

Summary of Benefits

January 1, 2027 - December 31, 2027

BlueCHiP for Medicare Essential (HMO-POS)

BlueCHiP for Medicare Enhanced (HMO-POS)

BlueCHiP for Medicare Extra (HMO-POS)

BlueCHiP for Medicare Core (HMO)

Summary of Benefits

This Summary of Benefits booklet is a summary of drug and health services covered by BlueCHiP for Medicare Essential (HMO-POS), BlueCHiP for Medicare Enhanced (HMO- POS), BlueCHiP for Medicare Extra (HMO-POS), and BlueCHiP for Medicare Core (HMO).

These plans are Medicare Advantage HMO Plans 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 www.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 Essential** (HMO-POS), **BlueCHiP for Medicare Enhanced** (HMO-POS), **BlueCHiP for Medicare Extra** (HMO-POS) and **BlueCHiP for Medicare Core** (HMO), 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 Essential (HMO-POS), **BlueCHiP for Medicare Enhanced** (HMO-POS), and **BlueCHiP for Medicare Extra** (HMO-POS) have 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. These plans offer a Point of Service benefit meaning you can use providers outside the plan’s network for an additional cost on some services.

BlueCHiP for Medicare Core (HMO) has a network of doctors, hospitals, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

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

BlueCHiP for Medicare Essential (HMO- POS), **BlueCHiP for Medicare Enhanced** (HMO-POS), and **BlueCHiP for Medicare Extra** (HMO-POS) group 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 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.

BlueCHiP for Medicare Core (HMO) does not cover Part D prescription drugs.

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 **bcbsri.com/medicare**.

Premiums and Benefits	BlueCHIP for Medicare Essential (HMO-POS)	BlueCHIP for Medicare Enhanced (HMO-POS)
Monthly Plan Premium	\$0 per month You must continue to pay your Medicare Part B premium	\$39 per month You must continue to pay your Medicare Part B premium
Deductible	This plan does not have a medical deductible.	This plan does not have a medical deductible.
Maximum Out-of-Pocket Responsibility (<i>does not include Part D prescription drugs</i>)	• \$6,750 annually for services you receive from in-network providers. • \$15,000 annually for services you receive from out-of-network providers.	• \$6,750 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: \$458 copay per day for days 1 - 6 per admission/per stay. • \$0 copay per day for days 7 and beyond Our plan covers an unlimited number of days for an in-network inpatient hospital stay. • Out-of-network: 40% coinsurance Out-of-network stays are limited to 90 days. You pay these amounts each benefit period until you reach the in-network or out-of-network out-of-pocket maximum.	• In-network: \$400 copay per day for days 1 - 6 per admission/per stay. • \$0 copay per day for days 7 and beyond Our plan covers an unlimited number of days for an in-network inpatient hospital stay. • Out-of-network: 30% coinsurance Out-of-network stays are limited to 90 days. You pay these amounts each benefit period until you reach the in-network or out-of-network out-of-pocket maximum.
Outpatient Hospital Services*	• In-network: \$0-\$550 copay • Observation: \$550 copay • Out-of-network: 40% coinsurance	• In-network: \$0-\$450 copay • Observation: \$450 copay • Out-of-network: 30% coinsurance
Ambulatory Surgery Center (ASC)*	• In-network: \$0-\$450 copay • Out-of-network: 40% coinsurance	• In-network: \$0-\$350 copay • Out-of-network: 30% coinsurance
Doctor Visits		
• Primary Care Physician (PCP)	• In-network: \$0 copay per visit • Out-of-network: 40% coinsurance	• In-network: \$0 copay per visit • Out-of-network: 30% coinsurance
• Specialist^	• In-network: \$0-\$50 copay per visit • Out-of-network: 40% coinsurance	• In-network: \$0-\$40 copay per visit • Out-of-network: 30% coinsurance
Preventive Care (e.g., flu vaccine, diabetic screenings)	• In-network: \$0 copay • Out-of-network: 40% coinsurance Any additional preventive services approved by Medicare during the contract year will be covered.	• In-network: \$0 copay • Out-of-network: 30% coinsurance Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	\$130 copay per visit See the "Inpatient Hospital Care" section of this booklet for other costs	\$130 copay per visit See the "Inpatient Hospital Care" section of this booklet for other costs
Urgently Needed Services	\$50 copay per visit	\$50 copay per visit

