Outline of Coverage

Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010.

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. Medicare Supplement Plans A, F, G, N, and Select F are currently being offered by Blue Cross & Blue Shield of Rhode Island.

Basic Benefits:

- **Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses:** Part B coinsurance (generally 20% of Medicare - approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or co-payments.
- **Blood:** First three pints of blood each year.
- **Hospice:** Part A coinsurance.

Plan A	Plan B	Plan C	Plan D	Plan F	Plan F*	Plan G	Plan K	Plan L	Plan M	Plan N
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance		Basic, including 100% Part B co-insurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility co-insurance		Skilled nursing facility co-insurance	50% Skilled nursing facility co-insurance	75% Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility co-insurance
	Part A deductible	Part A deductible	Part A deductible	Part A deductible		Part A deductible	50% Part A deductible	75% Part A deductible	50% Part A deductible	Part A deductible
		Part B deductible		Part B deductible						
				Part B excess (100%)		Part B excess (100%)				
		Foreign travel emergency	Foreign travel emergency	Foreign travel emergency		Foreign travel emergency			Foreign travel emergency	Foreign travel emergency
***Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,240 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**							Out-of-pocket limit $5,240; paid at 100% after limit reached	Out-of-pocket limit $2,620; paid at 100% after limit reached		

Monthly Subscriber Fees
Monthly subscriber fees are based on how a member enrolls in Plan 65. Monthly subscriber fees vary by age for existing members and for new members eligible for Medicare due to attaining age 65 or retired new members over age 65 who were enrolled in active commercial group coverage.

If you enrolled in Medicare due to disability or early stage renal disease (ESRD), your Plan 65 A subscriber fee is the Base Rate regardless of your age at enrollment.

Rate Level	Plan 65 A	Plan 65 F	Plan 65 Select F	Plan 65 G	Plan 65 N
Age 65-67					
Non-Tobacco*	$131.06	$153.36	$114.62	$122.51	$110.97
Tobacco*	$145.62	$170.40	$127.35	$136.12	$123.30
Age 68-70					
Non-Tobacco*	$157.27	$184.03	$137.54	$147.01	$133.16
Tobacco*	$174.74	$204.48	$152.82	$163.34	$147.96
Age 71-72					
Non-Tobacco*	$181.46	$212.34	$158.70	$169.62	$153.64
Tobacco*	$201.62	$235.93	$176.33	$188.47	$170.71
Base Rate					
Non-Tobacco*	$201.62	$235.94	$176.33	$188.48	$170.71
Tobacco*	$224.02	$262.15	$195.92	$209.42	$189.68

After age 72, the subscriber pays the Base Rate.

*****Members enrolling on or after May 1, 2016, with no tobacco use within the last 12 months, may be eligible for the non-tobacco rate by submitting an attestation form. The non-tobacco rate becomes effective on the first of the month following receipt of the attestation, if received by the 1st day of the prior month (For example, if we receive your form on or by April 1, your new rate will be effective on May 1). We may discontinue this rate in our discretion concurrent with a filed and approved rate change. We will provide prior written notice of such discontinuance.

Members who opt to pay their bill using electronic funds transfer are eligible for a discount off their rate of $2 per month. The electronic funds transfer discount becomes effective on the next monthly bill if the electronic funds transfer form is received by the 13th day of the prior month. Please call our Medicare Concierge Team for more information on monthly subscriber fees.

Premium Information
We, Blue Cross & Blue Shield of Rhode Island can only raise your subscriber fee if we raise the subscriber fee for all policies like yours in this state.

Disclosures
Use this outline to compare benefits and subscriber fees among subscriber agreements.

Read your Subscriber Agreement Very Carefully
This is only an outline describing your agreement's most important features. The agreement is your insurance contract. You must read the agreement itself to understand all of the rights and duties of both you and your insurance company.

Right to Return Agreement
If you find that you are not satisfied with your agreement, you may return it to 500 Exchange Street, Providence, RI 02903. If you send the agreement back to us within 30 days after you receive it, we will treat the agreement as if it had never been issued and return all of your payments.

Agreement Replacement
If you are replacing another health insurance agreement, do NOT cancel it until you have actually received your new agreement and are sure you want to keep it.

Notice
The subscriber agreement may not fully cover all of your medical costs. Blue Cross & Blue Shield of Rhode Island is not connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult Medicare and You for more details.

Complete Answers are Very Important
When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. **Review the application carefully before you sign it. Be certain that all information has been properly recorded.**

Plan 65 Select Disclosure Statement

Plan 65 Select is a Medicare Select Benefit Plan. The following information is provided in order to make a full and fair disclosure of the provisions, restrictions and limitations of a Medicare Select Benefit Plan.

