Blue Cross Blue Shield of Rhode Island

www.bcbsri.com

BlueCHiP for Medicare Core (HMO)
BlueCHiP for Medicare Select (HMO)
BlueCHiP for Medicare Value (HMO-POS)

Summary of Benefits

January 1, 2015 - December 31, 2015

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Blue Cross
Blue Shield
of Rhode Island

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

BlueCHiP for Medicare Core and BlueCHiP for Medicare Select: A Medicare Advantage Health Maintenance Organization (HMO) offered by BLUE CROSS & BLUE SHIELD OF RHODE ISLAND with a Medicare contract.

BlueCHiP for Medicare Value: A Medicare Advantage Health Maintenance Organization with Point of Service Option (HMO-POS) offered by BLUE CROSS & BLUE SHIELD OF RHODE ISLAND with a Medicare contract.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **BlueCHiP for Medicare Core (HMO), BlueCHiP for Medicare Select (HMO), or BlueCHiP for Medicare Value (HMO-POS)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **BlueCHiP for Medicare Core (HMO), BlueCHiP for Medicare Select (HMO), and BlueCHiP for Medicare Value (HMO-POS)** cover and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **BlueCHiP for Medicare Core (HMO), BlueCHiP for Medicare Select (HMO), and BlueCHiP for Medicare Value (HMO-POS)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits (Not applicable to BlueCHiP for Medicare Core)
- Optional Benefits (You must pay an extra premium for these benefits)

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-800-267-0439 (TTY/TDD: 711).

Este documento está disponible en otros formatos como sistema braille y en texto con letras grandes.

También puede estar disponible en otro idioma que no sea inglés. Para obtener información adicional, llámenos al 1-800-267-0439 (usuarios de TTY/TDD: 711).

Things to Know About BlueCHiP for Medicare Core (HMO), BlueCHiP for Medicare Select (HMO), and BlueCHiP for Medicare Value (HMO-POS)

Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

BlueCHiP for Medicare Core (HMO), BlueCHiP for Medicare Select (HMO), and BlueCHiP for Medicare Value (HMO-POS) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-800-267-0439 (TTY/TDD: 711).
- If you are not a member of this plan, call toll-free 1-800-351-2583 (TTY/TDD: 711).
- Our website: http://www.BCBSRI.com/Medicare

Who can join?

To join **BlueCHiP for Medicare Core (HMO), BlueCHiP for Medicare Select (HMO), and BlueCHiP for Medicare Value (HMO-POS)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes: Rhode Island.

Which doctors, hospitals, and pharmacies can I use?

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.

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

BlueCHiP for Medicare Value (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network.

BlueCHiP for Medicare Core (HMO) plan members:

You can see our plan's provider directory at our website (http://findadoctor.bcbsri.com/).

Or, call us and we will send you a copy of the provider directory.

BlueCHiP for Medicare Select (HMO) and BlueCHiP for Medicare Value (HMO-POS) plan members:

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider directory at our website (http://findadoctor.bcbsri.com/).

You can see our plan's pharmacy directory at our website (http://www.BCBSRI.com/Medicare).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers — and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

BlueCHiP for Medicare Core (HMO) covers Part B drugs including chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.

BlueCHiP for Medicare Select (HMO) and BlueCHiP for Medicare Value (HMO-POS)
We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, http://www.BCBSRI.com/Medicare.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

BlueCHiP for Medicare Select (HMO) and BlueCHiP for Medicare Value (HMO-POS) plan members:

Our plan groups each medication into one of four "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 after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

	BlueCHiP for Medicare Core (HMO)
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	
How much is the monthly premium?	$0 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. In this plan, you will pay nothing for Medicare-covered services from in-network providers. Your yearly limit(s) in this plan: • $3,950 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.
Covered Medical and Hospital Benefits Note: • Services with a [1] may require prior authorization. • Services with a [2] may require a referral from your doctor.	
Outpatient Care and Services	
Acupuncture and Other Alternative Therapies	Not covered
Ambulance[1]	$75 copay Copayment applies per trip.
Chiropractic Care[1]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • $20 copay
Dental Services[1]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • 20% of the cost

