2014 Summary of Benefits

Blue Cross Blue Shield of Rhode Island

BlueCHiP for Medicare
Group Preferred (HMO-POS)

Introduction to the Summary of Benefits Report for

BlueCHiP For Medicare Group Preferred (HMO-POS)

January 1, 2014 – December 31, 2014

STATE OF RHODE ISLAND, BRISTOL COUNTY, MA; PARTIAL NEW LONDON COUNTY, CT

Thank you for your interest in BlueCHiP for Medicare Group Preferred (HMO-POS). Our plan is offered by BLUE CROSS & BLUE SHIELD OF RHODE ISLAND, a Medicare Advantage Health Maintenance Organization (HMO) with a point-of-service option (POS), that contracts with the Federal government. This Summary of Benefits tells you some features of our plan.

It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call BlueCHiP for Medicare Group Preferred (HMO-POS) and ask for the "Group Preferred Evidence of Coverage."

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan like BlueCHiP for Medicare Group Preferred (HMO-POS). You may have other options, too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call BlueCHiP for Medicare Group Preferred (HMO-POS) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare BlueCHiP for Medicare Group Preferred (HMO-POS) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS BLUECHIP FOR MEDICARE GROUP PREFERRED (HMO-POS) AVAILABLE?

The service area for this plan includes: New London County, CT*; Bristol, Kent, Newport, Providence, Washington Counties, RI; and Bristol County, MA*. You must live in one of these areas to join the plan.

*Includes the following ZIP codes: New London County, CT - 06320, 06339, 06340, 06355, 06359, 06378, 06385, 06388. Bristol County, MA - 02031, 02048, 02334, 02356, 02357, 02375, 02702, 02703, 02712, 02714, 02715, 02717, 02718, 02719, 02720, 02721, 02722, 02723, 02724, 02725, 02726, 02740, 02741, 02742, 02743, 02744, 02745, 02746, 02747, 02748, 02760, 02761, 02762, 02763, 02764, 02766, 02767, 02768, 02769, 02771, 02777, 02779, 02780, 02783, 02790, 02791

WHO IS ELIGIBLE TO JOIN BLUECHIP FOR MEDICARE GROUP PREFERRED (HMO-POS)?

You can join BlueCHiP for Medicare Group Preferred (HMO-POS) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease generally are not eligible to enroll in BlueCHiP for Medicare Group Preferred (HMO-POS) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

BlueCHiP for Medicare Group Preferred (HMO-POS) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. In some cases, you may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list visit us at http://findadoctor.bcbsri.com/.

Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

Generally, you are restricted to a doctor who is part of your network. However, we will cover your care from any provider for emergency or urgently needed care. Also, our point of service benefit allows you to get care from providers not in your network under certain conditions. For more information, please call the customer service number listed at the end of this introduction.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

BlueCHiP for Medicare Group Preferred (HMO-POS) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at http://www.BCBSRI.com. Our customer service number is listed at the end of this introduction.

WHAT IF MY DOCTOR PRESCRIBES LESS THAN A MONTH'S SUPPLY?

In consultation with your doctor or pharmacist, you may receive less than a month's supply of certain drugs. Also, if you live in a long-term care facility, you will receive less than a month's supply of certain brand [and generic] drugs. Dispensing fewer drugs at a time can help reduce cost and waste in the Medicare Part D program, when this is medically appropriate.

The amount you pay in these circumstances will depend on whether you are responsible for

paying coinsurance (a percentage of the cost of the drug) or a copay (a flat dollar amount for the drug.) If you are responsible for coinsurance for the drug, you will continue to pay the applicable percentage of the drug cost. If you are responsible for a copay for the drug, a "daily cost-sharing rate" will be applied. If your doctor decides to continue the drug after a trial period, you should not pay more for a month's supply than you otherwise would have paid. Contact your plan if you have questions about cost-sharing when less than a one-month supply is dispensed.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

BlueCHiP for Medicare Group Preferred (HMO-POS) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

BlueCHiP for Medicare Group Preferred (HMO-POS) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at http://www.BCBSRI.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

* 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week; and see http://www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
* The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
* Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage plans agree to stay in the program for a full year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of BlueCHiP for Medicare Group Preferred (HMO-POS), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of BlueCHiP for Medicare Group Preferred (HMO-POS), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an

exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected. Contact BlueCHiP for Medicare Group Preferred (HMO-POS) for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact BlueCHiP for Medicare Group Preferred (HMO-POS) for more details.

— Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.

— Osteoporosis Drugs: Injectable osteoporosis drugs for some women.

— Erythropoietin: By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

— Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.

— Injectable Drugs: Most injectable drugs administered incident to a physician's service.

— Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.

— Some Oral Cancer Drugs: If the same drug is available in injectable form.

— Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.

— Inhalation and Infusion Drugs administered through Durable Medical Equipment.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients, and customer service). If you have access to the Web, you may use the Web tools on http://.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

PLEASE CALL BLUE CROSS & BLUE SHIELD OF RHODE ISLAND FOR MORE INFORMATION ABOUT BLUECHIP FOR MEDICARE GROUP PREFERRED (HMO-POS).