*Prior authorization may be required ^ Referrals are required

BlueCHiP for Medicare Extra (HMO-POS)	BlueCHiP for Medicare Core (HMO)
\$159 per month You must continue to pay your Medicare Part B premium	\$0 per month You must continue to pay your Medicare Part B premium
This plan does not have a medical deductible.	This plan does not have a medical deductible.
• \$6,000 annually for services you receive from in-network providers. • \$7,500 annually for services you receive from out-of-network providers.	• \$5,000 annually for services you receive from in-network providers.
• In-network: \$325 copay per day for days 1 - 6 per admission/per stay. • \$0 copay per day for days 7 and beyond 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. You pay these amounts each benefit period until you reach the in-network or out-of-network out-of-pocket maximum.	• In-network: \$275 copay per day for days 1 - 6 per admission/per stay. • \$0 copay per day for days 7 and beyond Our plan covers an unlimited number of days for an in-network inpatient hospital stay. You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum.
• In-network: \$0-\$400 copay • Observation: \$400 copay • Out-of-network: 20% coinsurance	• In-network: \$0-\$250 copay • Observation: \$250 copay
• In-network: \$0-\$300 copay • Out-of-network: 20% coinsurance	• In-network: \$0-\$200 copay
• In-network: \$0 copay per visit • Out-of-network: 20% coinsurance	• In-network: \$0 copay per visit
• In-network: \$0-\$35 copay per visit • Out-of-network: 20% coinsurance	• In-network: \$0-\$30 copay per visit
• 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: \$0 copay Any additional preventive services approved by Medicare during the contract year will be covered.
\$130 copay per visit See the "Inpatient Hospital Care" section of this booklet for other costs	\$130 copay per visit See the "Inpatient Hospital Care" section of this booklet for other costs
\$50 copay per visit	\$50 copay per visit

Premiums and Benefits	BlueCHIP for Medicare Essential (HMO-POS)	BlueCHIP for Medicare Enhanced (HMO-POS)
Diagnostic Services Tests/Labs/Imaging*: • High-tech radiology services such as MRIs, CT Scans, etc.	• In-network: \$0-\$250 copay • Out-of-network: 40% coinsurance	• In-network: \$0-\$200 copay • Out-of-network: 30% coinsurance
• Lab Services	• In-network: \$0 copay • Out-of-network: 40% coinsurance	• In-network: \$0 copay • Out-of-network: 30% coinsurance
• Diagnostic Imaging (X-rays)	• In-network: \$25 copay • Out-of-network: 40% coinsurance	• In-network: \$25 copay • Out-of-network: 30% coinsurance
• Diagnostic Procedures & Tests	• In-network: up to \$50 copay • Out-of-network: 40% coinsurance	• In-network: up to \$50 copay • Out-of-network: 30% coinsurance
• Therapeutic radiology	• In-network: 20% coinsurance • Out-of-network: 40% coinsurance	• In-network: 20% coinsurance • Out-of-network: 30% coinsurance
Hearing Services: • Hearing exam - routine	• In-network: \$0 copay per visit • Out-of-network: 40% coinsurance Limit one visit per year.	• In-network: \$0 copay per visit • Out-of-network: 30% coinsurance Limit one visit per year.
• Hearing exam - diagnostic/non-routine	• In-network: \$50 copay per visit • Out-of-network: 40% coinsurance	• In-network: \$40 copay per visit • Out-of-network: 30% coinsurance
• Hearing aid	You pay \$300 - \$1,775 for each hearing aid. Coverage is for 2 hearing aids every year.	You pay \$300-\$1,775 for each hearing aid. Coverage is for 2 hearing aids every year.
Dental Services • Medicare covered	• In-network: 20% coinsurance • Out-of-network: 40% coinsurance Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	• In-network: 20% coinsurance • Out-of-network: 30% coinsurance Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).
• Preventive Dental Care (exams, cleanings, x-rays, and fluoride treatment)	\$0 copay	\$0 copay
• Comprehensive Dental Care (fillings, palliative treatment, simple extractions, denture repairs, root canals and oral surgery)	Not covered	\$0 copay
• Crowns and onlays	Not covered	Not covered
• Annual benefit maximum	\$500	\$2,000

