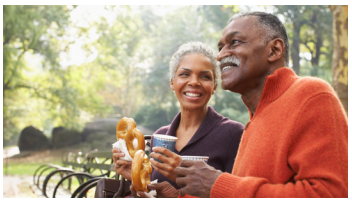
# BlueCHiP for Medicare
# Group Preferred Unlimited (HMO-POS)



## Summary of Benefits

January 1, 2016 - December 31, 2016

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 Group Preferred Unlimited (HMO-POS):** 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 Group Preferred Unlimited (HMO-POS)**].

## Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **BlueCHiP for Medicare Group Preferred Unlimited (HMO-POS)** covers 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 Group Preferred Unlimited (HMO-POS)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug 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: 711).

Este documento estádisponible 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: 711).

## Things to Know About BlueCHiP for Medicare Group Preferred Unlimited (HMO-POS)

### Hours of Operation

- October 1 - February 14, seven days a week, 8:00 a.m. to 8:00 p.m.
- February 15 - September 30, Monday through Friday, 8:00 a.m. to 8:00 p.m.; Saturday & Sunday, 8:00 a.m. to noon

  You can use our automated answering system outside of these hours.

## BlueCHiP for Medicare Group Preferred Unlimited (HMO-POS) Phone Numbers and Website

- If you are a member of this plan, call (401) 277-2958 or 1-800-267-0439 (TTY: 711).
- If you are not a member of this plan, call (401) 351-2583 or 1-800-505-2583 (TTY: 711).
- Our website: http://www.bcbsri.com/

## Who can join?

To join **BlueCHiP for Medicare Group Preferred Unlimited (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: Bristol, Kent, Newport, Providence, and Washington Counties in Rhode Island; all of Bristol County, Massachusetts; and the following ZIP codes in New London County, Connecticut: 06320, 06339, 06340, 06355, 06359, 06378, 06385, 06388.

## Which doctors, hospitals, and pharmacies can I use?

**BlueCHiP for Medicare Group Preferred Unlimited (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.

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

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

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 Group Preferred Unlimited (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/.
- Or, call us and we will send you a copy of the formulary.

## How will I determine my drug costs?

**Blue CHiP for Medicare Group Preferred Unlimited (HMO-POS):** 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: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

| | BlueCHiP for Medicare Group Preferred Unlimited (HMO-POS) |
|---|---|
| **Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services** | |
| How much is the monthly premium? | $293 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.<br><br>Your yearly limit(s) in this plan:<br>• $3,000 for services you receive from in-network providers.<br>• $3,000 for services you receive from out-of-network providers.<br><br>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.<br><br>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. |
| 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**<br>Note:<br>• Services with a [1] may require prior authorization.<br>• Services with a [2] may require a referral from your doctor. | |
| Outpatient Care and Services | |
| Acupuncture and Other Alternative Therapies | Not covered |
| Ambulance[1] | • In-network: $50 copay<br>• Out-of-network: $50 copay<br><br>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):<br>• In-network: $10 copay<br>• Out-of-network: 20% of the cost |
| Dental Services[1] | Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):<br>• In-network: 20% of the cost<br>• Out-of-network: 20% of the cost<br><br>$0 copay for the following preventive dental benefits:<br>-up to one oral exam every year<br>-up to two cleanings every year<br>-up to one dental X-ray every year<br><br>Plan offers additional comprehensive dental benefits.<br><br>$1,500 plan coverage limit for comprehensive dental benefits every year. |

