing X-rays every 6 months. One series of full mouth X-rays every 24 months.
• Fluoride treatment	$0 copay	Two visits every 12 months for fluoride treatment.
• Oral exam	$0 copay	
Vision services		
• Exam to diagnose and treat diseases and conditions of the eye	20% coinsurance for each Medicare-covered visit	**A referral from your doctor may be required for an exam and treat diseases and conditions of the eye.**
• Routine eye exam and refraction	$0 copay per visit	One visit every 12 months with a network provider.
• Eyeglasses (lenses and frames) or contact lenses	$0 copay	Our plan pays up to $300 for either eyeglasses (frames and lenses) or for contact lenses every 12 months when obtained from a network provider.
Mental health services		**A referral from your doctor may be required for mental health services.**
• Inpatient mental health care	Days 1-60: $1,484 deductible Days 61-90: $371 copay per day Days 91-150: $742 copay per lifetime reserve day (up to 60 days over your lifetime)	150 days per benefit period, up to the 190-day 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	20% coinsurance per visit	
• Outpatient individual therapy visit	20% coinsurance per visit	

Premiums and benefits	You pay	What you should know
Skilled nursing facility (SNF) care	$0 copay per day for days 1 - 20 $185.50 copay per day for days 21-100	**A referral from your doctor may be required for skilled nursing facility care.** 100 days per benefit period; no prior hospitalization required with network provider. 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 do into the hospital after one benefit period has ended, a new benefit period begins.
Rehabilitation Services • Occupational therapy • Physical therapy and speech and language therapy	 20% coinsurance per visit 20% coinsurance per visit	**A referral from your doctor may be required for rehabilitation services.**
Ambulance	20% coinsurance per trip (each way)	
Transportation	$0 copay	Limited to 48 one-way trips to plan-approved health-related locations every 12 months.
Medicare Part B Drugs	20% coinsurance for chemotherapy/radiation drugs and other Part B drugs	Some Part B drugs may require a prior authorization from your provider.

Additional benefits included in your plan

Premiums and benefits	You pay	What you should know
Annual Physical Exam	$0 copay	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	
Additional telehealth services	$0 copay	Teladoc Physicians can diagnose and treat basic medical conditions, and can also prescribe certain medication.
Foot care (podiatry services) • Foot exams and treatment • Routine (non-Medicare covered) foot care	 20% coinsurance for each Medicare-covered visit $0 copay per visit	**A referral from your doctor may be required for foot care services.**
Diabetic Supplies & Services •Blood glucose monitors • Diabetes self- management training, diabetic services and supplies	 $0 copay for FreeStyle® blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers $0 copay for all training, services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	**A referral from your doctor may be required for diabetic supplies & services.** Prior authorization from the plan may be required for durable medical equipment, blood glucose monitors and test strips. See the plan EOC for more information.
Durable Medical Equipment (DME) and Related Supplies • Durable medical equipment (e.g., wheelchairs, oxygen	 20% coinsurance	**A referral from your doctor may be required for DME and related supplies.** Prior authorization from the plan may be required for DME. See the plan EOC for more information.

Premiums and benefits	You pay	What you should know
Prosthetics/Medical Supplies		**A referral from your doctor may be required for prosthetics/ medical supplies.**
• Prosthetics (e.g., braces, artificial limbs)	20% coinsurance	
• Medical supplies (e.g., splints, casts)	20% coinsurance	
Health and Wellness programs		
• Basic gym access through SilverSneakers Fitness	$0 copay	
• NurseHelp 24/7[SM] (telephone and online support)	$0 copay	
• Personal Emergency Response System (PERS) (24/7 medical alert)	$0 copay	
Over-the-Counter Items	You have a $185 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.
Acupuncture (non Medicare-covered)	$0 copay per visit	Limited to 24 visits per year.
Routine (non-Medicare covered) chiropractic services	$0 copay per visit	Limited to 24 visits per year.

You pay the following:

Part D prescription drug benefit			
Stage 1: Annual Deductible Stage	You pay $445 (Tier 1 excluded)		
Stage 2: Initial Coverage Stage	**Standard retail cost-sharing (in-network)^**		
	30-day supply	**90-day supply[NDS]**	**100-day supply[NDS]**
Tier 1: Preferred Generic Drugs	$0 copay	See 100-day supply	$0 copay
Tier 2: Generic Drugs	25% coinsurance	25% coinsurance	Not Covered
Tier 3: Preferred Brand Drugs	25% coinsurance	25% coinsurance	Not Covered
Tier 4: Non-Preferred Drugs	25% coinsurance	25% coinsurance	Not Covered
Tier 5: Specialty Tier Drugs	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.

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 reach $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: • 5% of the cost, or • $3.70 copay for a generic drug (including brand-name drugs treated as generic) and a $9.20 copay for all other drugs (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.

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 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 depends on contract renewal.

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