SUMMARY OF BENEFITS

January 1, 2019 – December 31, 2019

BlueCHiP for Medicare Extra (HMO-POS)

BlueCHiP for Medicare Plus (HMO)

BlueCHiP for Medicare Preferred (HMO-POS)

BlueCHiP for Medicare Core (HMO)

Blue Cross Blue Shield of Rhode Island

Summary of Benefits

This is a summary of drug and health services covered by BlueCHiP for Medicare Extra (HMO-POS), BlueCHiP for Medicare Plus (HMO), BlueCHiP for Medicare Preferred (HMO-POS), and BlueCHiP for Medicare Core (HMO).

BlueCHiP for Medicare Plus (HMO) and **BlueCHiP for Medicare Core (HMO)** are Medicare Advantage Health Maintenance Organization (HMO) plans with a Medicare contract. **BlueCHiP for Medicare Extra (HMO-POS)** and **BlueCHiP for Medicare Preferred (HMO-POS)** are Medicare Advantage HMO plans with a Point of Service Option (POS) with a Medicare contract. Enrollment in these plans depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the **"Evidence of Coverage."**

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.

BlueCHiP for Medicare Extra (HMO-POS), BlueCHiP for Medicare Plus (HMO), BlueCHiP for Medicare Preferred (HMO-POS), and **BlueCHiP for Core (HMO)** 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 also require you to get referrals for some specialist visits from your PCP.

For **BlueCHiP for Medicare Extra (HMO-POS)** and **BlueCHiP for Medicare Preferred (HMO-POS),** you can use providers that are not in our network for some services.

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

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

This information is available for free in other languages and alternate formats including Spanish and large print.

For more information, interested prospects can contact the Medicare sales team at **1-800-505-BLUE (2583)** (TTY: 711). Hours: Monday through Friday, 8:00 a.m. to 8:00 p.m. (Open seven days a week, 8:00 a.m. to 8:00 p.m., from October 1 – March 31.) You can use our automated answering system outside of these hours.

If you are a member of our plan and would like more information, please call the Medicare Concierge Team at **(401) 277-2958 or 1-800-267-0439 (TTY: 711)**. Hours: October 1 – March 31, you can call us seven days a week, 8:00 a.m. to 8:00 p.m. From April 1 – September 30, you can call us Monday through Friday, 8:00 a.m. to 8:00 p.m. Saturday & Sunday, 8:00 a.m. to noon. You can use our automated answering system outside of these hours.

You can see our plan's provider and pharmacy directories at **bcbsri.com/Medicare**.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **bcbsri.com/Medicare**.

Premiums and Benefits	BlueCHiP for Medicare Extra (HMO-POS)	BlueCHiP for Medicare Plus (HMO)
Monthly Plan Premium	$99 per month. You must continue to pay your Medicare Part B premium.	$165 per month. You must continue to pay your Medicare Part B premium.
Annual Medical Deductible	This plan does not have a medical deductible.	This plan does not have a medical deductible.
Maximum Out-of-Pocket Amount (does not include prescription drugs)	• $3,500 annually for services you receive from in-network providers. • $10,000 annually for services you receive from out-of-network providers.	$2,800 annually for services you receive from in-network providers.
Inpatient Hospital Coverage	In-network: • $250 copay per day for days 1-5. • $0 copay per day for days 6 and beyond. Out-of-network: 20% of the cost. • Our plan covers an unlimited number of days for an inpatient hospital stay. • Copays for hospital 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.	• $190 copay per day for days 1-5. • $0 copay per day for days 6 and beyond. • Our plan covers an unlimited number of days for an inpatient hospital stay. • Copays for hospital benefits are based on benefit periods. You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum.
Outpatient Hospital Coverage	• In-network: 20% of the cost. • Out-of-network: 20% of the cost.	$150 copay per visit.
Doctor's Office Visits: • Primary care	• In-network: $0 PCMH or $10 non-PCMH copay per visit. • Out-of-network: 20% of the cost.	$0 PCMH or $5 non-PCMH copay per visit.
• Specialist	• In-network: $25 copay per visit. • Out-of-network: 20% of the cost. Referral is required for specialist visits.	$25 copay per visit. Referral is required for specialist visits.
Preventive Care	• In-network: $0. • Out-of-network: 20% of the cost. Any additional preventive services approved by Medicare during the contract year will be covered.	$0. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$90 copay per visit. • If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. • See the "Inpatient Hospital Coverage" section of this booklet for other costs.	$75 copay per visit. • If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. • See the "Inpatient Hospital Coverage" section of this booklet for other costs.
Urgently Needed Services	$50 copay per visit.	$50 copay per visit.

