Summary of Benefits

January 1, 2026 - December 31, 2026

BlueCHiP for Medicare Essential (HMO-POS)

BlueCHiP for Medicare Enhanced (HMO-POS)

BlueCHiP for Medicare Extra (HMO-POS)

BlueCHiP for Medicare Core (HMO)

Blue Cross Blue Shield of Rhode Island

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 aday, 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. EasternTime, 7 days a week. From April 1 to September 30, 8 a.m. – 8 p.m. Eastern Time, Monday throughFriday. Saturday, 8:00 a.m. to noon. You may also visit our website **bcbsri.com/medicare**.

Benefits and Services	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.	$35 per month You must continue to pay your Medicare Part B premium.
Deductible	$160	This plan does not have a medical deductible.
Maximum Out-of-Pocket Responsibility *(does not include Part D prescription drugs)*	$6,750 annually for services you receive from in-network providers. $15,000 annually for services you receive from out-of-network providers.	$5,750 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. 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. 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 Surgical 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.

 * Prior authorization may be required † Services apply to deductible on BlueCHiP for Medicare Essential only. ^ Referrals are required.

BlueCHiP for Medicare Extra (HMO-POS)	BlueCHiP for Medicare Core (HMO)
$143 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.
$5,000 annually for services you receive from in-network providers.	$5,000 annually for services you receive from in-network providers.
$7,500 annually for services you receive from out-of-network providers.	
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 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. 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.

Benefits and Services	BlueCHiP for Medicare Essential (HMO - POS)	BlueCHiP for Medicare Enhanced (HMO-POS)
Emergency Care	$130 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" section of this booklet for other costs.	$130 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" section of this booklet for other costs.
Urgently Needed Services	$50 copay per visit	$50 copay per visit
Diagnostic Services Tests/Labs/Imaging*		
• High-tech radiology services such as MRI's, 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)† • Diagnostic Procedures&Tests†	In-network: $25 copay Out-of-network: 40% coinsurance In-network: up to $50 copay Out-of-network: 40% coinsurance	In-network: $25 copay Out-of-network: 30% 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	Not covered	You pay $300-$1,775 for each hearing aid. Coverage is for 2 hearing aids every year.

* Prior authorization may be required

† Services apply to deductible on BlueCHiP for Medicare Essential only.

BlueCHiP for Medicare Extra (HMO-POS)	BlueCHiP for Medicare Core (HMO)
$130 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" section of this booklet for other costs.	$130 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" section of this booklet for other costs.
$50 copay per visit	$50 copay per visit
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: up to $50 copay Out-of-network: 20% coinsurance	In-network: $25 copay 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.

Benefits and Services	BlueCHiP for Medicare Essential (HMO - POS)	BlueCHiP for Medicare Enhanced (HMO-POS)
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
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

† Services apply to deductible on BlueCHiP for Medicare Essential only.

BlueCHiP for Medicare Extra (HMO-POS)	BlueCHiP for Medicare Core (HMO)
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
$0 copay	Not Covered
$2,500	$1,500
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

Benefits and Services	BlueCHiP for Medicare Essential (HMO - POS)	BlueCHiP for Medicare Enhanced (HMO-POS)
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 copay 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 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: 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
Transportation	Not covered	Not covered
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

† Services apply to deductible on BlueCHiP for Medicare Essential only.

BlueCHiP for Medicare Extra (HMO-POS)	BlueCHiP for Medicare Core (HMO)
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 per admission/per 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 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	$0 copay 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 or out-of-network out-of-pocket maximum.	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
Not covered	Not covered
In-network: 20% coinsurance Out-of-network: 20% coinsurance	In-network: 20% coinsurance