| | BlueCHiP for Medicare Group Preferred Unlimited (HMO-POS) |
|---|---|
| **Outpatient Care and Services *(continued)*** | |
| **Diabetes Supplies and Services**[1] | Diabetes monitoring supplies:<br>• In-network: You pay nothing when using OneTouch plan-designated monitors and test strips.<br>• Out-of-network: 20% of the cost<br><br>Diabetes self-management training:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br><br>Therapeutic shoes or inserts:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost |
| **Diagnostic Tests, Lab and Radiology Services, and X-Rays**[1] | Diagnostic radiology services (such as MRIs, CT scans):<br>• In-network: $50 copay<br>• Out-of-network: 20% of the cost<br><br>Diagnostic tests and procedures:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br><br>Lab services:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br><br>Outpatient X-rays:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br><br>Therapeutic radiology services (such as radiation treatment for cancer):<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br><br>For in-network: 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:<br>• In-network: $0-5 copay, depending on the service<br>• Out-of-network: 20% of the cost<br><br>Specialist visit:<br>• In-network: $25 copay<br>• Out-of-network: 20% of the cost<br><br>For primary care physician visit: Covered 100% if you see a BCBSRI designated patient-centered medical home (PCMH) provider.<br><br>For specialist visit in-network: Copayment does not apply to covered surgery services rendered in an outpatient office setting. |
| **Durable Medical Equipment** *(wheelchairs, oxygen, etc.)*[1] | • In-network: You pay nothing<br>• Out-of-network: 20% of the cost |

| | BlueCHiP for Medicare Group Preferred Unlimited (HMO-POS) |
|---|---|
| **Outpatient Care and Services *(continued)*** | |
| **Emergency Care** | $65 copay<br><br>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. |
| **Foot Care** *(podiatry services)*[1] | Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:<br>• In-network: $25 copay<br>• Out-of-network: 20% of the cost<br><br>Routine foot care:<br>• In-network: $25 copay<br>• Out-of-network: 20% of the cost<br><br>For in-network: 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:<br>• In-network: $25 copay<br>• Out-of-network: 20% of the cost<br><br>Routine hearing exam:<br>• In-network: $25 copay. You are covered for up to 1 every year.<br>• Out-of-network: 20% of the cost. There may be a limit to how often these services are covered.<br><br>For in-network:<br>Copayment does not apply to covered surgery services rendered in an outpatient office setting.<br><br>Hearing aid:<br>• In-network: You pay nothing<br><br>Our plan pays up to $500 every three years for hearing aids from an in-network provider. |
| **Home Health Care**[1] | • In-network: You pay nothing<br>• Out-of-network: 20% of the cost |

| | BlueCHiP for Medicare Group Preferred Unlimited (HMO-POS) |
|---|---|
| **Outpatient Care and Services *(continued)*** | |
| **Mental Health Care**[1] | Inpatient visit:<br><br>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.<br><br>Our plan covers 90 days for an inpatient hospital stay.<br><br>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.<br>• In-network:<br>  • $250 copay per admission<br><br>You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum.<br><br>• Out-of-network:<br>  • 20% of the cost per stay<br><br>Outpatient group therapy visit:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br><br>Outpatient individual therapy visit:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost |
| **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):<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br><br>Occupational therapy visit:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br><br>Physical therapy and speech and language therapy visit:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost |
| **Outpatient Substance Abuse**[1] | Group therapy visit:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br><br>Individual therapy visit:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost |

| | BlueCHiP for Medicare Group Preferred Unlimited (HMO-POS) |
|---|---|
| **Outpatient Care and Services *(continued)*** | |
| **Outpatient Surgery**[1] | Ambulatory surgical center:<br>• In-network: 20% of the cost<br>• Out-of-network: 20% of the cost<br><br>Outpatient hospital:<br>• In-network: 20% of the cost<br>• Out-of-network: 20% of the cost<br><br>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:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br><br>Related medical supplies:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost |
| **Renal Dialysis**[1] | • In-network: You pay nothing<br>• Out-of-network: You pay nothing |
| **Transportation** | Not covered |
| **Urgent Care** | $40 copay |
| **Vision Services**[1] | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):<br>• In-network: $25 copay<br>• Out-of-network: 20% of the cost<br><br>Routine eye exam:<br>• In-network: $25 copay<br>You are covered for up to 1 every year.<br>• Out-of-network: 20% of the cost<br>There may be a limit to how often these services are covered.<br><br>For in-network:<br>Copayment does not apply to covered surgery services rendered in an outpatient office setting.<br><br>There is no copayment for glaucoma screening.<br><br>Contact lenses:<br>• In-network: You pay nothing<br><br>Eyeglasses (frames and lenses):<br>• In-network: You pay nothing |