Visit us at http://www.BCBSRI.com/Medicare or, call us:

Customer Service Hours for **October 1 – February 14**: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. – 8:00 p.m. Eastern

Customer Service Hours for **February 15 – September 30**: Monday, Tuesday, Wednesday, Thursday, Friday, 8:00 a.m. – 8:00 p.m. Eastern

Current members should call toll-free (800) 267-0439. (TTY/TDD: (711))

Prospective members should call toll-free (800) 505-2583. (TTY/TDD: (711))

Current members should call locally (401) 277-2958. (TTY/TDD: (711))

Prospective members should call locally (401) 351-2583. (TTY/TDD: (711))

Current members should call toll-free (800) 267-0439 for questions related to Medicare Part D Prescription Drug Program. (TTY/TTD (711))

Prospective members should call toll-free (800) 505-2583 for questions related to Medicare Part D Prescription Drug Program. (TTY/TTD (711))

Current members should call locally (401) 277-2958 for questions related to Medicare Part D Prescription Drug Program. (TTY/TTD (711))

Prospective members should call locally (401) 351-2583 for questions related to Medicare Part D Prescription Drug Program. (TTY/TTD (711))

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

You can call 24 hours a day, 7 days a week. Or, visit http://www.medicare.gov on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

Este documento puede estar disponible en idiomas que no sea el inglés.

Para obtener más información, comuníquese con Servicio al Cliente al número que se indica anteriormente.

Blue Cross & Blue Shield of Rhode Island		
Benefit Category	**Original Medicare**	**BlueCHiP for Medicare Group Preferred (HMO-POS)**
IMPORTANT INFORMATION		
1–Premium and Other Important Information	In 2013, the monthly Part B Premium was $104.90 and may change for 2014 and the annual Part B deductible amount was $147 and may change for 2014. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	**General** $232 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. **In-Network** $3,000 out-of-pocket limit for Medicare-covered services.
2–Doctor and Hospital Choice *(For more information, see Emergency Care – #15 and Urgently Needed Care – #16.)*	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** No referral required for network doctors, specialists, and hospitals.
SUMMARY OF BENEFITS INPATIENT CARE		
3–Inpatient Hospital Care *(includes Substance Abuse and Rehabilitation Services)*	In 2013, the amounts for each benefit period were: Days 1-60: $1,184 deductible Days 61-90: $296 per day Days 91-150: $592 per lifetime reserve day These amounts may change for 2014. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once.	**In-Network** No limit to the number of days covered by the plan each hospital stay. $250 copay for each Medicare-covered hospital stay. $0 copay for additional non-Medicare-covered hospital days. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Benefit Category	Original Medicare	BlueCHiP for Medicare Group Preferred (HMO-POS)
INPATIENT CARE *(continued)*		
3–Inpatient Hospital Care *(includes Substance Abuse and Rehabilitation Services)*	A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	
4–Inpatient Mental Health Care	In 2013 the amounts for each benefit period were: Days 1-60: $1,184 deductible Days 61-90: $296 per day Days 91-150: $592 per lifetime reserve day These amounts may change for 2014. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. $250 copay for each Medicare-covered hospital stay. Plan covers 60 lifetime reserve days. $0 copay per lifetime reserve day. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
5–Skilled Nursing Facility (SNF) *(in a Medicare-certified skilled nursing facility)*	In 2013, the amounts for each benefit period after at least a 3-day Medicare-covered hospital stay were: Days 1-20: $0 per day Days 21-100: $148 per day These amounts may change for 2014. 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period. No prior hospital stay is required. For SNF stays: Days 1-29: $0 copay per day Days 30-100: $50 copay per day

Benefit Category	Original Medicare	BlueCHiP for Medicare Group Preferred (HMO-POS)
6–Home Health Care *(includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)*	$0 copay.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.
7–Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice. You must consult your plan before you select hospice.
OUTPATIENT CARE		
8–Doctor Office Visits	20% coinsurance.	**In-Network** $10 copay for each Medicare-covered primary care doctor visit. $30 copay for each Medicare-covered specialist visit.
9–Chiropractic Services	Supplemental routine care not covered. 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).	**General** Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered chiropractic visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).
10–Podiatry Services	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**General** Authorization rules may apply. **In-Network** $30 copay for each Medicare-covered podiatry visit. Medicare-covered podiatry visits are for medically necessary foot care.
11–Outpatient Mental Health Care	20% coinsurance for most outpatient mental health services. Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**General** Authorization rules may apply. **In-Network** $0 copay for each Medicare-covered individual therapy visit. $0 copay for each Medicare-covered group therapy visit. $0 copay for each Medicare-covered individual therapy visit with a psychiatrist. $0 copay for each Medicare-covered group therapy visit with a psychiatrist. $0 copay for Medicare-covered partial hospitalization program services.

Benefit Category	Original Medicare	BlueCHiP for Medicare Group Preferred (HMO-POS)
OUTPATIENT CARE *(continued)*		
12–Outpatient Substance Abuse Care	20% coinsurance.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered individual substance abuse outpatient treatment visits. $0 copay for Medicare-covered group substance abuse outpatient treatment visits.
13–Outpatient Services	20% coinsurance for the doctor's services. Specified copayment for outpatient hospital facility services. Copay cannot exceed Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services.	**General** Authorization rules may apply. **In-Network** 20% of the cost for each Medicare-covered ambulatory surgical center visit. 20% of the cost for each Medicare-covered outpatient hospital facility visit.
14–Ambulance Services *(medically necessary ambulance services)*	20% coinsurance.	**General** Authorization rules may apply. **In-Network** $50 copay for Medicare-covered ambulance benefits.
15–Emergency Care *(You may go to any emergency room if you reasonably believe you need emergency care.)*	20% coinsurance for the doctor's services. Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances.	**General** $65 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 1 day for the same condition, you pay $0 for the emergency room visit.
16–Urgently Needed Care *(This is NOT emergency care, and in most cases, is out of the service area.)*	20% coinsurance, or a set copay. If your are admitted to the hospital within 3 days for the same condition, you pay $0 for the urgently needed care visit. NOT covered outside the U.S. except under limited circumstances.	**General** $40 copay for Medicare-covered urgently needed care visits.

