



2024 Summary of Benefits

Blue Shield Inspire (HMO)

Medicare Advantage Prescription Drug Plan
for Alameda and San Mateo Counties

Effective January 1, 2024 – December 31, 2024

blueshieldca.com/medicare

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2024 Summary of Benefits

Blue Shield Inspire

Alameda and San Mateo Counties

Effective January 1, 2024 – December 31, 2024

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/MAPDdocuments2024 or by calling Customer Service at **(800) 776-4466** [TTY: 711], 8 a.m. to 8 p.m., seven days a week. **Note: The EOC will be available on our website by October 15, 2023.**

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 and San Mateo 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 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/medicare/providerdirectory.

Our plan ***Pharmacy Directory*** is located on our website at blueshieldca.com/medpharmacy2024.

To get the most complete and current information about which drugs are covered, you can visit our website at blueshieldca.com/medformulary2024.

Summary of benefits

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Alameda and San Mateo Counties

Effective January 1, 2024 - December 31, 2024

Premiums and benefits	You pay	What you should know
Monthly plan premium	\$18.50	You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.
Health plan deductible	\$0	
Annual out-of-pocket maximum amount	\$4,400	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	\$250 copay per day for days 1 – 5 \$0 copay per day for days 6 and over	Prior authorization and a referral from your doctor may be required for inpatient hospital care. 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	\$200 copay for each visit to an outpatient hospital facility \$0 copay for observation services \$120 copay for each visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition)	A referral and/or prior authorization may be required for outpatient hospital facility and 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	\$50 copay for each visit to an ambulatory surgical center \$200 copay for each visit to an outpatient hospital facility	A referral and prior authorization from your doctor may be required.
Doctor visits • Primary care physician • Specialists	\$0 copay per visit \$15 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.

Summary of benefits (cont'd)

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Premiums and benefits	You pay	What you should know
<p>Emergency care</p> <ul style="list-style-type: none"> Worldwide coverage 	<p>\$120 copay per visit</p> <p>No combined annual limit for emergency care or urgently needed services outside the United States and its territories</p>	<p>This copay is waived if you are admitted to the hospital within one day for the same condition.</p>
<p>Urgently needed services</p> <ul style="list-style-type: none"> Worldwide coverage 	<p>\$15 copay for each visit to a network urgent care center within the plan service area</p> <p>\$15 copay for each visit to an urgent care center outside of the plan service area but within the United States and its territories</p> <p>\$120 copay for each visit to an emergency room outside of the plan service area but within the United States and its territories</p> <p>\$120 copay for each visit to an emergency room or urgent care center that is outside of the United States and its territories</p> <p>No combined annual limit for emergency care or urgently needed services outside the United States and its territories</p>	<p>These copays are waived if you are admitted to the hospital within one day for the same condition.</p>

Summary of benefits (cont'd)

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<p>Diagnostic services, labs, and imaging</p> <ul style="list-style-type: none"> • Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.) • Lab services • Diagnostic tests and procedures • Outpatient X-rays • Therapeutic radiology services (such as radiation treatment for cancer) 	<p>\$70 copay for each diagnostic radiology service</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>20% coinsurance for each therapeutic radiology service</p>	<p>A referral from your doctor may be required for diagnostic services, labs and imaging services.</p> <p>Covered according to Medicare guidelines.</p> <p>While you pay 20% coinsurance for therapeutic radiology services, you will never pay more than your \$4,400 total out-of-pocket maximum for the year.</p>
<p>Hearing services</p> <ul style="list-style-type: none"> • Hearing exam (Medicare-covered) • Routine (non-Medicare covered) hearing exam • Hearing aids 	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$449 copay for each Silver Technology level hearing aid or \$699 copay for each Gold Technology level hearing aid</p>	<p>A referral from your doctor may be required for Medicare-covered hearing services.</p> <p>Routine hearing exams are unlimited if provided by your doctor but are limited to one exam every 12 months with network hearing aid provider.</p> <p>Coverage is limited to 2 hearing aids per year.</p>

Summary of benefits (cont'd)

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Dental services (Medicare-covered)	\$0 copay per visit if performed by your PCP \$15 copay per visit if performed by a specialist	A referral from your doctor may be required.
Dental services (non-Medicare covered) <ul style="list-style-type: none"> • Prophylaxis (cleaning) • Dental X-rays • Fluoride • Oral exam 	\$0 copay \$0 copay \$0 copay \$0 copay	One cleaning every 6 months. One series of bitewing X-rays every 6 months. One series of full mouth X-rays every 24 months. One visit every 6 months for fluoride. One exam every 6 months. See the "Optional Supplemental Dental HMO and PPO plans" section for more information about dental services for an additional plan premium.