Outline of Coverage

The Outline of Medicare Supplement Coverage which accompanies this Disclosure Statement allows you to compare the benefits and premiums of all open Medicare Supplement Plans offered by Blue Cross & Blue Shield of Rhode Island, including Plan 65 Select Plan F.

Plan 65 Select Hospital Network Listing

A Plan 65 Select Hospital Network listing is included with your enrollment package. This listing contains all the hospitals participating in the Plan 65 Select Hospital Network. All hospital hours of operation are 24 hours a day, 7 days a week.

Limited Benefit Reductions

Generally, Plan 65 Select benefits are paid in full as long as the Medicare Part A Eligible Expenses are received from Plan 65 Select Hospital Network Providers. Benefit reductions are limited to the Medicare Part A deductibles and copayments for services rendered by hospitals who are NOT participants in the Plan 65 Select Hospital Network.

Emergency Care and Coverage Outside the Network

Emergency and urgently needed care will be covered at hospitals who are not participants in the Plan 65 Select Hospital Network. In addition, all Medicare Part A eligible services which are not available through Plan 65 Select Hospital Network providers will be covered outside the network without a benefit reduction.

Referrals

There are no limitations on referrals to Plan 65 Select Hospital Network. Other than the benefit reductions listed above, there are no limitations on referrals to other providers.

Right to Purchase

At the time of initial purchase, you have the right to choose any other Medicare Supplement Benefit Plan that we offer, instead of Plan 65 Select. Once enrolled in Plan 65 Select, you may request a transfer to a Medicare Supplement Benefit Plan that does not have a restricted network and we will give you an opportunity to choose a plan which has comparable or lesser benefits.

Grievance Procedures

You may submit a written objection to us if you disagree with any aspect of our performance relative to the delivery of health care services, claim payments and handling, and related services. A grievance committee will review your request. Grievances will be fully investigated in a timely manner. If necessary, the committee will obtain the opinion of outside consultants regarding the claim. If a grievance is found to be valid, corrective actions will be taken promptly. All concerned parties will be notified in writing of the review decision. Any and all other legal and equitable remedies will be available to you upon decision of an appeal. See your Subscriber Agreement for details.

Quality Assurance Programs

All Plan 65 Network Hospitals are licensed by the appropriate state regulatory authority and accredited by the applicable accreditation organization and/or Medicare certified.

Plan Benefit Tables: Plan A

Medicare Part A: Hospital Services per Benefit Period(*)				
Service		**Medicare Pays**	**Plan Pays**	**You Pay**
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies	First 60 days	All but $1,340	$0	$1,340 (Part A deductible)
	Days 61 thru 90	All but $335 per day	$335 per day	$0
	Days 91 and after while using 60 lifetime reserve days	All but $670 per day	$670 per day	$0
	Once lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses (**)	$0(**)
	Beyond the additional 365 days	$0	$0	100%
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days	All approved amounts	$0	$0
	Days 21 thru 100	All but $167.50 per day	$0	Up to $167.50 per day
	Days 101 and after	$0	$0	100%
Blood	First 3 pints	$0	100%	$0
	Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.		All but very limited copayment or coinsurance for outpatient drugs and inpatient respite care	Medicare copayment or coinsurance for outpatient drugs and inpatient respite care	$0

(Continued on next page)

(*) A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

(**) When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan Benefit Tables: Plan A (continued)

Medicare Part B: Medical Services per Calendar Year(*)				
Service		**Medicare Pays**	**Plan Pays**	**You Pay**
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First $183 of Medicare-approved amounts(*)	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)		$0	$0	100%
Blood	First 3 pints	$0	100%	$0
	Next $183 of Medicare-approved amounts(*)	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Medicare Parts A and B				
Service		**Medicare Pays**	**Plan Pays**	**You Pay**
Home Health Care Medicare-approved Services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment Medicare-approved Services	First $183 of Medicare-approved amounts(*)	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0

(*) Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan F and Plan Select F

Medicare Part A: Hospital Services per Benefit Period(*)				
Service		**Medicare Pays**	**Plan Pays**	**You Pay**
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies	First 60 days	All but $1,340	$1,340 (Part A deductible)(++)	$0
	Days 61 thru 90	All but $335 per day	$335 per day	$0
	Days 91 and after while using 60 lifetime reserve days	All but $670 per day	$670 per day	$0
	Once lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses (**)	$0(**)
	Beyond the additional 365 days	$0	$0	100%
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days	All approved amounts	$0	$0
	Days 21 thru 100	All but $167.50 per day	Up to $167.50 per day	$0
	Days 101 and after	$0	$0	100%
Blood	First 3 pints	$0	100%	$0
	Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.		All but very limited copayment or coinsurance for outpatient drugs and inpatient respite care	Medicare copayment or coinsurance for outpatient drugs and inpatient respite care	$0