Benefit Category	Original Medicare	BlueCHiP for Medicare Group Preferred (HMO-POS)
17–Outpatient Rehabilitation Services *(Occupational Therapy, Physical Therapy, Speech and Language Therapy)*	20% coinsurance. Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered.	**General** Authorization rules may apply. Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered. **In-Network** $0 copay for Medicare-covered occupational therapy visits. $0 copay for Medicare-covered physical therapy and/or speech and language pathology visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18–Durable Medical Equipment *(includes wheelchairs, oxygen, etc.)*	20% coinsurance.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered durable medical equipment.
19–Prosthetic Devices *(includes braces, artificial limbs and eyes, etc.)*	20% coinsurance. 20% coinsurance for Medicare-covered medical supplies related to prosthetics, splints, and other devices.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered prosthetic devices. $0 copay for Medicare-covered medical supplies related to prosthetics, splints, and other devices.
20–Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training. 20% coinsurance for diabetes supplies. 20% coinsurance for diabetic therapeutic shoes or inserts.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered diabetes self-management training $0 copay for Medicare-covered diabetes monitoring supplies $0 copay for Medicare-covered therapeutic shoes or inserts

Benefit Category	Original Medicare	BlueCHiP for Medicare Group Preferred (HMO-POS)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES *(continued)*		
21–Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and X-rays. $0 copay for Medicare-covered lab services. Lab services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: – lab services – diagnostic procedures and tests – X-rays – therapeutic radiology services $50 copay per day for Medicare-covered diagnostic radiology services (not including X-rays). If the doctor provides you services in addition to outpatient diagnostic procedures, tests and lab services, separate cost-sharing of $5 to $25 may apply. If the doctor provides you services in addition to outpatient diagnostic and therapeutic radiology services, separate cost-sharing of $5 to $25 may apply.
22–Cardiac and Pulmonary Rehabilitation Services	20% coinsurance for Cardiac Rehabilitation services. 20% coinsurance for Pulmonary Rehabilitation services. 20% coinsurance for Intensive Cardiac Rehabilitation services.	**General** Authorization rules may apply. **In-Network** $0 copay for: - Medicare-covered cardiac rehabilitation services. - Medicare-covered intensive cardiac rehabilitation services. - Medicare-covered pulmonary rehabilitation services.

Benefit Category	Original Medicare	BlueCHiP for Medicare Group Preferred (HMO-POS)
PREVENTIVE SERVICES		
23–Preventive Services	No coinsurance, copayment or deductible for the following: - Abdominal Aortic Aneurysm Screening - Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. - Cardiovascular Screening. - Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. - Colorectal Cancer Screening. - Diabetes Screening. - Influenza Vaccine. - Hepatitis B Vaccine for people with Medicare who are at risk. - HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. - Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. - Medical Nutrition Therapy Services. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	**General** $0 copay for all preventive services covered under Original Medicare at zero cost-sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. **In-Network** $0 copay for a supplemental annual physical exam.

Benefit Category	Original Medicare	BlueCHiP for Medicare Group Preferred (HMO-POS)
PREVENTIVE SERVICES *(continued)*		
23–Preventive Services	- Personalized Prevention Plan Services (Annual Wellness Visits) - Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. - Prostate Cancer Screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. - Smoking and Tobacco Use Cessation (counseling to stop smoking and tobacco use). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. - Screening and behavioral counseling interventions in primary care to reduce alcohol misuse. - Screening for depression in adults - Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs. - Intensive behavioral counseling for Cardiovascular Disease (bi-annual) - Intensive behavioral therapy for obesity. - Welcome to Medicare Preventive Visits (initial preventive physical exam). When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Preventive Visit or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.	
24–Kidney Disease and Conditions	20% coinsurance for renal dialysis. 20% coinsurance for kidney disease education services.	**In-Network** $0 copay for Medicare-covered renal dialysis. $10 copay for Medicare-covered kidney disease education services.

Benefit Category	Original Medicare	BlueCHiP for Medicare Group Preferred (HMO-POS)
PRESCRIPTION DRUG BENEFITS		
25–Outpatient Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs covered under Medicare Part B** **General** 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. **Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.BCBSRI.com on the web. Different out-of-pocket costs may apply for people who: -have limited incomes, -live in long-term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from BlueCHiP for Medicare Group Preferred (HMO-POS) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and BlueCHiP for Medicare Group Preferred (HMO-POS) approves the exception, you will pay Tier 3: Non-Preferred Brand cost-sharing for that drug.

Benefit Category	Original Medicare	BlueCHiP for Medicare Group Preferred (HMO-POS)
PRESCRIPTION DRUG BENEFITS *(continued)*		
25–Outpatient Prescription Drugs		**In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,850: **Retail Pharmacy** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): **Tier 1: Generic** – $6 copay for a one-month (30-day) supply of drugs in this tier – $12 copay for a two-month (60-day) supply of drugs in this tier – $18 copay for a three-month (90-day) supply of drugs in this tier **Tier 2: Preferred Brand** – $20 copay for a one-month (30-day) supply of drugs in this tier – $40 copay for a two-month (60-day) supply of drugs in this tier – $60 copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** – $50 copay for a one-month (30-day) supply of drugs in this tier – $100 copay for a two-month (60-day) supply of drugs in this tier – $150 copay for a three-month (90-day) supply of drugs in this tier **Tier 4: Specialty Tier** – 25% coinsurance for a one-month (30-day) supply of drugs in this tier **Long-Term Care Pharmacy** Long-term care pharmacies must dispense brand name drugs in amounts less than a 14-day supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): **Tier 1: Generic** – $6 copay for a one-month (31-day) supply of drugs in this tier **Tier 2: Preferred Brand** – $20 copay for a one-month (31-day) supply of drugs in this tier