Summary of benefits (cont'd)

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Premiums and benefits	You pay	What you should know
Vision services <ul style="list-style-type: none"> Exam to diagnose and treat diseases and conditions of the eye Routine (non-Medicare covered) eye exam and refraction Eyeglass frames Eyeglass lenses or contact lenses 	<p>\$15 copay for each Medicare-covered visit</p> <p>\$0 copay per visit</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>A referral from your doctor may be required for an exam to diagnose and treat diseases and conditions of the eye.</p> <p>One visit every 12 months with network provider. Some coverage at non-network providers included; see the plan EOC for details.</p> <p>Our plan pays for one pair of eyeglass frames (priced up to a regular retail value of \$175) every 24 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.</p> <p>Our plan pays for either one pair of prescription eyeglass lenses (regardless of size or power) OR for contact lenses (priced up to \$175 for contact lens service and materials) every 12 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.</p>
Mental health services <ul style="list-style-type: none"> Inpatient services in a psychiatric hospital Outpatient individual therapy visit Outpatient group therapy visit 	<p>\$900 copay per Medicare-covered stay for days 1-150</p> <p>\$30 copay per visit</p> <p>\$30 copay per visit</p>	<p>A referral and/or prior authorization from your doctor may be required for mental health services.</p> <p>If you go over the 150-day limit, you will be responsible for all costs. See EOC for more information.</p>

Summary of benefits (cont'd)

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Premiums and benefits	You pay	What you should know
Skilled nursing facility (SNF) care	\$0 copay per day for days 1 - 20 \$145 copay per day for days 21 - 100	A referral and prior authorization from your doctor may be required for skilled nursing facility care. If you go over the 100-day limit, you will be responsible for all costs; no prior hospitalization required with network provider.
Rehabilitation Services • Occupational therapy • Physical therapy • Speech and language therapy	\$15 copay per visit \$15 copay per visit \$15 copay per visit	A referral and prior authorization from your doctor may be required for rehabilitation services.
Ambulance services	Medicare-covered ground ambulance services: \$260 copay per trip (each way) Medicare-covered air ambulance services: 20% coinsurance per trip (each way)	
Transportation services (non-Medicare covered)	\$0 copay	Limited to 12 one-way trips to plan-approved health-related locations every year.
Medicare Part B Prescription drugs	0% to 20% coinsurance	Some Part B drugs may require a prior authorization from your doctor. Members may pay 0% to 20% coinsurance for select Medicare Part B drugs, which can change each quarter as established by CMS. Insulin obtained under Part B (when taken with an insulin pump) should not exceed a \$35 copay for a one-month supply.

Summary of benefits (cont'd)

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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	A referral and prior authorization from your doctor may be required for Opioid Treatment Program Services.
Additional telehealth services	\$0 copay	Teladoc physicians can diagnose and treat basic medical conditions and can also prescribe certain medication.
Foot care (podiatry services) <ul style="list-style-type: none"> • Foot exams and treatment • Routine (non-Medicare covered) foot care 	\$15 copay for each Medicare-covered visit \$15 copay for each routine (non-Medicare covered) visit	A referral from your doctor may be required for Medicare-covered foot care services.
Diabetic Supplies & Services <ul style="list-style-type: none"> • Blood glucose monitors • Diabetes self-management training, diabetic services and supplies 	\$0 copay for ACCU-CHEK 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)	Prior authorization from the plan may be required for diabetic supplies and services (including blood glucose monitors). See the plan EOC for more information.

Summary of benefits (cont'd)

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Premiums and benefits	You pay	What you should know
Durable Medical Equipment (DME) and Related Supplies <ul style="list-style-type: none"> Durable medical equipment (e.g., wheelchairs, oxygen) 	20% coinsurance	Prior authorization from the plan may be required for DME. See the plan EOC for more information
Prosthetics/Medical supplies <ul style="list-style-type: none"> Prosthetics (e.g., braces, artificial limbs) Medical supplies (e.g., splints, casts) 	20% coinsurance \$0 copay	Prior authorization from your doctor may be required for prosthetics/medical supplies.
Health and Wellness programs <ul style="list-style-type: none"> Basic gym access through SilverSneakers Fitness NurseHelp 24/7SM (telephone and online support) 	\$0 copay \$0 copay	
Over-the-Counter (OTC) Items	You have a \$70 allowance per quarter to spend on covered items.	You can place two orders per quarter and cannot roll over your unused allowance into the next quarter.
Routine chiropractic services (non-Medicare covered)	\$0 copay per visit	Limited to 12 visits per year.