BlueCHiP for Medicare Select (HMO)	BlueCHiP for Medicare Value (HMO-POS)
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	
$0 per month. In addition, you must keep paying your Medicare Part B premium.	$0 per month. In addition, you must keep paying your Medicare Part B premium.
$200 per year for Part D prescription drugs.	$320 per year for Part D prescription drugs.
Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. In this plan, you will pay nothing for Medicare-covered services from in-network providers. Your yearly limit(s) in this plan: • $3,850 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $5,000 for services you receive from in-network providers. • $5,000 for services you receive from out-of-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.
Covered Medical and Hospital Benefits Note: • Services with a [1] may require prior authorization. • Services with a [2] may require a referral from your doctor.	
Outpatient Care and Services	
Not covered	Not covered
$200 copay Copayment applies per trip.	• In-network: $200 copay • Out-of-network: $200 copay Copayment applies per trip.
Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • $20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: 20% of the cost
Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • 20% of the cost	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: 20% of the cost • Out-of-network: 20% of the cost

	BlueCHiP for Medicare Core (HMO)
Outpatient Care and Services *(continued)*	
Diabetes Supplies and Services[1]	Diabetes monitoring supplies: • You pay nothing Diabetes self-management training: • You pay nothing Therapeutic shoes or inserts: • 20% of the cost
Diagnostic Tests, Lab and Radiology Services, and X-Rays[1]	Diagnostic radiology services (such as MRIs, CT scans): • $150 copay Diagnostic tests and procedures: • You pay nothing Lab services: • You pay nothing Outpatient X-rays: • You pay nothing Therapeutic radiology services (such as radiation treatment for cancer): • You pay nothing One copayment per date of service, per provider applies. If service is received at a facility or office visit, the applicable cost-sharing may apply.
Doctor's Office Visits[1]	Primary care physician visit: • $0-10 copay, depending on the service Specialist visit: • $0-30 copay, depending on the service For primary care physician visit: Covered 100% if you see a BCBSRI designated patient-centered medical home (PCMH) provider. For specialist visit: Copayment does not apply to covered surgery services rendered in an outpatient office setting.
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	20% of the cost
Emergency Care	$65 copay If you are admitted to the hospital within 1 day, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.

BlueCHiP for Medicare Select (HMO)	BlueCHiP for Medicare Value (HMO-POS)
Outpatient Care and Services *(continued)*	
Diabetes monitoring supplies: • You pay nothing Diabetes self-management training: • You pay nothing Therapeutic shoes or inserts: • 20% of the cost	Diabetes monitoring supplies: • In-network: You pay nothing • Out-of-network: 20% of the cost Diabetes self-management training: • In-network: You pay nothing • Out-of-network: 20% of the cost Therapeutic shoes or inserts: • In-network: 20% of the cost • Out-of-network: 20% of the cost
Diagnostic radiology services (such as MRIs, CT scans): • $150 copay Diagnostic tests and procedures: • $15 copay Lab services: • $15 copay Outpatient X-rays: • $15 copay Therapeutic radiology services (such as radiation treatment for cancer): • $15 copay One copayment per date of service, per provider applies for each service. If service is received at a facility or office visit, the applicable cost-sharing may apply	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $150 copay • Out-of-network: 20% of the cost Diagnostic tests and procedures: • In-network: $15 copay • Out-of-network: 20% of the cost Lab services: • In-network: $15 copay • Out-of-network: 20% of the cost Outpatient X-rays: • In-network: $15 copay • Out-of-network: 20% of the cost Therapeutic radiology services (such as radiation treatment for cancer): • In-network: $15 copay • Out-of-network: 20% of the cost For in-network: One copayment per date of service, per provider applies for each service. If service is received at a facility or office visit, the applicable cost-sharing may apply.
Primary care physician visit: • You pay nothing Specialist visit: • $0-45 copay, depending on the service For primary care physician: You must see a BlueCHiP for Medicare Select network provider. For specialist visit: Copayment does not apply to covered surgery services rendered in an outpatient office setting.	Primary care physician visit: • In-network: $0-25 copay, depending on the service • Out-of-network: 20% of the cost Specialist visit: • In-network: $0-45 copay, depending on the service • Out-of-network: 20% of the cost For primary care physician visit: Covered 100% if you see a BCBSRI designated patient-centered medical home (PCMH) provider. For specialist visit in-network: Copayment does not apply to covered surgery services rendered in an outpatient office setting.
20% of the cost	• In-network: 20% of the cost • Out-of-network: 20% of the cost
$65 copay If you are admitted to the hospital within 1 day, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	$65 copay If you are admitted to the hospital within 1 day, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.