Benefit Category	Original Medicare	BlueCHiP for Medicare Group Preferred (HMO-POS)
PRESCRIPTION DRUG BENEFITS *(continued)*		
25–Outpatient Prescription Drugs		**Tier 3: Non-Preferred Brand** – $50 copay for a one-month (31-day) supply of drugs in this tier **Tier 4: Specialty Tier** – 25% coinsurance for a one-month (31-day) supply of drugs in this tier **Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): **Tier 1: Generic** – $15 copay for a three-month (90-day) supply of drugs in this tier **Tier 2: Preferred Brand** – $50 copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** – $125 copay for a three-month (90-day) supply of drugs in this tier **Tier 4: Specialty Tier** – 25% coinsurance for a one-month (30-day) supply of drugs in this tier **Coverage Gap** After your total yearly drug costs reach $2,850, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand-name drugs and generally pay no more than 47.5% of the plan's costs for brand drugs and 72% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,550. **Additional Coverage Gap** The plan covers all formulary generics (100% of formulary generic drugs) through the coverage gap. The plan offers additional coverage in the gap for the following tiers. You pay the following: **Retail Pharmacy** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. You can get drugs the following way(s): **Tier 1: Generic** - $6 copay for a one-month (30-day) supply of all drugs covered in this tier - $12 copay for a two-month (60-day) supply of all drugs covered in this tier - $18 copay for a three-month (90-day) supply of all drugs covered in this tier

Benefit Category	Original Medicare	BlueCHiP for Medicare Group Preferred (HMO-POS)
PRESCRIPTION DRUG BENEFITS *(continued)*		
25–Outpatient Prescription Drugs		**Long Term Care Pharmacy** Long-term care pharmacies must dispense brand name drugs in amounts less than a 14-day supply at a time. They may also dispense less than a one-month supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. **Tier 1: Generic** - $6 copay for a one-month (31-day) supply of all drugs covered in this tier **Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. **Tier 1: Generic** - $15 copay for a three-month (90-day) supply of all drugs covered in this tier **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: – 5% coinsurance, or – A $2.55 copay for generic (including brand drugs treated as generic) and $6.35 copay for all other drugs. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from BlueCHiP for Medicare Group Preferred (HMO-POS). **Out-of-Network Initial Coverage** You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,850: **Tier 1: Generic** – $6 copay for a one-month (30-day) supply of drugs in this tier **Tier 2: Preferred Brand** – $20 copay for a one-month (30-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** – $50 copay for a one-month (30-day) supply of drugs in this tier **Tier 4: Specialty Tier** – 25% coinsurance for a one-month (30-day) supply of drugs in this tier

Benefit Category	Original Medicare	BlueCHiP for Medicare Group Preferred (HMO-POS)
PRESCRIPTION DRUG BENEFITS *(continued)*		
25–Outpatient Prescription Drugs		**Out-of-Network Coverage Gap** You will be reimbursed up to 28% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). You will be reimbursed up to 52.5% of the plan allowable cost for brand-name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). **Additional Out-of-Network Coverage Gap** The plan covers all formulary generics (100% of formulary generic drugs) through the coverage gap. You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: **Tier 1: Generic** - $6 copay for a one-month (30-day) supply of all drugs covered in this tier **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus your cost share which is the greater of: – 5% coinsurance, or – A $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs

Benefit Category	Original Medicare	BlueCHiP for Medicare Group Preferred (HMO-POS)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
26–Dental Services	Preventive dental services (such as cleaning) not covered.	**In-Network** 20% of the cost for Medicare-covered dental benefits. $0 copay for the following preventive dental benefits: – up to one oral exam(s) every year – up to two cleaning(s) every year – dental X-ray(s) Plan offers additional comprehensive dental benefits. $1,500 plan coverage limit for comprehensive dental benefits every year.
27–Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**In-Network** $0 copay for supplemental hearing aids. $30 copay for Medicare-covered diagnostic hearing exams. $30 copay for up to one supplemental routine hearing exam(s) every year. $30 copay for each hearing aid fitting evaluation. $500 plan coverage limit for hearing aids every three years.
28–Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye including an annual glaucoma screening for people at risk. Supplemental routine eye exams and eyeglasses (lenses and frames) not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.	**In-Network** – $30 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye including an annual glaucoma screening for people at high risk. – $30 copay for up to 1 supplemental routine eye exam(s) every year. $0 copay for: – one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery – eyeglasses (lenses and frames) – contact lenses – eyeglass lenses – eyeglass frames $70 plan coverage limit for eyewear every year.

Benefit Category	Original Medicare	BlueCHiP for Medicare Group Preferred (HMO-POS)
Wellness/Education and Other Supplemental Benefits & Services	Not covered.	**In-Network** The plan covers the following supplemental education/wellness programs: - Additional Smoking and Tobacco Use Cessation Visits - Health Club Membership/Fitness Classes Copays may apply for these benefits. $0 copay for Wig Coverage (Cranial Prosthetic). Contact plan for details.
Over-the-Counter Items	Not covered.	**General** The plan does not cover over-the-counter items.
Transportation *(Routine)*	Not covered.	**In-Network** This plan does not cover supplemental routine transportation.
Acupuncture and Other Alternative Therapies	Not covered.	**In-Network** This plan does not cover acupuncture, and other alternative therapies.