Prescription drug coverage

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You pay the following:

Part D prescription drug benefit						
Stage 1: Annual Deductible Stage	This stage does not apply because there is no deductible.					
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 supply^{NDS}	30-day supply	90-day supply^{NDS}	100-day supply^{NDS}
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	\$5 copay	\$7.50 copay	Not Covered	\$12 copay	\$36 copay	Not Covered
Tier 3: Preferred Brand Drugs	\$40 copay	\$100 copay	Not Covered	\$47 copay	\$141 copay	Not Covered
Tier 3: Covered Insulins^{**}	\$30 copay	\$90 copay	Not Covered	\$35 copay	\$105 copay	Not Covered
Tier 4: Non-Preferred Drugs	\$95 copay	\$237.50 copay	Not Covered	\$100 copay	\$300 copay	Not Covered
Tier 4: Covered Insulins^{**}	\$35 copay	\$105 copay	Not Covered	\$35 copay	\$105 copay	Not Covered
Tier 5: Specialty Tier Drugs	33% coinsurance	Not Covered	Not Covered	33% coinsurance	Not Covered	Not Covered

^{**} Covered Insulins are marked with the symbol INS on the drug list. This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help").

[^]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)

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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 \$5,030, until your yearly out-of-pocket drug costs reach \$8,000.	Tier 1: Preferred Generic Drugs, Tier 3: Covered Insulins and Tier 4: Covered Insulins 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 \$8,000, 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 Stage	After your yearly out-of-pocket drug costs (including drugs you bought through your retail pharmacy and through mail service) reach \$8,000, the plan pays the full cost for your covered Part D drugs. For excluded drugs covered under our enhanced benefit, you pay the Tier 2: Generic Drugs copayments listed in the table shown above. (This stage protects you from any additional costs once you have paid your yearly out-of-pocket drug costs.)	

Important Message About What You Pay for Vaccines: Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information

Mail Service Pharmacy

CVS Caremark® is our network mail service pharmacy where you can get a 90- or 100-day supply of maintenance drugs at a lower cost share. Your order will be delivered to your home or office with no charge for standard shipping. See plan EOC for more information.

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]**
- Safeway and Vons pharmacies[‡] **(877) 723-3929 [TTY: 711]**
- Albertsons/Sav-on/Osco pharmacies[‡] **(877) 932-7948 [TTY: 711]**
- Costco[‡] **(800) 955-2292 [TTY: 711]**
- Ralphs[‡], Walmart,[‡] and many more.

You do not have to be a Costco member to use Costco Pharmacies. Other pharmacies are available in our network.

[‡]Accepts e-prescribing

Optional supplemental dental HMO and PPO plans

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You pay the following:

	Optional supplemental dental HMO plan	Optional supplemental dental PPO plan	
	Participating dentists only	Participating dentists	Non-participating dentists
Monthly optional supplemental dental plan premium	\$15.00	\$45.00	
Calendar year deductible (not applicable to diagnostic and preventive services)	\$0	You pay \$50 before coverage for major services begins.	
Calendar year benefit maximum*	None	<p>\$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.</p> <p>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.</p> <p>You pay any amount above the \$1,500 calendar year benefit maximum.</p>	
Waiting Period	No 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 HMO and PPO plans (cont'd)

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	Optional supplemental dental HMO plan	Optional supplemental dental PPO plan	
	Participating dentists only	Participating dentists	Non-participating dentists
Summary list of services covered (ADA code)[†]			
	You pay	You pay	You pay
Diagnostic services			
Comprehensive oral exam (D0150)	\$5 copay	0% coinsurance (1 visit every 6 months)	20% coinsurance (1 visit every 6 months)
Comprehensive X-rays (D0210)	\$0 copay (1 series every 24 months)	0% coinsurance (1 series every 24 months)	20% coinsurance (1 series every 24 months)
Preventive care			
Prophylaxis – adult (D1110)	\$5 copay (1 cleaning every 6 months)	0% coinsurance (1 cleaning every 6 months)	20% coinsurance (1 cleaning every 6 months)
Restorative services			
One surface composite resin restoration – anterior (D2330)	\$11 copay	20% coinsurance	30% coinsurance
Crown (porcelain fused to noble metal) (D2750)	\$275 copay [‡]	50% coinsurance	50% coinsurance
Periodontics			
Periodontal scaling & root planing/four or more teeth per quadrant (D4341)	\$45 copay	50% coinsurance	50% coinsurance
Endodontics			
Anterior root canal therapy (D3310)	\$195 copay	50% coinsurance	50% coinsurance
Surgical placement of implant services body: endosteal implant (D6010)	Not covered	50% coinsurance	50% coinsurance
Molar tooth therapy (D3330)	\$335 copay	50% coinsurance	50% coinsurance

[†]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 are 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.

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