BlueCHiP for Medicare Preferred (HMO-POS)	BlueCHiP for Medicare Core (HMO)
$255 per month. You must continue to pay your Medicare Part B premium.	$0. You must continue to pay your Medicare Part B premium.
This plan does not have a medical deductible.	This plan does not have a deductible
• $2,250 annually for services you receive from in-network providers. • $5,000 annually for services you receive from out-of-network providers.	$3,950 annually for services you receive from in-network providers.
In-network: • $180 copay per day for days 1-5. • $0 copay per day for days 6 and beyond. Out-of-network: 20% of the cost. • Our plan covers an unlimited number of days for an inpatient hospital stay. • Copays for hospital 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.	• $180 copay per day for days 1-5. • $0 copay per day for days 6 and beyond. • Our plan covers an unlimited number of days for an inpatient hospital stay. • Copays for hospital 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: $150 copay per visit. • Out-of-network: 20% of the cost.	20% of the cost.
• In-network: $0 PCMH or $5 non-PCMH copay per visit. • Out-of-network: 20% of the cost.	$0 PCMH or $10 non-PCMH copay per visit.
• In-network: $25 copay per visit. • Out-of-network: 20% of the cost. Referral is required for specialist visits.	$40 copay per visit. Referral is required for specialist visits.
• In-network: $0. • Out-of-network: 20% of the cost. Any additional preventive services approved by Medicare during the contract year will be covered.	$0. Any additional preventive services approved by Medicare during the contract year will be covered.
$75 copay per visit. • If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. • See the "Inpatient Hospital Coverage" section of this booklet for other costs.	$90 copay per visit. • If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. • See the "Inpatient Hospital Coverage" section of this booklet for other costs.
$50 copay per visit.	$50 copay per visit.

Premiums and Benefits	BlueCHiP for Medicare Extra (HMO-POS)	BlueCHiP for Medicare Plus (HMO)
Diagnostic Services/ Labs/Imaging: • High-tech diagnostic radiology services (such as MRIs, CT scans, etc.)	• In-network: $100 copay per visit. • Out-of-network: 20% of the cost.	$150 copay per visit.
• Lab services	• In-network: $0. • Out-of-network: 20% of the cost.	$0.
• Outpatient X-rays and diagnostic tests and	• In-network: $0. • Out-of-network: 20% of the cost.	$0.
• Therapeutic radiology	• In-network: $0. • Out-of-network: 20% of the cost.	$0.
Hearing Services: • Hearing exam - routine	• In-network: $0. • Out-of-network: 20% of the cost. Limit one visit per year.	$0. Limit one visit per year.
• Hearing exam - diagnostic/non-routine	• In-network: $25 copay per visit. • Out-of-network: 20% of the cost.	$25 copay per visit.
• Hearing aid	Not covered	Our plan pays up to $500 every 3 years for hearing aids. The maximum plan amount is for both ears.
Dental Services • Medicare covered	• In-network: 20% of the cost. • Out-of-network: 20% of the cost. Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth).	20% of the cost. Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth).
• Preventive	$0.	$0.
• Comprehensive	$0.	$0.
• Annual benefit maximum	$1,500 limit on all covered dental services for Preventive and Comprehensive Dental	$1,500 limit on all covered dental services for Preventive and Comprehensive Dental
Vision Services: • Vision exam - routine	• In-network: $0. • Out-of-network: 20% of the cost. Limit one visit per year.	$0. Limit one visit per year.
• Vision exam - diagnostic/non-routine	• In-network: $25 copay per visit. • Out-of-network: 20% of the cost.	$25 copay per visit.
• Vision eyewear	Our plan pays up to $150 every year for eyewear.	Our plan pays up to $150 every year for eyewear.
Mental Health Services: • Inpatient visit	In-network: • $250 copay per day for days 1 - 4. • $0 copay per day for days 5 - 90. Out-of-network: 20% of the cost. • Our plan covers 90 days for an inpatient hospital stay.	• $190 copay per day for days 1 - 4. • $0 copay per day for days 5 - 90. Our plan covers 90 days for an inpatient hospital stay.
• Outpatient group/ individual therapy visit	• In-network: $25 copay per visit. • Out-of-network: 20% of the cost.	$25 copay per visit.