Benefit Category	Original Medicare	BlueCHiP for Medicare Group Preferred (HMO-POS)
Point of Service	You may go to any doctor, specialist, or hospital that accepts Medicare.	**General** Authorization rules may apply. **Out-of-Network** Point of Service coverage is available for the following benefits: Medicare-covered - Inpatient Hospital Acute - Inpatient Hospital Psychiatric - Skilled Nursing Facility (SNF) - Cardiac Rehabilitation Services - Intensive Cardiac Rehabilitation Services - Pulmonary Rehabilitation Services - Partial Hospitalization - Home Health Services - Primary Care Physician Services - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Mental Health Specialty Services - Podiatry Services - Other Health Care Professional - Psychiatric Services - Physical Therapy and Speech-Language Pathology Services - Diagnostic Procedures/Tests - Laboratory Services - Diagnostic Radiological Services - Therapeutic Radiological Services - Outpatient X-Rays - Outpatient Hospital Services - Ambulatory Surgical Center (ASC) Services - Outpatient Substance Abuse - Outpatient Blood Services - Durable Medical Equipment (DME) - Prosthetics/Medical Supplies - Diabetic Supplies and Services - Preventive Services - Kidney Disease Education Services - Diabetes Self-Management Training - Medicare Part B Rx Drugs - Eye Exams - Hearing Exams

Benefit Category	Original Medicare	BlueCHiP for Medicare Group Preferred (HMO-POS)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES *(continued)*		
Point of Service		Supplemental - Supplemental Education/Health Manageent Programs - Eye Exams - Hearing Exams $3,000 out-of-pocket limit every year for POS benefits. 20% of the cost for each Medicare-covered inpatient acute hospital stay. 20% of the cost per inpatient psychiatric hospital stay. 20% of the cost for each Medicare-covered SNF stay. 20% of the cost for Medicare-covered: - Cardiac Rehabilitation Services - Intensive Cardiac Rehabilitation Services - Pulmonary Rehabilitation Services - Partial Hospitalization - Home Health Services - Primary Care Physician Services - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Mental Health Specialty Services - Podiatry Services - Other Health Care Professional - Psychiatric Services - Physical Therapy and Speech-Language Pathology Services - Diagnostic Procedures/Tests - Laboratory Services - Diagnostic Radiological Services - Therapeutic Radiological Services - Outpatient X-Rays - Outpatient Hospital Services - Ambulatory Surgical Center (ASC) Services - Outpatient Substance Abuse - Outpatient Blood Services - Durable Medical Equipment (DME) - Prosthetics/Medical Supplies - Diabetic Supplies and Services - Preventive Services - Kidney Disease Education Services - Diabetes Self-Management Training - Medicare Part B Rx Drugs - Eye Exams - Hearing Exams Supplemental - Supplemental Education/Health Management Programs - Eye Exams - Hearing Exams

Understanding BlueCHiP for Medicare Group Preferred (HMO-POS) Benefits and How to Use Them

If you are enrolling through a former employer as part of a retiree plan, please consult your former employer to see what options may be available.

Your Primary Care Physician

When you become a member of BlueCHiP for Medicare Group Preferred (HMO-POS), you must choose a primary care physician. Your primary care physician is your healthcare partner. He or she will work with you to coordinate your healthcare needs. As a BlueCHiP for Medicare Group Preferred (HMO-POS) member, you will get your routine or basic care from your primary care physician.

We encourage you to visit your primary care physician on a regular basis. We want you to be as healthy as you can be. An essential part of this approach is good preventive care and early detection of illness.

If you already have a primary care doctor, use our online Find a Doctor tool to find out whether your doctor is in our network. Upon enrollment into a BlueCHiP for Medicare Group Preferred (HMO-POS) plan, you will receive the BlueCHiP for Medicare Group Provider Directory. If you do not have a doctor, you will be required to select one from the Provider Directory.

You may request to change your primary care doctor at any time by calling Customer Service. Your change will be effective the next business day following your request.

About Our Network

Our network includes hospitals, primary care physicians, specialists, and behavioral healthcare professionals located throughout the state of Rhode Island and parts of Massachusetts. All BlueCHiP for Medicare network providers have met our credentialing standards for quality. Our initial review process includes an examination of licenses, education, and professional standing.

Inpatient and Outpatient Mental Healthcare

Hospital and facility-based behavioral healthcare services may require preauthorization, continued stay, and/or continued treatment by the plan and/or plan designee. Plan-contracted facilities will call for preauthorization.

Emergency and Urgently Needed Care

If you need urgent care and you are inside the service area, you must seek care from a plan-contracted urgent care provider. A list of plan-contracted urgent care centers is included in the BlueCHiP for Medicare Group Provider Directory. Keep in mind that if you have an urgent need for care while you are in the plan's service area, we expect you to get this care from BlueCHiP for Medicare providers. Generally, we will not pay for urgently needed care that you get from a non-network provider while you are in our service area. If you need urgent care while you are outside the service area, seek care from an urgent care center or hospital emergency room.

There is a $40 copayment for Medicare-covered urgently needed care visits at an urgent care facility. If you have a medical emergency, call 911 or go to the nearest hospital emergency room. If possible, call your primary care physician within 48 hours, or have someone call for you, so your primary care physician can assist in the coordination of your care after you leave the hospital. There is a $65 copayment for Medicare-covered emergency room visits. If you are admitted to the hospital within one day for the same condition, your copayment will be waived for the emergency room visit.