(Continued on next page)

(*) A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

(**) When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

(++) If you choose the Plan 65 Select version of Plan F, you must use a Plan 65 Select Hospital Network for Medicare Part A benefits, unless the services are required for Emergency treatment or the services are not available within the Plan 65 Select Hospital Network.

Plan Benefit Tables: Plan F and Plan Select F (continued)

Medicare Part B: Medical Services per Calendar Year(*)				
Service		**Medicare Pays**	**Plan Pays**	**You Pay**
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First $183 of Medicare-approved amounts(*)	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)		$0	100%	$0
Blood	First 3 pints	$0	100%	$0
	Next $183 of Medicare-approved amounts(*)	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Medicare Parts A and B				
Service		**Medicare Pays**	**Plan Pays**	**You Pay**
Home Health Care Medicare-approved Services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment Medicare-approved Services	First $183 of Medicare-approved amounts(*)	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0

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(*) Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan F and Plan Select F (continued)

Other Benefits not Covered by Medicare				
Service		**Medicare Pays**	**Plan Pays**	**You Pay**
Foreign Travel NOT COVERED BY MEDICARE. Medically necessary emergency care services beginning during the first 60 days of each trip outside of USA	First $250 each calendar year	$0	$0	$250
	Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan Benefit Tables: Plan G

Medicare Part A: Hospital Services per Benefit Period(*)				
Service		**Medicare Pays**	**Plan Pays**	**You Pay**
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies	First 60 days	All but $1,340	$1,340 (Part A deductible)	$0
	Days 61 thru 90	All but $335 per day	$335 per day	$0
	Days 91 and after while using 60 lifetime reserve days	All but $670 per day	$670 per day	$0
	Once lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses (**)	$0(**)
	Beyond the additional 365 days	$0	$0	100%
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days	All approved amounts	$0	$0
	Days 21 thru 100	All but $167.50 per day	Up to $167.50 per day	$0
	Days 101 and after	$0	$0	100%
Blood	First 3 pints	$0	100%	$0
	Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.		All but very limited copayment or coinsurance for outpatient drugs and inpatient respite care	Medicare copayment or coinsurance for outpatient drugs and inpatient respite care	$0

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(*) A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

(**) When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan Benefit Tables: Plan G (continued)

Medicare Part B: Medical Services per Calendar Year(*)				
Service		**Medicare Pays**	**Plan Pays**	**You Pay**
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First $183 of Medicare-approved amounts(*)	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)		$0	100%	$0
Blood	First 3 pints	$0	100%	$0
	Next $183 of Medicare-approved amounts(*)	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Medicare Parts A and B				
Service		**Medicare Pays**	**Plan Pays**	**You Pay**
Home Health Care Medicare-approved Services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment Medicare-approved Services	First $183 of Medicare-approved amounts(*)	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0

(Continued on next page)

(*) Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan G (continued)

Other Benefits not Covered by Medicare				
Service		**Medicare Pays**	**Plan Pays**	**You Pay**
Foreign Travel NOT COVERED BY MEDICARE. Medically necessary emergency care services beginning during the first 60 days of each trip outside of USA	First $250 each calendar year	$0	$0	$250
	Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan Benefit Tables: Plan N

Medicare Part A: Hospital Services per Benefit Period(*)				
Service		**Medicare Pays**	**Plan Pays**	**You Pay**
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies	First 60 days	All but $1,340	$1,340 (Part A deductible)	$0
	Days 61 thru 90	All but $335 per day	$335 per day	$0
	Days 91 and after while using 60 lifetime reserve days	All but $670 per day	$670 per day	$0
	Once lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses (**)	$0(**)
	Beyond the additional 365 days	$0	$0	100%
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days	All approved amounts	$0	$0
	Days 21 thru 100	All but $167.50 per day	Up to $167.50 per day	$0
	Days 101 and after	$0	$0	100%
Blood	First 3 pints	$0	100%	$0
	Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.		All but very limited copayment or coinsurance for outpatient drugs and inpatient respite care	Medicare copayment or coinsurance for outpatient drugs and inpatient respite care	$0

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(*) A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

(**) When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan Benefit Tables: Plan N (continued)