| | BlueCHiP for Medicare Group Preferred Unlimited (HMO-POS) |
|---|---|
| **Outpatient Care and Services *(continued)*** | |
| | Eyeglass frames:<br>• In-network: You pay nothing<br><br>Eyeglass lenses:<br>• In-network: You pay nothing<br><br>Eyeglasses or contact lenses after cataract surgery:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br><br>Our plan pays up to $150 every year for eyewear from an in-network provider. |
| **Preventive Care** | |
| | • In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br><br>Our plan covers many preventive services, including:<br>• Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease (behavioral therapy)<br>• Cardiovascular screenings<br>• Cervical and vaginal cancer screening<br>• Colonoscopy<br>• Colorectal cancer screenings<br>• Depression screening<br>• Diabetes screenings<br>• Fecal occult blood test<br>• Flexible sigmoidoscopy<br>• HIV screening<br>• Medical nutrition therapy services<br>• Obesity screening and counseling<br>• Prostate cancer screenings (PSA)<br>• Sexually transmitted infections screening and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots<br>• “Welcome to Medicare” preventive visit (one-time)<br>• Yearly “Wellness” visit<br><br>Any additional preventive services approved by Medicare during the contract year will be covered. |

| | BlueCHiP for Medicare Group Preferred Unlimited (HMO-POS) |
|---|---|
| **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.<br>• In-network:<br>  • $250 copay per admission<br>• Out-of-network:<br>  • 20% of the cost per stay<br>For in-network: 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.<br>• In-network:<br>  • You pay nothing per day for days 1 through 29<br>  • $50 copay per day for days 30 through 100<br>• Out-of-network:<br>  • 20% of the cost per stay<br>For in-network: You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum. |

| | BlueCHiP for Medicare Group Preferred Unlimited (HMO-POS) |
|---|---|
| **Prescription Drug Benefits** | |
| **How much do I pay?**[1] | For Part B drugs such as chemotherapy drugs:<br>• In-network: 20% of the cost<br>• Out-of-network: 20% of the cost<br><br>Other Part B drugs:<br>• In-network: 20% of the cost<br>• Out-of-network: 20% of the cost |
| **Initial Coverage** | |
| | You pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.<br><br>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 copay | $0 copay | $0 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) | 33% 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 copay |
| Tier 2 (Preferred Brand) | Not Offered | $112.50 copay |
| Tier 3 (Non-Preferred Brand) | Not Offered | $237.50 copay |
| Tier 4 (Specialty Tier) | 33% 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 Group Preferred Unlimited (HMO-POS)

### Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310.

After you enter the coverage gap, you receive continuous coverage by the plan for your drugs until your yearly out-of-pocket drug costs reach $4,850.

**Standard Retail Cost-Sharing**

| Tier | One-month supply | Two-month supply | Three-month supply |
|---|---|---|---|
| Tier 1 (Generic) | $0 copay | $0 copay | $0 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) | 33% 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 copay |
| Tier 2 (Preferred Brand) | Not Offered | $112.50 copay |
| Tier 3 (Non-Preferred Brand) | Not Offered | $237.50 copay |
| Tier 4 (Specialty Tier) | 33% of the cost | Not Offered |

### Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of:

- 5% of the cost, or
- $2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.

# Notes

# Notes

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. [Benefits, premium and/or co-payments/co-insurance] may change on January 1 of each year. The [formulary, pharmacy network, and/or provider network] may change at any time. You will receive notice when necessary. 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.

Blue Cross
Blue Shield
of Rhode Island

www.bcbsri.com

500 Exchange Street • Providence, RI 02903-2699

08/15 BMED-16859 • 1343