*Prior authorization may be required

BlueCHiP for Medicare Extra (HMO-POS)	BlueCHiP for Medicare Core (HMO)
- In-network: \$0-\$175 copay - Out-of-network: 20% coinsurance	In-network: \$0-\$150 copay
- In-network: \$0 copay - Out-of-network: 20% coinsurance	In-network: \$0 copay
- In-network: \$25 copay - Out-of-network: 20% coinsurance	In-network: \$25 copay
- In-network: up to \$50 copay - Out-of-network: 20% coinsurance	In-network: up to \$50 copay
- In-network: 20% coinsurance - Out-of-network: 20% coinsurance	In-network: 20% coinsurance
- In-network: \$0 copay per visit - Out-of-network: 20% coinsurance Limit one visit per year.	In-network: \$0 copay per visit Limit one visit per year.
- In-network: \$35 copay per visit - Out-of-network: 20% coinsurance	In-network: \$30 copay per visit
You pay \$200 - \$1,675 for each hearing aid. Coverage is for 2 hearing aids every year.	You pay \$300 - \$1,775 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: 20% coinsurance Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).
\$0 copay	\$0 copay
\$0 copay	\$0 copay
50% coinsurance	Not covered
\$2,500	\$1,500

Premiums and Benefits	BlueCHIP for Medicare Essential (HMO-POS)	BlueCHIP for Medicare Enhanced (HMO-POS)
Vision Services: • Exam - Routine	- In-network: \$0 copay per visit - Out-of-network: 40% coinsurance Limit one visit per year.	- In-network: \$0 copay per visit - Out-of-network: 30% coinsurance Limit one visit per year.
• Exam - Non-routine/ Diagnostic	- In-network: \$50 copay per visit - Out-of-network: 40% coinsurance	- In-network: \$40 copay per visit - Out-of-network: 30% coinsurance
• Vision hardware	\$100 allowance	\$200 allowance
Mental Health Services: • Inpatient Visit	- In-network: \$390 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: 40% coinsurance per admission/per stay Out-of-network stays are covered for 90 days You pay these amounts each time you are admitted to the hospital until you reach your in-network or out-of-network out-of-pocket maximum.	- In-network: \$375 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: 30% coinsurance per admission/per stay Out-of-network stays are covered for 90 days You pay these amounts each time you are admitted to the hospital until you reach your in-network or out-of-network out-of-pocket maximum.
• Outpatient Therapy (individual and group sessions)	- In-network: \$0-\$50 copay per visit - Out-of-network: 40% coinsurance	- In-network: \$0-\$40 copay per visit - Out-of-network: 30% coinsurance
Skilled Nursing Facility (SNF)*	\$10 per day for days 1-20 \$218 copay per day for days 21-100 - Out-of-network: 40% 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.	\$10 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: 30% 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-\$50 copay per visit - Out-of-network: 40% coinsurance	- In-network: \$0-\$40 copay per visit - Out-of-network: 30% coinsurance
Ambulance*	\$200 copay per trip	\$200 copay per trip
Medicare Part B Drugs	- In-network: 20% coinsurance - Out-of-network: 40% coinsurance	- In-network: 20% coinsurance - Out-of-network: 30% coinsurance

*Prior authorization may be required

BlueCHiP for Medicare Extra (HMO-POS)	BlueCHiP for Medicare Core (HMO)
- In-network: \$0 copay per visit - Out-of-network: 20% coinsurance Limit one visit per year.	In-network: \$0 copay per visit Limit one visit per year.
- In-network: \$35 copay per visit - Out-of-network: 20% coinsurance	In-network: \$30 copay per visit
\$300 allowance	\$150 allowance
- In-network: \$325 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 per admission/per stay Out-of-network stays are covered for 90 days You pay these amounts each time you are admitted to the hospital until you reach your in-network or out-of-network out-of-pocket maximum.	In-network: \$275 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. You pay these amounts each time you are admitted to the hospital until you reach your in-network out-of-pocket maximum.
- In-network: \$0-\$35 copay per visit - Out-of-network: 20% coinsurance	In-network: \$0-\$30 copay per visit
\$0 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.	\$0 per day for days 1-20 \$218 copay per day for days 21-45 \$0 copay per day for days 46-100 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 out-of-pocket maximum.
- In-network: \$0-\$35 copay per visit - Out-of-network: 20% coinsurance	In-network: \$0-\$30 copay per visit
\$200 copay per trip	\$200 copay per trip
- In-network: 20% coinsurance - Out-of-network: 20% coinsurance	In-network: 20% coinsurance