Medicare Part B: Medical Services per Calendar Year(*)				
Service		**Medicare Pays**	**Plan Pays**	**You Pay**
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First $183 of Medicare-approved amounts(*)	$0	$0	$183 (Part B *deductible*)
	Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered as a *Medicare* Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered as a *Medicare* Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)		$0	$0	All costs
Blood	First 3 pints	$0	100%	$0
	Next $183 of Medicare-approved amounts(*)	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Medicare Parts A and B				
Service		**Medicare Pays**	**Plan Pays**	**You Pay**
Home Health Care Medicare-approved Services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment Medicare-approved Services	First $183 of Medicare-approved amounts(*)	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0

(Continued on next page)

(*) Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan N (continued)

Other Benefits not Covered by Medicare				
Service		**Medicare Pays**	**Plan Pays**	**You Pay**
Foreign Travel NOT COVERED BY MEDICARE. Medically necessary emergency care services beginning during the first 60 days of each trip outside of USA	First $250 each calendar year	$0	$0	$250
	Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Nondiscrimination and Language Assistance

Blue Cross & Blue Shield of Rhode Island (BCBSRI) complies with applicable Federal civil rights laws and does not discriminate or treat people differently on the basis of race, color, national origin, age, disability, or sex.

BCBSRI provides free aids and services to people with disabilities and to people whose primary language is not English when such services are necessary to communicate effectively with us.

If you need these services, contact us at 1-800-267-0439 TTY: 711.

If you believe that BCBSRI 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: Director of Grievance and Appeals Department, Blue Cross & Blue Shield of Rhode Island, 500 Exchange Street, Providence RI 02903, or by calling 1-800-267-0439 TTY: 711. You can file a grievance in person, by phone or by mail, fax at (401) 459-5668 or electronically through our member portal at bcbsri.com/Medicare.

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 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English: If you, or someone you're helping, has questions about Blue Cross & Blue Shield of Rhode Island, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-267-0439.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross & Blue Shield of Rhode Island, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-267-0439.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue Cross & Blue Shield of Rhode Island, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-267-0439.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross & Blue Shield of Rhode Island 方面 的問題，您有權利免費以您的母語得到幫助和訊息. 洽詢一位翻譯員，請撥電話 [在此插入數字 1-800-267-0439.

French Creole: Si oumenm oswa yon moun w ap ede gen kesyon konsènan Blue Cross & Blue Shield of Rhode Island, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-267-0439.

Cambodian-Mon-Khmer: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងតែជួយ មានសំណួរអំពី Blue Cross & Blue Shield of Rhode Island ទេ, អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មាន នៅក្នុងភាសា របស់អ្នក ដោយមិនអស់ប្រាក់ ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូម 1-800-267-0439.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross & Blue Shield of Rhode Island, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-267-0439.

Italian: Se tu o qualcuno che stai aiutando avete domande su Blue Cross & Blue Shield of Rhode Island, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-267-0439.

Laotian: ຖ້າທ່ານ, ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Blue Cross & Blue Shield of Rhode Island, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-800-267-0439.

Arabic: إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross & Blue Shield of Rhode Island، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.
للتحدث مع مترجم اتصل بـ 1-800-267-0439.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross & Blue Shield of Rhode Island, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-267-0439.

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross & Blue Shield of Rhode Island, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-267-0439.

Kru: I bale we, tole mut u ye hola, a gwee mbarga inyu Blue Cross & Blue Shield of Rhode Island, U gwee Kunde I kosna mahola ni biniiguene I hop wong nni nsaa wogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel 1-800-267-0439.

Ibo: Ọ bụrụ gị, ma o bụ onye I na eyere-aka, nwere ajụjụ gbasara Blue Cross & Blue Shield of Rhode Island, I nwere ohere iwenta nye maka na ọmụma na asụsụ gị na akwu gị ụgwọ. I chọrọ I kwụrụ onye-ntapịa okwu, kpọ 1-800-267-0439.

Yoruba: Bí ìwọ, tàbí ẹnikẹni tí o n ranlọwọ, bá ní ibeere nípa Blue Cross & Blue Shield of Rhode Island, o ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó.
Láti bá ongbufọ kan sọrọ, pè sórí 1-800-267-0439.

Polish: Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Blue Cross & Blue Shield of Rhode Island, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-267-0439.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Blue Cross & Blue Shield of Rhode Island 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-267-0439 로 전화하십시오.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross & Blue Shield of Rhode Island, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-267-0439.

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Blue Cross Blue Shield of Rhode Island

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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