BlueCHiP for Medicare Preferred (HMO-POS)	BlueCHiP for Medicare Core (HMO)
• In-network: $150 copay per visit. • Out-of-network: 20% of the cost.	$150 copay per visit.
• In-network: $0. • Out-of-network: 20% of the cost.	$0.
• In-network: $0. • Out-of-network: 20% of the cost.	$0.
• In-network: $0. • Out-of-network: 20% of the cost.	$0.
• In-network: $0. • Out-of-network: 20% of the cost. Limit one visit per year.	$0. Limit one visit per year.
• In-network: $25 copay per visit. • Out-of-network: 20% of the cost.	$40 copay per visit.
Our plan pays up to $750 every 3 years for hearing aids. The maximum plan amount is for both ears.	Not covered
• In-network: 20% of the cost. • Out-of-network: 20% of the cost. Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth).	20% of the cost. Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth).
$0.	Not covered
$0.	Not covered
$1,500 limit on all covered dental services for Preventive and Comprehensive Dental Services.	Not covered
• In-network: $0. • Out-of-network: 20% of the cost. Limit one visit per year.	$0. Limit one visit per year.
• In-network: $25 copay per visit. • Out-of-network: 20% of the cost.	$40 copay per visit.
Our plan pays up to $200 every year for eyewear.	Our plan pays up to $100 every year for eyewear.
In-network: • $180 copay per day for days 1 - 4. • $0 copay per day for days 5 - 90. Out-of-network: 20% of the cost. Our plan covers 90 days for an inpatient hospital stay.	• $180 copay per day for days 1 - 4. • $0 copay per day for days 5 - 90. Our plan covers 90 days for an inpatient hospital stay.
• In-network: $25 copay per visit. • Out-of-network: 20% of the cost.	$30 copay per visit.

Premiums and Benefits	BlueCHiP for Medicare Extra (HMO-POS)		BlueCHiP for Medicare Plus (HMO)	
Skilled Nursing Facility (SNF)	In-network: • $0 copay per day for days 1-20. • $135 copay per day for days 21-45. • $0 copay per day for days 46-100. Out-of-network: 20% of the cost. • 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.		• $0 copay per day for days 1-20. • $135 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.	
Physical therapy (PT), occupational therapy (OT), and speech and language therapy (ST) visit	• In-network: $25 copay per provider per visit. • Out-of-network: 20% of the cost. Referral is required for PT/OT/ST visits.		$15 copay per provider per visit. Referral is required for PT/OT/ST visits.	
Ambulance	$150 copay per trip.		$75 copay per trip.	
Transportation	Not covered		Not covered	
Medicare Part B Drugs	• In-network: 20% of the cost. • Out-of-network: 20% of the cost.		20% of the cost.	
Prescription Drug Benefits				
Stage 1: Annual Prescription Deductible	This plan does not have a prescription deductible.		This plan does not have a prescription deductible.	
Stage 2: Initial Coverage	You pay the following until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.		You pay the following until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	
Pharmacy Network	**Preferred Retail 30-day supply**	**Standard Retail 30-day supply**	**Preferred Retail 30-day supply**	**Standard Retail 30-day supply**
Tier 1: Preferred Generic	$0 copay	$8 copay	$3 copay	$11 copay
Tier 2: Non-Preferred Generic	$5 copay	$13 copay	$6 copay	$14 copay
Tier 3: Preferred Brand	$47 copay	$47 copay	$47 copay	$47 copay
Tier 4: Non-Preferred Brand	$100 copay	$100 copay	$100 copay	$100 copay
Tier 5: Specialty	33% of the cost	33% of the cost	33% of the cost	33% of the cost
	Mail Order 90-day supply		**Mail Order 90-day supply**	
Tier 1: Preferred Generic	$0 copay		$0 copay	
Tier 2: Non-Preferred Generic	$0 copay		$0 copay	
Tier 3: Preferred Brand	$117.50 copay		$117.50 copay	
Tier 4: Non-Preferred Brand	$250 copay		$250 copay	
Tier 5: Specialty	N/A		N/A	