Premiums and Benefits	BlueCHIP for Medicare Essential (HMO-POS)	BlueCHIP for Medicare Enhanced (HMO-POS)		
Prescription Drug Benefits				
Deductible	\$500 (T3-5)		\$500 (T3-5)	
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 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.		During this stage, the plan pays its share of the cost of your drugs and you pay your 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		Standard Retail 30-day supply	
Tier 1: Preferred Generic	\$0 copay		\$0 copay	
Tier 2: Generic	\$0 copay		\$0 copay	
Tier 3: Preferred Brand	25% coinsurance		25% coinsurance	
Tier 4: Non-Preferred Drug	30% coinsurance		30% coinsurance	
Tier 5: Specialty	28% coinsurance		28% coinsurance	
Pharmacy Network	Mail Order 100-day supply		Mail Order 100-day supply	
	Preferred	Standard	Preferred	Standard
Tier 1: Preferred Generic	\$0	\$24	\$0	\$24
Tier 2: Generic	\$0	\$48	\$0	\$48
Tier 3: Preferred Brand	25%	25%	25%	25%
Tier 4: Non-Preferred Drug	30%	30%	30%	30%
Tier 5: Specialty	Specialty drugs are limited to a 30-day supply		Specialty drugs are limited to a 30-day supply	
Catastrophic Coverage Stage	You pay nothing for your Part D drugs in this stage		You pay nothing for your Part D drugs in this stage	

BlueCHiP for Medicare Extra (HMO-POS)		BlueCHiP for Medicare Core (HMO)	
		This plan does not have Prescription Drug Benefits	
\$450 (T3-5)		N/A	
During this stage, the plan pays its share of the cost of your drugs and you pay your 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.		N/A	
Standard Retail 30-day supply		Standard Retail 30-day supply	
\$0 copay		N/A	
\$0 copay			
25% coinsurance			
30% coinsurance			
28% coinsurance			
Mail Order 100-day supply		Mail Order 100-day supply	
Preferred	Standard	Preferred	Standard
\$0	\$24	N/A	
\$0	\$36		
25%	25%		
30%	30%		
Specialty drugs are limited to a 30-day supply			
You pay nothing for your Part D drugs in this stage		N/A	

Premiums and Benefits	BlueCHIP for Medicare Essential (HMO-POS)	BlueCHIP for Medicare Enhanced (HMO-POS)
Additional Benefits		
Chiropractic Office Visits [^]	- In-network: \$15 copay - Out-of-network: 40% coinsurance	- In-network: \$15 copay - Out-of-network: 30% coinsurance
Fitness Benefit	\$0 - \$40 per month	\$0 - \$20 per month
Foot Care (Podiatry services) [^]		
Foot exams and treatment	- In-network: \$50 copay per visit - Out-of-network: 40% coinsurance	- In-network: \$40 copay per visit - Out-of-network: 30% coinsurance
Routine foot care for members with certain medical conditions	- In-network: \$50 copay per visit - Out-of-network: 40% coinsurance	- In-network: \$40 copay per visit - Out-of-network: 30% coinsurance
Durable Medical Equipment (DME) and Prosthetics*	- In-network: 25% coinsurance - Out-of-network: 40% coinsurance	- In-network: 20% coinsurance - Out-of-network: 30% coinsurance
Diabetes monitoring supplies	- In-network: 0% - 25% coinsurance - Out-of-network: 40% coinsurance You must use Abbott branded products (Freestyle) monitors and test strips.	- In-network: 0% - 20% coinsurance - Out-of-network: 30% coinsurance You must use Abbott branded products (Freestyle) monitors and test strips.
Over-the-Counter (OTC) Benefit	Not covered	\$25 per quarter to use on everyday health items

*Prior authorization may be required [^] Referrals are required

BlueCHiP for Medicare Extra (HMO-POS)	BlueCHiP for Medicare Core (HMO)
• In-network: \$15 copay • Out-of-network: 20% coinsurance	• In-network: \$15 copay
\$0 per month	\$0 - \$40 per month
• In-network: \$35 copay per visit • Out-of-network: 20% coinsurance	• In-network: \$30 copay per visit
• In-network: \$35 copay per visit • Out-of-network: 20% coinsurance	• In-network: \$30 copay per visit
• In-network: 10% coinsurance • Out-of-network: 20% coinsurance	• In-network: 20% coinsurance
• In-network: 0% - 10% coinsurance • Out-of-network: 20% coinsurance You must use Abbott branded products (Freestyle) monitors and test strips.	• In-network: 0% - 20% coinsurance You must use Abbott branded products (Freestyle) monitors and test strips.
\$40 per quarter to use on every day health items	\$50 per quarter to use on every day health items