Blue Cross Blue Shield of Rhode Island

Blue MedicareRx℠ (PDP)

2018 Summary of Benefits
Blue MedicareRx℠ (PDP)

S2893

Blue MedicareRx℠ Value Plus (PDP)

Blue MedicareRx℠ Premier (PDP)

S2893_1743 Accepted

Blue MedicareRx Value Plus (PDP) / Blue MedicareRx Premier (PDP)
(a Medicare Prescription Drug Plan (PDP) offered by ANTHEM INSURANCE CO. & BCBSMA & BCBSRI & BCBSVT with a Medicare contract)

SUMMARY OF BENEFITS

January 1, 2018 - December 31, 2018

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."

For More Information

Hours of Operation

You can call us 24 hours a day, 7 days a week.

Blue MedicareRx Value Plus and Blue MedicareRx Premier Phone Numbers and Website

- If you are a member of our plans, call toll-free 1-888-620-1748 (TTY/TDD: 711)
- If you are not a member of our plans, call toll-free 1-800-505-2583 (TTY/TDD: 711)
- Our website: http://www.rxmedicareplans.com

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.

This document is available in other formats such as Braille and large print. For additional information, call us at 1-800-505-2583.

Who can join?

To join **Blue MedicareRx Value Plus or Blue MedicareRx Premier**, you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, be a U.S. citizen or be lawfully present in the United States and live in our service area.

Our service area includes the following: Central New England (Connecticut, Massachusetts, Rhode Island, and Vermont).

Which drugs are covered?

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

How will I determine my drug costs?

Our plans group each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. There are four benefit stages in your Medicare prescription drug coverage: Deductible Stage, Initial Coverage Stage, Coverage Gap Stage, and Catastrophic Coverage Stage. For more information about formulary tiers and stages of the benefit, please see the plan's formulary and the *Evidence of Coverage* on our website at www.rxmedicareplans.com, or contact Customer Care.

Which pharmacies can I use?

We have a network of pharmacies and you must generally use these pharmacies to fill your prescriptions for covered Part D drugs.

Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plans' pharmacy directories at our website (http://www.rxmedicareplans.com). Or, call us and we will send you a copy of the pharmacy directory.

Summary of Benefits

January 1, 2018 – December 31, 2018

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

Stage 1: Annual Deductible

	Blue MedicareRx Value Plus (PDP)	Blue MedicareRx Premier (PDP)
How much is the monthly premium?	$38.20 per month	$122.60 per month
How much is the deductible?	$235.00 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2 which are excluded from the deductible.	This plan does not have a deductible.

Stage 2: Initial Coverage Stage

	Blue MedicareRx Value Plus (PDP)	Blue MedicareRx Premier (PDP)
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $3,750. 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. If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.	You pay the following until your total yearly drug costs reach $3,750. 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. If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Stage 2: Initial Coverage Stage (cont.)

Preferred Retail Cost-Sharing

	Blue MedicareRx Value Plus (PDP)		Blue MedicareRx Premier (PDP)	
Tier	One-month supply	Three-month supply	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$2 copay	$6 copay	$1 copay	$3 copay
Tier 2 (Generic)	$7 copay	$21 copay	$7 copay	$21 copay
Tier 3 (Preferred Brand)	$35 copay	$105 copay	$30 copay	$90 copay
Tier 4 (Non-Preferred Drug)	40% of the cost	40% of the cost	$70 copay	$210 copay
Tier 5 (Specialty Tier)	28% of the cost	N/A	33% of the cost	N/A

Stage 2: Initial Coverage Stage (cont.)

Standard Retail Cost-Sharing

	Blue MedicareRx Value Plus (PDP)		Blue MedicareRx Premier (PDP)	
Tier	One-month supply	Three-month supply	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$7 copay	$21 copay	$6 copay	$18 copay
Tier 2 (Generic)	$19 copay	$57 copay	$12 copay	$36 copay
Tier 3 (Preferred Brand)	$45 copay	$135 copay	$40 copay	$120 copay
Tier 4 (Non-Preferred Drug)	50% of the cost	50% of the cost	$80 copay	$240 copay
Tier 5 (Specialty Tier)	28% of the cost	N/A	33% of the cost	N/A

Stage 2: Initial Coverage Stage (cont.)

Mail Order Cost-Sharing

	Blue MedicareRx Value Plus (PDP)		Blue MedicareRx Premier (PDP)	
Tier	One-month supply	Three-month supply	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$2 copay	$2 copay	$1 copay	$1 copay
Tier 2 (Generic)	$7 copay	$14 copay	$7 copay	$14 copay
Tier 3 (Preferred Brand)	$35 copay	$70 copay	$30 copay	$60 copay
Tier 4 (Non-Preferred Drug)	40% of the cost	40% of the cost	$70 copay	$140 copay
Tier 5 (Specialty Tier)	28% of the cost	N/A	33% of the cost	N/A

Stage 3: Coverage Gap Stage

	Blue MedicareRx Value Plus (PDP)	Blue MedicareRx Premier (PDP)
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 $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

Preferred Retail Cost-Sharing

	Blue MedicareRx Value Plus (PDP)		Blue MedicareRx Premier (PDP)	
Tier	One-month supply	Three-month supply	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	After you enter the coverage gap, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.		$1 copay	$3 copay
Tier 2 (Generic)			$7 copay	$21 copay

Stage 3: Coverage Gap Stage (cont.)

