

Summary of Benefits

January 1, 2027 - December 31, 2027

BlueCHiP for Medicare Access (HMO-POS)

Summary of Benefits

This Summary of Benefits booklet is a summary of drug and health services covered by BlueCHiP for Medicare Access (HMO-POS).

BlueCHiP for Medicare Access (HMO-POS) is a Medicare Advantage HMO Plan with a Medicare contract. 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, you can call us and ask for the **"Evidence of Coverage."** You can also view the Evidence of Coverage on our website **bcbsri.com/medicare**.

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.

To join BlueCHiP for Medicare Access (HMO-POS), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes these counties in Rhode Island: Bristol, Kent, Newport, Providence, and Washington.

BlueCHiP for Medicare Access (HMO-POS) has a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in our network, the plan may not pay for these services. This plan offers a Point of Service benefit meaning you can use providers outside the plan's network for an additional cost on some services.

You must generally use network pharmacies to fill your prescriptions. You can view our plan's provider and pharmacy directory on our website **bcbsri.com/medicare**.

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on whether you are enrolled in Medicare's Low-Income Subsidy (LIS) program, the drug's tier, and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible Stage, Initial Coverage and Catastrophic Coverage. You can view the plan formulary on our website or call us and we will send you a copy.

For BlueCHiP for Medicare Access (HMO-POS), Blue Cross & Blue Shield of Rhode Island offers Special Supplemental Benefits for the Chronically Ill (SSBCI). Members who have one or more chronic conditions may be eligible for the monthly grocery benefit. Members may also qualify for lower-cost sharing on Medicare Part A & Part B services if they have a High-Value Provider as their Primary Care Provider. Refer to your Evidence of Coverage (EOC) for full details.

This document is available in other formats such as Spanish and large print. This document may be available in a non-English language. For more information if you are not a member of this plan, call us at 1-800-505-2583 (TTY: 711). If you are a member of this plan, call us at 1-800-267-0439 or 401-277-2958 (TTY: 711). Hours of operation are October 1 to March 31, 8 a.m. – 8 p.m. Eastern Time, 7 days a week. From April 1 to September 30, 8 a.m. – 8 p.m. Eastern Time, Monday through Friday. Saturday, 8:00 a.m. to noon. You may also visit our website **bcsri.com/medicare**.

Benefits and Services	BlueCHiP for Medicare Access (HMO-POS) Low-Income Subsidy (LIS) + Special Supplemental Benefits for Chronically Ill (SSBCI)	
	With BlueCHiP for Medicare network PCP	With BlueCHiP for Medicare network High Value Provider PCP
Monthly Plan Premium	\$0 per month	
	You must continue to pay your Medicare Part B premium.	
Deductible	This plan does not have a medical deductible.	
Maximum Out-of-Pocket Responsibility (<i>does not include Part D prescription drugs</i>)	\$6,000 annually for services you receive from in-network providers.	
	\$10,000 annually for services you receive from out-of-network providers.	
Inpatient Hospital Care*	In-network: \$400 copay per day for days 1 - 6 per admission/per stay.	In network: \$150 copay per day for days 1 - 6 per admission/per stay.
	Our plan covers an unlimited number of days for an in-network inpatient hospital stay.	
	Out-of-network: 20% coinsurance Out-of-network stays are limited to 90 days.	
	Copays for hospital benefits are based on per admission/per stay. You pay these amounts each time you are admitted to the hospital until you reach the in-network or out-of-network out-of-pocket maximum.	
Outpatient Hospital Services*	In-network: \$0 - \$400 copay	In-network: \$0 - \$200 copay
	Observation: \$400 copay	Observation: \$200 copay
	Out-of-network: 20% coinsurance	
Ambulatory Surgical Center (ASC)*	In-network: \$0 - \$300 copay	In-network: \$0 - \$200 copay
	Out-of-network: 20% coinsurance	
Doctor Visits	In-network: \$0 copay per visit	
• Primary care physician (PCP)	Out-of-network: 20% coinsurance	
• Specialist ^	In-network: \$0 - \$35 copay per visit	In-network: \$0 - \$10 copay per visit
	Out-of-network: 20% coinsurance	
Preventive Care (e.g., flu vaccine, diabetic screenings)	In-network: \$0 copay	
	Out-of-network: 20% coinsurance	
	Any additional preventive services approved by Medicare during the contract year will be covered.	
Emergency Care	In-network: \$130 copay per visit See the "Inpatient Hospital" section of this booklet for other costs	

*Prior authorization may be required

^Referrals are required

**BlueCHIP for Medicare Access
(HMO-POS)**

\$31.30 per month

You must continue to pay your Medicare Part B premium.