	BlueCHiP for Medicare Core (HMO)
Outpatient Care and Services *(continued)*	
Foot Care *(podiatry services)*[1]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • $0-30 copay, depending on the service Routine foot care: • $0-30 copay, depending on the service Copayment does not apply to covered surgery services rendered in an outpatient office setting.
Hearing Services[1]	Exam to diagnose and treat hearing and balance issues: • $0-30 copay, depending on the service Routine hearing exam (for up to 1 every year): • $30 copay Copayment does not apply to covered surgery services rendered in an outpatient office setting. A separate office visit copayment may apply in addition to the hearing services copayment.
Home Health Care[1]	You pay nothing
Mental Health Care[1]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit applies to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • $180 copay per day for days 1 through 4 • You pay nothing per day for days 5 through 90 You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum. Outpatient group therapy visit: • $30 copay Outpatient individual therapy visit: • $30 copay

BlueCHiP for Medicare Select (HMO)	BlueCHiP for Medicare Value (HMO-POS)
Outpatient Care and Services *(continued)*	
Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • $0-45 copay, depending on the service Routine foot care: • $0-45 copay, depending on the service Copayment does not apply to covered surgery services rendered in an outpatient office setting.	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $0-45 copay, depending on the service • Out-of-network: 20% of the cost Routine foot care: • In-network: $0-45 copay, depending on the service • Out-of-network: 20% of the cost For in-network: Copayment does not apply to covered surgery services rendered in an outpatient office setting.
Exam to diagnose and treat hearing and balance issues: • $0-45 copay, depending on the service Routine hearing exam (for up to 1 every year): • $45 copay Copayment does not apply to covered surgery services rendered in an outpatient office setting. A separate office visit copayment may apply in addition to the hearing services copayment.	Exam to diagnose and treat hearing and balance issues: • In-network: $0-45 copay, depending on the service • Out-of-network: 20% of the cost Routine hearing exam: • In-network: $45 copay. You are covered for up to 1 every year. • Out-of-network: 20% of the cost. There may be a limit to how often these services are covered. For in-network: A separate office visit copayment may apply in addition to the hearing services copayment. Copayment does not apply to covered surgery services rendered in an outpatient office setting.
You pay nothing	• In-network: You pay nothing • Out-of-network: 20% of the cost

Inpatient visit:
 	
Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit applies to inpatient mental services provided in a general hospital.
 	
Our plan covers 90 days for an inpatient hospital stay.
 	
Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.
• $285 copay per day for days 1 through 4
• You pay nothing per day for days 5 through 90
 	
You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum.
 	
Outpatient group therapy visit:
• $40 copay
 	
Outpatient individual therapy visit:
• $40 copay
	Inpatient visit:
	
	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit applies to inpatient mental services provided in a general hospital.
	
	Our plan covers 90 days for an inpatient hospital stay.
	
	Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.
	• In-network:
	  • $345 copay per day for days 1 through 4
	  • You pay nothing per day for days 5 through 90
	
	You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum.
	
	• Out-of-network:
	  • 20% of the cost per stay
	
	Outpatient group therapy visit:
	• In-network: $40 copay
	• Out-of-network: 20% of the cost
	
	Outpatient individual therapy visit:
	• In-network: $40 copay
	• Out-of-network: 20% of the cost

	BlueCHiP for Medicare Core (HMO)
Outpatient Care and Services *(continued)*	
Outpatient Rehabilitation[1]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • You pay nothing Occupational therapy visit: • $15 copay Physical therapy and speech and language therapy visit: • $15 copay Copayment applies for each service rendered.
Outpatient Substance Abuse[1]	Group therapy visit: • $30 copay Individual therapy visit: • $30 copay
Outpatient Surgery[1]	Ambulatory surgical center: • 20% of the cost Outpatient hospital: • 20% of the cost Coinsurance applies to all services done in an outpatient hospital or an ambulatory surgical center, including, but not limited to hospital or facility charges, physician charges, and surgical charges.
Over-the-Counter Items	Not covered
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: • 20% of the cost Related medical supplies: • 20% of the cost
Renal Dialysis[1]	$25 copay
Transportation	Not covered
Urgent Care	$50 copay