Standard Retail Cost-Sharing

	Blue MedicareRx Value Plus (PDP)		Blue MedicareRx Premier (PDP)	
Tier	One-month supply	Three-month supply	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	After you enter the coverage gap, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.		$6 copay	$18 copay
Tier 2 (Generic)			$12 copay	$36 copay

Mail Order Cost-Sharing

	Blue MedicareRx Value Plus (PDP)		Blue MedicareRx Premier (PDP)	
Tier	One-month supply	Three-month supply	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	After you enter the coverage gap, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.		$1 copay	$1 copay
Tier 2 (Generic)			$7 copay	$14 copay

Stage 4: Catastrophic Coverage Stage

	Blue MedicareRx Value Plus (PDP)	Blue MedicareRx Premier (PDP)
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of: • 5% of the cost, • or $3.35 copay for generic (including brand drugs treated as generic) and a $8.35 copay for all other drugs.	

Blue MedicareRx[SM] (PDP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue MedicareRx does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue MedicareRx:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the number on the back of your Member ID Card. TTY/TDD users should call 711.

If you believe that Blue MedicareRx has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Blue MedicareRx (PDP)
Grievance Department Coordinator
P.O. Box 53991
Phoenix, AZ 85072-3991

Phone: 1-866-884-9478
Fax: 1-866-217-3353

You can file a grievance in person, by mail, or fax. If you need help filing a grievance, Blue MedicareRx Grievance Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ENGLISH
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your Member ID Card. TTY: 711.

ARABIC
م لاذإ :ةظوح ت نك ث دحتتا لة لغ علار بيةإ فن دخمت ا عا سملادة ةيو غللا
رفوتت كل اجملا بن. ل صتار لا بقم لاي بمن د لع هظر ةقاطبا ليوضعة
ةصاخلا بك. للمص ك بلاوم: 711.

CHINESE
小贴士：如果您说中文，欢迎使用免费语言协助服务。请拨打您会员身份证上的电话号码。（TTY：711）。

FRENCH
ATTENTION : Si vous parlez français, des services gratuits d’interprétation sont à votre disposition. Veuillez appeler le numéro figurant au verso de votre Carte de membre. TTY: 711.

FRENCH CREOLE
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou do Kat ID Manm ou an. TTY: 711.

GREEK
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχει διαθέσιμη υπηρεσία γλωσσικής υποστήριξης, η οποία παρέχεται δωρεάν. Καλέστε τον αριθμό στο πίσω μέρος της κάρτας μέλους (Αριθμός για άτομα με προβλήματα ακοής/ομιλίας: 711).

HINDI
ध्यान दीजिए : अगर आप हिंदी बोलते िंैं तो
आपके जलएभाषा

KOREAN
알림: 한국어를 하시는 경우 무료 통역 서비스가 준비되어 있습니다. 회원 카드 뒷면에 표시된 전화번호(TTY: 711)로 연락주시기 바랍니다.

MON-KHMER, CAMBODIAN
ប្រយ័ត ្ន៖ ប្រសិនបើអ្នក
កនិយ ាយភ ាសាខ្មែរ រ បសវាជំនួ
យខ្នុនះកភ ាសាបោយមិនគិត្លឈ្នួ ឈ្លួ
គឺអ ាចរកបានសំរាប់អ្នក។ សម្គជំ
ចូរទូរស័ព ្ទបៅបលមបៅខាងមុះងនេទ័ណ្ណា
សគ្គាល់ម៉ស នូករររស់អ្នក។ TTY: 711។

POLISH
UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie Twojej Członkowskiej karty ident. Tel. tekst.: 711.

PORTUGUESE
ATENÇÃO: Se fala português, estão disponíveis serviços gratuitos de assistência linguística na sua língua. Telefone para o número no verso do seu Cartão de Identificação de Membro. TTY: 711.

RUSSIAN
ВНИМАНИЕ: Если вы говорите на русском языке, вам будут бесплатно предоставлены услуги переводчика. Звоните по телефону, указанному на обороте вашей идентификационной карты участника. Телетайп: 711.

SPANISH
ATENCIÓN: Si usted habla español, tenemos servicios de asistencia lingüística disponibles para usted sin costo alguno. Llame al número que aparece al reverso de su tarjeta de membresía. TTY: 711.

सिंायता सेवाएं मुफ्त उपलब्ध हैं आपके सदस्य ID कार्ड के पीछे ददए गए नम्बर पर कॉल करें। TTY: 711.

ITALIAN
ATTENZIONE: Se lei parla italiano, sono disponibili servizi gratuiti di assistenza linguistica nella sua lingua. Chiami il numero che si trova sul retro della sua tessera (Member ID Card). TTY: 711.

TAGALOG
Pansinin: Kung nagsasalita ka ng Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. Tawagan ang numero sa likod ng iyong ID card ng Miyembro. TTY: 711.

VIETNAMESE
LƯU Ý: Nếu quý vị nói tiếng Việt, thì có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi tới số ở mặt sau Thẻ ID Thành Viên của quý vị. TTY: 711.

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This information is not a complete description of benefits. Contact the plan for more information.

Limitations, copay, and restrictions may apply.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1 of each year.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

You must continue to pay your Medicare Part B premium.

Blue Cross Blue Shield of Rhode Island

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