<table>
<tr><th>BlueCHiP for Medicare Preferred (HMO-POS)</th><th colspan="2">BlueCHiP for Medicare Core (HMO)</th></tr>
<tr><td>In-network:
• $0 copay per day for days 1-20.
• $130 copay per day for days 21-45.
• $0 copay per day for days 46-100.
Out-of-network: 20% of the cost.
• 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.</td><td colspan="2">• $0 copay per day for days 1-20.
• $130 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.</td></tr>
<tr><td>• In-network: $15 copay per provider per visit.
• Out-of-network: 20% of the cost.
Referral is required for PT/OT/ST visits.</td><td colspan="2">$15 copay per provider per visit.
Referral is required for PT/OT/ST visits.</td></tr>
<tr><td>$75 copay per trip.</td><td colspan="2">$150 copay per trip.</td></tr>
<tr><td>Not covered</td><td colspan="2">Not covered</td></tr>
<tr><td>• In-network: 20% of the cost.
• Out-of-network: 20% of the cost.</td><td colspan="2">20% of the cost.</td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td>This plan does not have a prescription deductible.</td><td colspan="2">Not covered</td></tr>
<tr><td colspan="2">You pay the following until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.
You may get your drugs at network retail pharmacies and mail order pharmacies.</td><td colspan="2">Not covered</td></tr>
<tr><td>Preferred Retail
30-day supply</td><td>Standard Retail
30-day supply</td><td>Preferred Retail
30-day supply</td><td>Standard Retail
30-day supply</td></tr>
<tr><td>$3 copay
$6 copay
$47 copay
$100 copay
33% of the cost</td><td>$11 copay
$14 copay
$47 copay
$100 copay
33% of the cost</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td colspan="2">Mail Order
90-day supply</td><td colspan="2">Mail Order
90-day supply</td></tr>
<tr><td colspan="2">$0 copay
$0 copay
$117.50 copay
$250 copay
N/A</td><td colspan="2">Not covered</td></tr>
</table>

Premiums and Benefits	BlueCHiP for Medicare Extra (HMO-POS)		BlueCHiP for Medicare Plus (HMO)	
Stage 3: Coverage Gap	Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,820. After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 37% of the plan’s cost for covered generic drugs until your costs total $5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap.		Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,820. After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 37% of the plan’s cost for covered generic drugs until your costs total $5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap.	
Pharmacy Network	**Preferred Retail 30-day supply**	**Standard Retail 30-day supply**	**Preferred Retail 30-day supply**	**Standard Retail 30-day supply**
Tier 1: Preferred Generic Tier 2: Non-Preferred Generic	Refer to Coverage Gap amounts	Refer to Coverage Gap amounts	Refer to Coverage Gap amounts	Refer to Coverage Gap amounts
	Mail Order		**Mail Order**	
Tier 1: Preferred Generic Tier 2: Non-Preferred Generic	Refer to Coverage Gap amounts		Refer to Coverage Gap amounts	
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of: 5% of the cost, or $3.40 copay for generic (including brand drugs treated as generic) and $8.50 copay for all other drugs.		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of: 5% of the cost, or $3.40 copay for generic (including brand drugs treated as generic) and $8.50 copay for all other drugs.	

<table>
<tr><th>BlueCHiP for Medicare Preferred (HMO-POS)</th><th>BlueCHiP for Medicare Core (HMO)</th></tr>
<tr><td>Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,820.