Outpatient Medical Service and Supplies

Durable Medical Equipment

Durable medical equipment is covered in full with BlueCHiP for Medicare Group Preferred (HMO-POS). All covered equipment must be prescribed by a BlueCHiP for Medicare doctor, and should be obtained from plan-contracted provider(s) of durable medical equipment.

Diabetes Self-monitoring Supplies

There is no copayment for diabetic supplies with BlueCHiP for Medicare Group Preferred (HMO-POS). Supplies can be obtained from plan-contracted provider(s) of durable medical equipment or at a network pharmacy.

Self-administered diabetes prescription drugs and diabetes supplies associated with the injection of insulin (specifically syringes, needles, alcohol swabs, and gauze) are covered under the Part D prescription drug benefit and must be purchased at a network pharmacy.

Diagnostic Tests, X-rays, and Laboratory Services

All covered outpatient laboratory services must be ordered by a BlueCHiP for Medicare doctor and provided by our exclusive plan-contracted lab network provider(s). Homebound lab services must be ordered by a BlueCHiP for Medicare doctor and performed by our exclusive plan-contracted lab. Certain lab services may be performed by physician offices, hospitals and/or urgent care centers that are BlueCHiP for Medicare network providers.

Diagnostic Radiological Services

Except for an emergency, urgent care, or during an inpatient hospital stay, preauthorization and/or continued treatment by the plan and/or plan designee may be required both in and out-of-network for MRIs, MRAs, PET Scans, CT Scans, and Nuclear Cardiology Services received in an outpatient setting. The ordering physician will need to call for preauthorization.

Dental Services

In addition to the preventive dental services referenced in the Summary of Benefits Chart, restorative dental services including fillings, simple extractions, oral surgery, root canal therapy (final restoration excluded), biopsies, denture repairs (repair full or partial dentures), denture reline (rebase or reline of a full or partial denture is limited to once in five years), and minor treatment for acute pain are also covered. These services require a 20 percent coinsurance. There is a $1,500 maximum per calendar year for covered dental services. You must use plan contracted providers in order for services to be covered.

Outpatient Prescription Drugs

The BlueCHiP for Medicare Group Preferred (HMO-POS) plan includes Medicare Part D coverage for prescription drugs. To receive coverage, BlueCHiP for Medicare Group Preferred (HMO-POS) plan members must have prescriptions filled at a network pharmacy, or through our mail-order service.

You pay only the appropriate copayment or coinsurance for each month's supply. Copayments and coinsurance are based on four levels, or tiers of drugs, as listed at right.

Category of Drug	BlueCHiP for Medicare Group Preferred (HMO-POS) members pay:
Tier 1 *generic*	$6 per 30-day supply
Tier 2 *preferred brand*	$20 per 30-day supply
Tier 3 *non-preferred brand*	$50 per 30-day supply
Tier 4 * *specialty*	25% coinsurance per 30-day supply

** Tier 4 speciality is limited to a 30-day retail and mail-order supply.*

Catastrophic Coverage

After your out-of-pocket costs reach $4,550, you will pay the greater of :
– $2.55 for generic (including brand-name drugs treated as generic) and $6.35 for all other drugs, OR
– 5% coinsurance.

Help with Drug Plan Costs

Medicare beneficiaries with low or limited income and resources may qualify for additional Medicare Part D assistance. If you qualify, your Medicare prescription drug plan costs, the amount of your premium, and your drug costs at the pharmacy will be less than those described above. Once you have enrolled in a BlueCHiP for Medicare plan with prescription drug coverage, Medicare will tell us how much assistance you are receiving, and we will send you information on the amount you will pay. If you are not receiving this additional assistance, you should contact the Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778. You can also go to www.SSA.gov on the Web or your State Medicaid Office to see if you qualify.

If you receive extra help to pay for your prescription drugs, you will not get any extra help to pay for drugs that are not normally covered in a Medicare prescription drug plan.

Cost Sharing for Mail Order

Category of Drug	BlueCHiP for Medicare Group Preferred (HMO-POS) members pay:
Tier 1 *generic drugs*	$15 per 90-day supply
Tier 2 *preferred brand drugs*	$50 per 90-day supply
Tier 3 *non-preferred brand drugs*	$125 per 90-day supply
Tier 4* *specialty drugs*	25% coinsurance per 30-day supply

** Tier 4 is limited to a 30-day retail and mail-order supply.*

Added Convenience with Our Mail-Order Service

To save time and monthly trips to the pharmacy, you can order medications that you take for an extended period of time from our mail-order service. You pay only two-and-a-half copayments for up to a three-month (90-day) supply of drugs. Please note that Tier 4 drugs are limited to a 30-day supply.

Additional Benefits

For the following benefits, the provider of the service should bill either their local Blue Cross and Blue Shield plan or Blue Cross & Blue Shield of Rhode Island directly by submitting claims to:

Blue Cross & Blue Shield of Rhode Island
Attention: Claims Department
500 Exchange Street
Providence, RI 02903

Hearing Aid Coverage

BlueCHiP for Medicare Group Preferred (HMO-POS) provides coverage of up to $500 every three years toward the purchase of a hearing aid. Use of a plan-contracted provider is not required.

Wig Coverage

With a cancer diagnosis, BlueCHiP for Medicare Group Preferred (HMO-POS) provides coverage of up to $350 per calendar year for wig purchases. Use of a plan-contracted provider is not required.

Save Money with Generic Drugs

Choosing a generic drug, when available, may save you money under your BlueCHiP for Medicare prescription drug plan. A generic drug is a drug product that meets the approval of the Food and Drug Administration (FDA) and is equivalent to a brand-name drug in terms of quality and performance. By law, generic drug products must contain the identical amounts of the same active ingredients as their brand-name equivalents. Talk to your doctor about whether a generic equivalent is available and appropriate for your treatment.