BlueCHiP for Medicare Select (HMO)	BlueCHiP for Medicare Value (HMO-POS)
Outpatient Care and Services *(continued)*	
Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • You pay nothing Occupational therapy visit: • $35 copay Physical therapy and speech and language therapy visit: • $35 copay Copayment applies for each service rendered.	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: $40 copay • Out-of-network: 20% of the cost Occupational therapy visit: • In-network: $40 copay • Out-of-network: 20% of the cost Physical therapy and speech and language therapy visit: • In-network: $40 copay • Out-of-network: 20% of the cost For in-network: Copayment applies for each service rendered.
Group therapy visit: • $40 copay Individual therapy visit: • $40 copay	Group therapy visit: • In-network: $40 copay • Out-of-network: 20% of the cost Individual therapy visit: • In-network: $40 copay • Out-of-network: 20% of the cost
Ambulatory surgical center: • 20% of the cost Outpatient hospital: • 20% of the cost Coinsurance applies to all services done in an outpatient hospital or an ambulatory surgical center, including, but not limited to hospital or facility charges, physician charges, and surgical charges.	Ambulatory surgical center: • In-network: 20% of the cost • Out-of-network: 20% of the cost Outpatient hospital: • In-network: 20% of the cost • Out-of-network: 20% of the cost Coinsurance applies to all services done in an outpatient hospital or an ambulatory surgical center, including, but not limited to hospital or facility charges, physician charges, and surgical charges.
Not covered	Not covered
Prosthetic devices: • 20% of the cost Related medical supplies: • 20% of the cost	Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 20% of the cost Related medical supplies: • In-network: 20% of the cost • Out-of-network: 20% of the cost
$30 copay	• In-network: $30 copay • Out-of-network: $30 copay
Not covered	Not covered
$55 copay	$55 copay

	BlueCHiP for Medicare Core (HMO)
Outpatient Care and Services *(continued)*	
Vision Services[1]	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • $0-30 copay, depending on the service Routine eye exam (for up to 1 every year): • $30 copay Copayment does not apply to covered surgery services rendered in an outpatient office setting. A separate office visit copayment may apply in addition to the vision care copayment. There is no copayment for glaucoma screening. Contact lenses: • You pay nothing Eyeglasses (frames and lenses): • You pay nothing Eyeglass frames: • You pay nothing Eyeglass lenses: • You pay nothing Eyeglasses or contact lenses after cataract surgery: • You pay nothing Our plan pays up to $100 every year for eyewear.
Preventive Care	
	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)

BlueCHiP for Medicare Select (HMO)	BlueCHiP for Medicare Value (HMO-POS)
Outpatient Care and Services *(continued)*	
Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • $0-45 copay, depending on the service Routine eye exam (for up to 1 every year): • $45 copay Copayment does not apply to covered surgery services rendered in an outpatient office setting. A separate office visit copayment may apply in addition to the vision care copayment. There is no copayment for glaucoma screening. Contact lenses: • You pay nothing Eyeglasses (frames and lenses): • You pay nothing Eyeglass frames: • You pay nothing Eyeglass lenses: • You pay nothing Eyeglasses or contact lenses after cataract surgery: • You pay nothing Our plan pays up to $100 every year for eyewear.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-45 copay, depending on the service • Out-of-network: 20% of the cost Routine eye exam: • In-network: $45 copay. You are covered for up to 1 every year. • Out-of-network: 20% of the cost. There may be a limit to how often these services are covered. For in-network: Copayment does not apply to covered surgery services rendered in an outpatient office setting. A separate office visit copayment may apply in addition to the vision care copayment. There is no copayment for glaucoma screening. Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing • Out-of-network: 20% of the cost
Preventive Care	
You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)	• In-network: You pay nothing • Out-of-network: 20% of the cost Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)

	BlueCHiP for Medicare Core (HMO)
Preventive Care *(continued)*	
	• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Hospice	
	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.
Inpatient Care	
Inpatient Hospital Care[1]	Our plan covers an unlimited number of days for an inpatient hospital stay. • $180 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 • You pay nothing per day for days 91 and beyond You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum.
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. • You pay nothing per day for days 1 through 20 • $130 copay per day for days 21 through 45 • You pay nothing per day for days 46 through 100 You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum.
Prescription Drug Benefits	
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: • 20% of the cost Other Part B drugs[1]: • 20% of the cost Our plan does not cover Part D prescription drugs.