This plan does not have a medical deductible.

\$6,000 annually for services you receive from in-network providers.

\$10,000 annually for services you receive from out-of-network providers.

In-network: \$400 copay per day for days 1 - 6 per admission/per stay.

Our plan covers an unlimited number of days for an in-network inpatient hospital stay.

Out-of-network: 20% coinsurance
Out-of-network stays are limited to 90 days.

Copays for hospital benefits are based on per admission/per stay. You pay these amounts each benefit period until you reach the in-network or out-of-network out-of-pocket maximum.

In-network: \$0 - \$400 copay

Observation: \$400 copay

Out-of-network: 20% coinsurance

In-network: \$0 - \$300 copay

Out-of-network: 20% Coinsurance

In-network: \$0 copay per visit

Out-of-network: 20% coinsurance

In-network: \$0 - \$35 copay per visit

Out-of-network: 20% coinsurance

In-network: \$0 copay

Out-of-network: 20% Coinsurance

Any additional preventive services approved by Medicare during the contract year will be covered.

In-network: \$130 copay per visit

See the "Inpatient Hospital" section of this booklet for other costs

Benefits and Services	BlueCHiP for Medicare Access (HMO-POS) Low-Income Subsidy (LIS) + Special Supplemental Benefits for Chronically Ill (SSBCI)	
	With BlueCHiP for Medicare network PCP	With BlueCHiP for Medicare network High Value Provider PCP
Urgently Needed Services	In-network: \$50 copay per visit	
Diagnostic Services Tests/Labs/Imaging* • High-tech radiology services (such as MRIs, CT scans, etc.)	In-network: \$0 - \$150 copay	In-network: \$0 - \$75 copay
	Out-of-network: 20% coinsurance	
• Lab services	In-network: \$0 copay	
	Out-of-network: 20% coinsurance	
• Diagnostic Imaging (X-Rays)	In-network: \$25 copay	In-network: \$0 copay
	Out-of-network: 20% coinsurance	
• Diagnostic Procedures & Tests	In-network: \$50 copay	In-network: \$0 copay
	Out-of-network: 20% coinsurance	
• Therapeutic radiology	In-network: 20% coinsurance	
	Out-of-network: 20% coinsurance	
Hearing Services • Hearing exam - routine	In-network: \$0 copay per visit	
	Out-of-network: 20% coinsurance	
	Limit one visit per year	
• Hearing exam - diagnostic/non-routine	In-network: \$35 copay per visit	In-network: \$10 copay per visit
	Out-of-network: 20% coinsurance	
• Hearing aid	You pay \$200 - \$1,675 for each hearing aid Coverage is for 2 hearing aids every year	
Dental Services • Medicare covered	In-network: 20% coinsurance	
	Out-of-network: 20% coinsurance	
	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	
• Preventive Dental Care (exam, cleanings, x-rays, and flouride treatment)	In-network: \$0 copay	
• Comprehensive Dental Care (fillings, palliative treatment, simple extractions, denture repairs, root canals and oral surgery)	In-network: \$0 copay	
• Crowns and Onlays	Not Covered	
• Annual benefit maximum	\$1,500	

**BlueCHIP for Medicare Access
(HMO-POS)**

In-network: \$50 copay per visit

In-network: \$0 - \$150 copay

Out-of-network: 20% coinsurance

In-network: \$0 copay

Out-of-network: 20% coinsurance

In-network: \$25 copay

Out-of-network: 20% coinsurance

In-network: \$50 copay

Out-of-network: 20% coinsurance

In-network: 20% coinsurance

Out-of-network: 20% coinsurance

In-network: \$0 copay per visit

Out-of-network: 20% coinsurance

Limit one visit per year

In-network: \$35 copay per visit

Out-of-network: 20% coinsurance

You pay \$200 - \$1,675 for each hearing aid
Coverage is for 2 hearing aids every year

In-network: 20% coinsurance

Out-of-network: 20% coinsurance

Limited dental services (this does not include services in connection
with care, treatment, filling, removal, or replacement of teeth).