For a complete list of drugs covered by BlueCHiP for Medicare Group Preferred (HMO-POS), please call Customer Service at the number located on page 5 of this booklet, or visit http://www.BCBSRI.com.

Point-of-Service (POS) Option

The POS option is an additional benefit that gives BlueCHiP for Medicare Group Preferred (HMO-POS) members the ability to receive coverage for specified services from non-network providers. Non-participating Medicare providers are not required to accept the POS plan, so it is best to check with your provider before using this benefit.

Member costs

- If the provider accepts Medicare assignment (accepts Medicare level of reimbursement, including the required 20 percent member coinsurance as payment in full for covered services), then you will be liable for 20 percent of the Medicare allowable amount for the service. For more information on what the Medicare charge is for a specific service, please contact customer service at the number listed on page 5.
- If the provider does not accept Medicare assignment, you will be liable for coinsurance up to 35 percent of the Medicare allowable amount. Before receiving services out of network, you should ask whether your provider accepts Medicare assignment, as this will lower your out-of-pocket expense.

Out-of-Pocket Maximum

- Your out-of-network, out-of-pocket maximum is $3,000. As a BlueCHiP for Medicare Group Preferred (HMO-POS) member, this is the most you will pay for covered services for the calendar year. Once you reach the $3,000 amount, you are no longer responsible for applicable coinsurance for POS-covered services during the 2014 calendar year. Please note that your in-network copayments do not apply to the $3,000 out-of-pocket maximum.

Prior Authorizations

If a service requires prior authorization in-network, that same service, if covered under the POS benefit, requires prior authorization out-of-network. If prior authorization is not received, the service will not be covered. Authorizations are not required for medical emergencies, urgently needed care, renal dialysis, or emergency and/or medically necessary ambulance services. These services are covered at the in-network level.

POS Limitations

- While in the plan service area, members must use plan-contracted laboratories, skilled nursing facilities, and durable medical equipment providers. There is no POS benefit within the plan's service area for these services.
- There is no POS benefit for pharmacy and health club membership.

Health & Wellness Benefits

Living Fit Health Club Membership

An unlimited-use health club membership is available through facilities in our plan network for only $5 per month, if you choose to use the benefit. With your membership, you can take advantage of:

- Group fitness classes. *(Some additional costs may apply.)*
- State-of-the-art exercise equipment.
- Knowledgeable, courteous staff.
- Indoor swimming pool. *(available at some facilities)*
- You may pay month to month.
- You may cancel at any time.

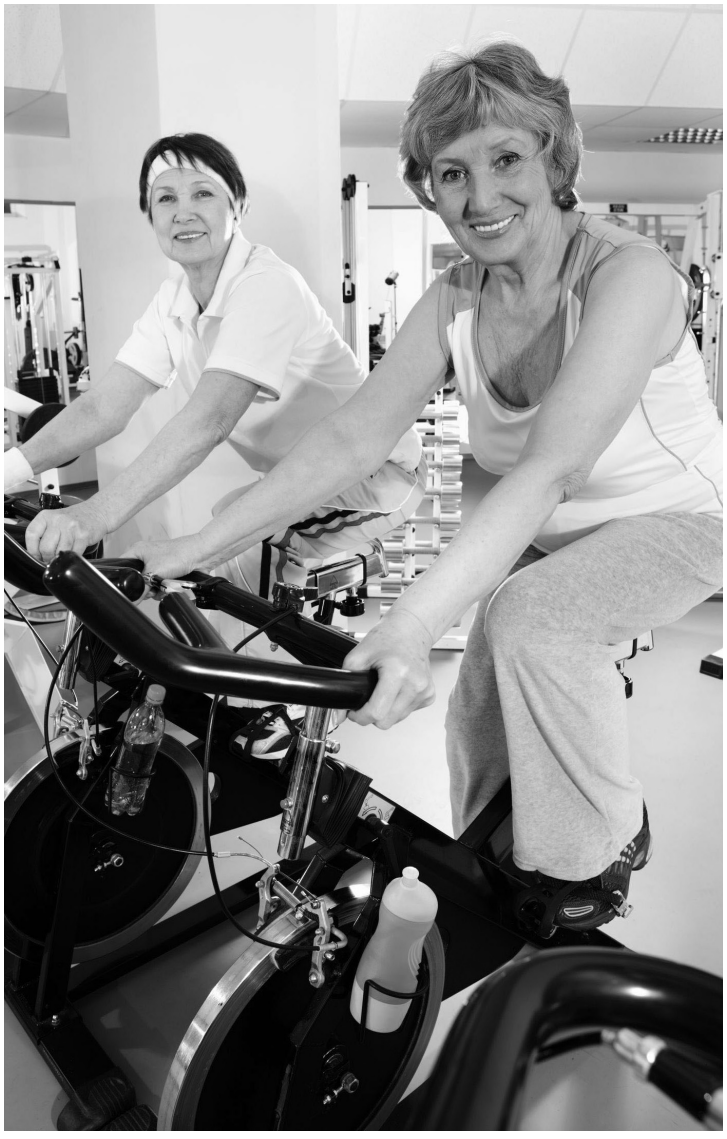
Visit **http://www.BCBSRI.com** for the most current listing of network health clubs.

Medical Nutrition Therapy/ Nutritional Counseling

Medical nutritional therapy/nutritional counseling is an important part of the prevention and treatment of many diseases and conditions. Coverage is not limited by diagnosis. Services must be received from a network provider in order for services to be covered. No copayment applies.