After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 37% of the plan’s cost for covered generic drugs until your costs total $5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug’s tier. See the chart that follows to find out how much it will cost you.</td><td>Not covered</td></tr>
<tr><td><table><tr><th>Preferred Retail 30-day supply</th><th>Standard Retail 30-day supply</th></tr><tr><td>$3 copay</td><td>$11 copay</td></tr><tr><td>$6 copay</td><td>$14 copay</td></tr></table></td><td></td></tr>
<tr><td>Mail Order</td><td>Mail Order</td></tr>
<tr><td>$0 copay

$0 copay</td><td>Not covered</td></tr>
<tr><td>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of:
5% of the cost, or $3.40 copay for generic (including brand drugs treated as generic) and $8.50 copay for all other drugs.</td><td>Not covered</td></tr>
</table>

Premiums and Benefits	BlueCHiP for Medicare Extra (HMO-POS)	BlueCHiP for Medicare Plus (HMO)
Additional Benefits		
Chiropractic Office Visits	• In-network: $20 copay per visit. • Out-of-network: 20% of the cost. Referral is required for specialist visits.	$20 copay per visit. Referral is required for specialist visits.
Fitness Benefit - Living Fit	$5 per month.	$5 per month.
Foot Care (podiatry • Foot exams and treatment	• In-network: $25 copay per visit. • Out-of-network: 20% of the cost. Referral is required for specialist visits.	$25 copay per visit. Referral is required for specialist visits.
• Routine foot care for members with certain medical conditions	• In-network: $25 copay per visit. • Out-of-network: 20% of the cost. Referral is required for specialist visits.	$25 copay per visit. Referral is required for specialist visits.
Medical Equipment/ • Durable medical equipment and prosthetics	• In-network: 20% of the cost. • Out-of-network: 20% of the cost.	20% of the cost.
• Diabetes monitoring supplies	• In-network: $0. • Out-of-network: 20% of the cost. You must use OneTouch plan designated monitors and test strips.	$0. You must use OneTouch plan designated monitors and test strips.
Virtual Doctors' Visits (Telemedicine)	$0 PCMH or $10 non-PCMH copay per visit. Speak to a primary care provider using your computer or mobile device	$0 PCMH or $5 non-PCMH copay per visit. Speak to a primary care provider using your computer or mobile device
Outpatient Surgery	• In-network: 20% of the cost. • Out-of-network: 20% of the cost.	$150 copay per visit.
Over the Counter (OTC) Benefit	$100 per quarter to use on approved health products.	$100 per quarter to use on approved health products.
Optional Supplemental Dental Rider		
Monthly Premium	Included in medical	Included in medical
• Preventive		
• Comprehensive		
• Annual benefit maximum		

BlueCHiP for Medicare Preferred (HMO-POS)	BlueCHiP for Medicare Core (HMO)
• In-network: $20 copay per visit. • Out-of-network: 20% of the cost. Referral is required for specialist visits.	$20 copay per visit. Referral is required for specialist visits.
$5 per month.	$5 per month.
• In-network: $25 copay per visit. • Out-of-network: 20% of the cost. Referral is required for specialist visits.	$40 copay per visit. Referral is required for specialist visits.
• In-network: $25 copay per visit. • Out-of-network: 20% of the cost. Referral is required for specialist visits.	$40 copay per visit. Referral is required for specialist visits.
• In-network: 20% of the cost. • Out-of-network: 20% of the cost.	20% of the cost.
• In-network: $0. • Out-of-network: 20% of the cost. You must use OneTouch plan designated monitors and test strips.	$0. You must use OneTouch plan designated monitors and test strips.
$0 PCMH or $5 non-PCMH copay per visit. Speak to a primary care provider using your computer or mobile device	$0 PCMH or $10 non-PCMH copay per visit. Speak to a primary care provider using your computer or mobile device
• In-network: $150 copay per visit. • Out-of-network: 20% of the cost.	20% of the cost.
$100 per quarter to use on approved health products.	Not covered
Included in medical	$21.60 per month.
	$0.
	50% of the cost for covered services.
	$1,000 limit on all covered dental services for Preventive and Comprehensive Dental Services.

Notes

This information is not a complete description of benefits. Existing members can call the Medicare Concierge Team at (401) 277-2958 or 1-800-267-0439 (TTY:711) for more information. Non-members can call the Medicare Sales Team at 1-800-505-BLUE (2583) (TTY:711. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary. You must continue to pay your Medicare Part B premium.

500 Exchange Street • Providence, RI 02903-2699 • bcbsri.com/Medicare

Blue Cross Blue Shield of Rhode Island

09/18 BMED-255008•1355