Benefits and Services	BlueCHiP for Medicare Essential (HMO - POS)		BlueCHiP for Medicare Enhanced (HMO-POS)	
	Prescription Drug Benefits			
Deductible	$615 (Tiers 3 - 5)		$500 (Tiers 3 - 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 until your total yearly drug costs reach $2,100. 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 until your total yearly drug costs reach $2,100. 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: Non-Preferred Generic	$2 copay		$0 copay	
Tier 3: Preferred Brand	25% coinsurance		25% coinsurance	
Tier 4: Non-Preferred Drug	30% coinsurance		30% coinsurance	
Tier 5: Specialty	25% coinsurance		27% coinsurance	
Pharmacy Network	**Mail Order 100-day supply**		**Mail Order 100-day supply**	
	Preferred	Standard	Preferred	Standard
Tier 1: Preferred Generic	$0 copay	$24 copay	$0 copay	$24 copay
Tier 2: Non-Preferred Generic	$0 copay	$48 copay	$0 copay	$48 copay
Tier 3: Preferred Brand	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Tier 4: Non-Preferred Drug	30% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance
Tier 5: Specialty	N/A	N/A	N/A	N/A
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	

<table>
<tr><th>BlueCHiP for Medicare Extra (HMO-POS)</th><th colspan="2">BlueCHiP for Medicare Core (HMO)</th></tr>
<tr><td></td><td colspan="2">This plan does not have Prescription Drug Benefits.</td></tr>
<tr><td>$350 (Tiers 3-5)</td><td colspan="2">Not Applicable</td></tr>
<tr><td>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 $2,100.
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.</td><td colspan="2">Not Applicable</td></tr>
<tr><td>Standard Retail
30-day supply</td><td colspan="2">Standard Retail
30-day supply</td></tr>
<tr><td>$0 copay</td><td colspan="2" rowspan="5">Not Applicable</td></tr>
<tr><td>$0 copay</td></tr>
<tr><td>$47 copay</td></tr>
<tr><td>30% coinsurance</td></tr>
<tr><td>29% coinsurance</td></tr>
<tr><td colspan="2">Mail Order
100-day supply</td><td colspan="2">Mail Order
100-day supply</td></tr>
<tr><td>Preferred</td><td>Standard</td><td>Preferred</td><td>Standard</td></tr>
<tr><td>$0 copay</td><td>$24 copay</td><td colspan="2" rowspan="5">Not Applicable</td></tr>
<tr><td>$0 copay</td><td>$36 copay</td></tr>
<tr><td>$117.50 copay</td><td>$141 copay</td></tr>
<tr><td>30% coinsurance</td><td>30% coinsurance</td></tr>
<tr><td>N/A</td><td>N/A</td></tr>
<tr><td colspan="2">You pay nothing for your Part D drugs this stage</td><td colspan="2">Not Applicable</td></tr>
</table>

Benefits and Services	BlueCHiP for Medicare Essential (HMO-POS)	BlueCHiP for Medicare Enhanced (HMO-POS)
		Additional Benefits
Chiropractic Office Visits^†	In-network: $15 copay per visit Out-of-network: 40% coinsurance	In-network: $15 copay per visit Out-of-network: 30% coinsurance
Fitness Benefit+	Starting at $0	Starting at $0
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 chronic 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 copay Out-of-network: 40% coinsurance	In network: $0 copay Out-of-network: 30% coinsurance
	You must use Abbott branded products (Freestyle) monitors and test strips.	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.
Flexible Benefit Card (Dental and Hearing Services)	Not covered	Not covered
Post Discharge Meals	Not covered	Not covered

*Prior authorization may be required

†Services apply to deductible on BlueCHiP for Medicare Essential only.

^Referrals are required.

+See Evidence of Coverage for details

BlueCHiP for Medicare Extra (HMO-POS)	BlueCHiP for Medicare Core (HMO)
In-network: $15 copay per visit Out-of-network: 20% coinsurance	In-network: $15 copay per visit
$0 copay per month	Starting at $0
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 Out-of-network: 20% coinsurance	In network: $0
You must use Abbott branded products (Freestyle) monitors and test strips.	You must use Abbott branded products (Freestyle) monitors and test strips.
$40 per quarter to use on everyday health items.	$50 per quarter to use on everyday health items.
Not covered	Not covered
Not covered	Not covered