Smoking Cessation Counseling

Up to eight face-to-face visits are covered per year. Visits must be ordered by a participating provider and provided by a qualified doctor or other Medicare-certified practitioner. No copayment applies.



Quality & Utilization Management

Blue Cross & Blue Shield of Rhode Island's quality management program is designed to help ensure optimal physical and behavioral health outcomes for our members. Our program focuses on maximizing member health and safety, and improving member and provider service and satisfaction.

Goals of Our Quality Management Program

- Monitor and improve the quality of clinical care delivered to members.
- Monitor and improve the quality and efficiency of service delivered to members and providers.
- Appreciate and address the cultural and linguistic requirements of our members.
- Promote member safety whenever and wherever possible, including safe medical and behavioral health practices in the provider network delivery system.
- Help members make healthy lifestyle choices and manage chronic diseases.

Measuring the Effectiveness of Our Quality Management Program

- **The Healthcare Effectiveness Data and Information Set (HEDIS)** – A tool used by more than 90 percent of America's health plans to measure performance in many areas of care and service. HEDIS is maintained by the National Committee for Quality Assurance.
- **The Health Outcomes Survey (HOS)** – A survey conducted each spring by the Centers for Medicare & Medicaid Services (CMS) to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health. All managed care plans with Medicare Advantage (MA) contracts must participate.
- **The Consumer Assessment of Healthcare Providers and Systems (CAHPS)** – A survey conducted annually by CMS to assess the experiences of beneficiaries in Medicare Advantage plans. CMS administers this survey and sends results to plans each fall.

Utilization Management Programs

Our utilization management programs include prospective review, concurrent review, discharge planning, and retrospective review.

Prospective Review

We require notification from our providers before admission to an inpatient acute hospital, inpatient rehabilitation hospital, inpatient mental health hospital, or long-term care facility, unless in an emergency. Registered nurses and medical directors will review the upcoming services to ensure medical necessity and appropriateness of care in the settings indicated above. In the case of an emergency, notification from the provider is requested, if possible, within 48 hours of admission.

If a member receives services outside the service area, he or she should contact their primary care physician (PCP) to coordinate care after he or she has left the hospital. We also require notification from providers for some services that occur in the outpatient setting. These include, but are not limited to, some durable medical equipment, high-tech radiology services, and cosmetic procedures. Refer to your Evidence of Coverage for information on services that require prior authorization.

Concurrent Review and Discharge Planning

For members in an inpatient setting, registered nurses and medical directors coordinate efforts with providers to maintain the quality and timeliness of healthcare delivery, determine when transition from the inpatient setting is appropriate, and identify and coordinate the member's needs following discharge.

Retrospective Review

For admissions or services in which prospective review was required, and not obtained, we review medical records after discharge to determine the medical necessity, appropriateness of service, and eligibility for coverage. A member may be held liable if a covered service was rendered by a non-participating provider. The member may also be held liable when a provider has not received the required authorization for the service and had advised the member prior to providing the service that they would not be covered.

Medicare Part D Prescription Drug Utilization Management Programs

For plan members of Group BlueCHiP for Medicare

Group BlueCHiP for Medicare Formulary

A formulary is a list of covered drugs selected by Group BlueCHiP for Medicare in consultation with a team of healthcare providers. The formulary represents the prescription therapies believed to be a necessary part of a quality treatment program.

Utilization Management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed these requirements and limits for our plan to help us provide quality coverage to our members. Please consult a copy of the formulary on our website at **www.BCBSRI.com** for more information about these requirements and limits. These requirements for coverage or limits on certain drugs include:

Prior Authorization: We require you to get prior authorization (prior approval) for certain drugs. This means that your provider will need to contact us before you fill your prescription. If we do not get the necessary information to satisfy the prior authorization, we may not cover the drug.

Quantity Limits*:* For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time.

Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies may recommend and/or provide you the generic version, unless your doctor has told us that you must take the brand-name drug and we have approved this request.

Step Therapy: In some cases, Group BlueCHiP for Medicare requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Group BlueCHiP for Medicare may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Group BlueCHiP for Medicare will then cover Drug B.

If your drug is subject to one of these additional restrictions or limits and your physician determines that you are not able to meet the additional restriction or limit for medical necessity reasons, you or your physician may request an exception.

Drug Utilization Review

We conduct drug utilization reviews for all of our members to make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribes their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication Therapy Management Programs

We offer medication therapy management (MTM) programs at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. If you qualify for the program, you will be sent an introduction letter which describes the MTM program. As part of the program, specially trained pharmacists will work closely with you and your doctors to solve any problems related to medicines and to help you get the best results. Remember, you do not need to pay anything extra to participate. These programs were developed by a team of pharmacists and doctors. We use these medication therapy management programs to help our members better understand their medications, lower health risks and improve overall health. For additional information on our MTM program, visit our website at **BCBSRI.com**.

Questions?

Please call Customer Service at **1-800-267-0439** or TTY/TDD: **711.** Our Customer Service hours are **October 1, 2013 – February 14, 2014**, seven days a week, 8:00 a.m. to 8:00 p.m.; **February 15, 2014 – September 30, 2014,** Monday – Friday, 8:00 a.m. to 8:00 p.m.

The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. Limitations, copayments, and restrictions may apply. [Benefits, formulary, pharmacy network, premium and/or co-payments/co-insurance] may change on January 1 of each year. Blue Cross & Blue Shield of Rhode Island is an HMO plan with a Medicare contract. Enrollment in Blue Cross & Blue Shield of Rhode Island depends on contract renewal. An independent licensee of the Blue Cross and Blue Shield Association.

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