In-network: \$0 copay

In-network: \$0 copay

Not Covered

\$1,500

Benefits and Services	BlueCHiP for Medicare Access (HMO-POS) Low-Income Subsidy (LIS) + Special Supplemental Benefits for Chronically Ill (SSBCI)	
	With BlueCHiP for Medicare network PCP	With BlueCHiP for Medicare network High Value Provider PCP
Vision Services • Exam - Routine	In-network: \$0 copay per visit	
	Out-of-network: 20% coinsurance	
	Limit one visit per year	
• Exam - Non-routine/Diagnostic (including annual glaucoma screening)	In-network: \$35 copay per visit	In-network: \$10 copay per visit
	Out-of-network: 20% coinsurance	
• Vision Hardware	\$200 allowance	
Mental Health Services: • Inpatient Visit	In-network: \$390 copay per day for days 1-6 per admission/per stay	In-network: \$150 copay per day for days 1-6 per admission/per stay
	Out-of-network: 20% coinsurance	
	Our plan covers an unlimited number of days for an in-network inpatient hospital stay. Out-of-network stays are covered for 90 days.	
	Copays for hospital benefits are based on per admission/per stay. You pay these amounts each time you are admitted to the hospital until you reach the in-network or out-of-network out-of-pocket maximum.	
• Outpatient Therapy (individual and group visits)	In-network: \$0 - \$35 copay per visit	In-network: \$0 - \$10 copay per visit
	Out-of-network: 20% coinsurance	
Skilled Nursing Facility (SNF)*	In-network: \$0 copay per day for days 1-20 \$218 copay per day for days 21-45 \$0 copay per day for days 46-100	
	Out-of-network: 20% coinsurance Our plan covers up to 100 days in a SNF. Copays for SNF benefits are based on benefit periods. You pay these amounts each benefit period until you reach the in-network or out-of-network out-of-pocket maximum.	
Physical Therapy*	In-network: \$0 - \$35 copay per visit	In-network: \$0 - \$10 copay per visit
	Out-of-network: 20% coinsurance	
Ambulance*	In-network: \$200 copay per trip	
Transportation	12 one way rides	
Medicare Part B Drugs	In-network: \$0 - 20% coinsurance	
	Out-of-network: 20% coinsurance	

**BlueCHIP for Medicare Access
(HMO-POS)**

In-network: \$0 copay per visit

Out-of-network: 20% coinsurance

Limit one visit per year

In-network: \$35 copay per visit

Out-of-network: 20% coinsurance

\$200 allowance

In-network: \$390 copay per day for days 1-6 per admission/per stay

Out-of-network: 20% coinsurance

Our plan covers an unlimited number of days for an in-network inpatient hospital stay. Out-of-network stays are covered for 90 days.

Copays for hospital benefits are based on per admission/per stay. You pay these amounts each time you are admitted to the hospital until you reach the in-network or out-of-network out-of-pocket maximum.

In-network: \$0 - \$35 copay per visit

Out-of-network: 20% coinsurance

In network: \$0 copay per day for days 1-20

\$218 copay per day for days 21-45

\$0 copay per day for days 46-100

Out-of-network: 20% coinsurance

Our plan covers up to 100 days in a SNF.

Copays for SNF benefits are based on benefit periods. You pay these amounts each benefit period until you reach the in-network or out-of-network out-of-pocket maximum.