BlueCHiP for Medicare Select (HMO)	BlueCHiP for Medicare Value (HMO-POS)
Preventive Care *(continued)*	
• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.	• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Hospice	
You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.
Inpatient Care	

Our plan covers an unlimited number of days for an inpatient hospital stay.
• $285 copay per day for days 1 through 5
• You pay nothing per day for days 6 through 90
• You pay nothing per day for days 91 and beyond
 	
You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum.
	Our plan covers an unlimited number of days for an inpatient hospital stay.
	• In-network:
	  • $345 copay per day for days 1 through 5
	  • You pay nothing per day for days 6 through 90
	  • You pay nothing per day for days 91 and beyond
	• Out-of-network:
	  • 20% of the cost per stay
	
	For in-network: You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum.

For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.

Our plan covers up to 100 days in a SNF.
• You pay nothing per day for days 1 through 20
• $150 copay per day for days 21 through 45
• You pay nothing per day for days 46 through 100
 	
You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum.
	Our plan covers up to 100 days in a SNF.
	• In-network:
	  • You pay nothing per day for days 1 through 20
	  • $155 copay per day for days 21 through 45
	  • You pay nothing per day for days 46 through 100
	• Out-of-network:
	  • 20% of the cost per stay
	
	For in-network: You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum.

Prescription Drug Benefits	
For Part B drugs such as chemotherapy drugs[1]: • 20% of the cost Other Part B drugs[1]: • 20% of the cost	For Part B drugs such as chemotherapy drugs[1]: • In-network: 20% of the cost • Out-of-network: 20% of the cost Other Part B drugs[1]: • In-network: 20% of the cost • Out-of-network: 20% of the cost

	BlueCHiP for Medicare Core (HMO)
Prescription Drug Benefits *(continued)*	
Initial Coverage	

BlueCHiP for Medicare Select (HMO)

Prescription Drug Benefits *(continued)*

Initial Coverage

After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

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

Standard Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Generic)	$0	$0	$0
Tier 2 (Preferred Brand)	$45 copay	$90 copay	$135 copay
Tier 3 (Non-Preferred Brand)	$95 copay	$190 copay	$285 copay
Tier 4 (Specialty Tier)	28% of the cost	Not Offered	Not Offered

Standard Mail Order Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Generic)	Not Offered	$0
Tier 2 (Preferred Brand)	Not Offered	$112.50 copay
Tier 3 (Non-Preferred Brand)	Not Offered	$237.50 copay
Tier 4 (Specialty Tier)	28% of the cost	Not Offered

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.

BlueCHiP for Medicare Value (HMO-POS)

Initial Coverage

After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

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

Standard Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Generic)	$2 copay	$4 copay	$6 copay
Tier 2 (Preferred Brand)	$45 copay	$90 copay	$135 copay
Tier 3 (Non-Preferred Brand)	$95 copay	$190 copay	$285 copay
Tier 4 (Specialty Tier)	25% of the cost	Not Offered	Not Offered

Standard Mail Order Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Generic)	Not Offered	$4 copay
Tier 2 (Preferred Brand)	Not Offered	$112.50 copay
Tier 3 (Non-Preferred Brand)	Not Offered	$237.50 copay
Tier 4 (Specialty Tier)	25% of the cost	Not Offered

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.

	BlueCHiP for Medicare Core (HMO)
Prescription Drug Benefits *(continued)*	
Coverage Gap	
Catastrophic Coverage	
Optional Benefits *(you must pay an extra premium each month for these benefits)*	
Package 1: Dental Rider	
	Benefits include: • Preventive Dental • Comprehensive Dental
How much is the monthly premium?	Additional $38.90 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium.
How much is the deductible?	There is no deductible.
Is there any limit on how much I will pay for my covered services?	Our plan pays up to $1,000 every year.

BlueCHiP for Medicare Select (HMO)	BlueCHiP for Medicare Value (HMO-POS)
Prescription Drug Benefits *(continued)*	
Coverage Gap	
Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $2,960. After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $2,960. After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage	
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of: • 5% of the cost, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of: • 5% of the cost, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.
Optional Benefits *(you must pay an extra premium each month for these benefits)*	
Package 1: Dental Rider	
Benefits include: • Preventive Dental • Comprehensive Dental	Benefits include: • Preventive Dental • Comprehensive Dental
Additional $38.90 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium.	Additional $38.90 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium.
There is no deductible.	There is no deductible.
Our plan pays up to $1,000 every year.	Our plan pays up to $1,000 every year.

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, provider 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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