In-network: \$0 - \$35 copay per visit

Out-of-network: 20% coinsurance

In-network: \$200 copay per trip

12 one way rides

In-network: \$0 - 20% coinsurance

Out-of-network: 20% coinsurance

Benefits and Services	BlueCHIP for Medicare Access (HMO-POS) Low-Income Subsidy (LIS) + Special Supplemental Benefits for Chronically Ill (SSBCI)	
	With BlueCHIP for Medicare network PCP	With BlueCHIP for Medicare network High Value Provider PCP
Prescription Drug Benefits		
Deductible	No Prescription Drug Deductible	
Initial Coverage Stage	During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost until your total yearly drug costs reach \$2,400.	
	You may get your drugs at network retail pharmacies and mail order pharmacies.	
	You won't pay more than \$35 or 25%, whichever is lesser for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	
Pharmacy Network	Standard Retail 30-day supply	
Tier 1: Preferred Generic	Generics: \$0 / \$1.65 / \$5.80 Brands: \$0 / \$5.00 / \$14.40	
Tier 2: Generic	Generics: \$0 / \$1.65 / \$5.80 Brands: \$0 / \$5.00 / \$14.40	
Tier 3: Preferred Brand	Generics: \$0 / \$1.65 / \$5.80 Brands: \$0 / \$5.00 / \$14.40	
Tier 4: Non-Preferred drug	Generics: \$0 / \$1.65 / \$5.80 Brands: \$0 / \$5.00 / \$14.40	
Tier 5: Specialty	Generics: \$0 / \$1.65 / \$5.80 Brands: \$0 / \$5.00 / \$14.40	
Pharmacy Network	Mail Order 100-day supply	
Tier 1: Preferred Generic	Generics: \$0 / \$1.65 / \$5.80 Brands: \$0 / \$5.00 / \$14.40	
Tier 2: Generic	Generics: \$0 / \$1.65 / \$5.80 Brands: \$0 / \$5.00 / \$14.40	
Tier 3: Preferred Brand	Generics: \$0 / \$1.65 / \$5.80 Brands: \$0 / \$5.00 / \$14.40	
Tier 4: Non-Preferred drug	Generics: \$0 / \$1.65 / \$5.80 Brands: \$0 / \$5.00 / \$14.40	
Tier 5: Specialty	Specialty drugs are limited to a 30-day supply	
Catastrophic Coverage Stage	You pay nothing for your Part D drugs in this stage.	

**BlueCHIP for Medicare Access
(HMO-POS)**

\$700 (All Tiers)

During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost until your total yearly drug costs reach \$2,400.

You may get your drugs at network retail pharmacies and mail order pharmacies.

You won't pay more than \$35 or 25%, whichever is lesser for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

**Standard Retail
30-day supply**

25% coinsurance

25% coinsurance

25% coinsurance

25% coinsurance

25% coinsurance

**Mail Order
100-day supply**

25% coinsurance

25% coinsurance

25% coinsurance

25% coinsurance

Specialty drugs are limited to a 30-day supply

You pay nothing for your Part D drugs in this stage.

Benefits and Services	BlueCHiP for Medicare Access (HMO-POS) Low-Income Subsidy (LIS) + Special Supplemental Benefits for Chronically Ill (SSBCI)	
	With BlueCHiP for Medicare network PCP	With BlueCHiP for Medicare network High Value Provider PCP
Additional Benefits		
Chiropractic Office Visits [^]	In-network: \$15 copay per visit	In-network: \$10 copay per visit
	Out-of-network: 20% coinsurance	
Fitness Benefit	\$0 - \$20 per month	
Foot Care (podiatry services) [^] • Foot exams and treatment	In-network: \$35 copay per visit	In-network: \$10 copay per visit
	Out-of-network: 20% coinsurance	
• Routine footcare for members with certain chronic conditions	In-network: \$35 copay per visit	In-network: \$10 copay per visit
	Out-of-network: 20% coinsurance	
Durable Medical Equipment (DME) and Prosthetics*	In-network: 20% coinsurance	
	Out-of-network: 20% coinsurance	
Diabetes monitoring supplies	In-network: 0% - 20% coinsurance	
	Out-of-network: 20% coinsurance	
	You must use Abbott branded products (Freestyle) monitors and test strips	
Over-the-Counter (OTC) Benefit	See OTC+Grocery Food Card below	
Over-the-Counter (OTC) + Grocery Food Card ⁽³⁾	\$50 per month allowance to use on every day health and food products	

[^] Referrals are required.

* Prior authorization may be required

⁽³⁾You may eligible for the monthly grocery benefit, which is part of Special Supplemental Benefits for the Chronically Ill (SSBCI) if you are living with one or more qualifying chronic condition(s), as defined by CMS, including but not limited to chronic heart failure, chronic lung diseases, dementia, diabetes mellitus, and frailty & fall risk, you receive a Low-Income Subsidy (also called Extra Help), and have selected a High-Value Provider as your Primary Care Provider. Receiving this benefit is not solely determined by your condition(s); all relevant eligibility criteria must be satisfied before benefit is available for use. Please see your Evidence of Coverage for full details.

**BlueCHIP for Medicare Access
(HMO-POS)**

In-network: \$15 copay per visit
Out-of-network: 20% coinsurance
\$0 - \$20 per month
In-network: \$35 copay per visit
Out-of-network: 20% coinsurance
In-network: \$35 copay per visit
Out-of-network: 20% coinsurance
In-network: 20% coinsurance
Out-of-network: 20% coinsurance
In network: 0% - 20% coinsurance
Out-of-network: 20% coinsurance
You must use Abbott branded products (Freestyle) monitors and test strips
\$25 per quarter to use on everyday health items.
Not covered