Summary of Benefits

January 1, 2022 - December 31, 2022

BlueCHiP for Medicare Value (HMO-POS)

BlueCHiP for Medicare Extra (HMO-POS)

HealthMate for Medicare (PPO)

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Blue Cross Blue Shield of Rhode Island

Summary of Benefits

This is a summary of drug and health services covered by BlueCHiP for Medicare Value, BlueCHiP for Medicare Extra, and HealthMate for Medicare.

BlueCHiP for Medicare Value and **BlueCHiP for Medicare Extra** are Medicare Advantage Health Maintenance Organization (HMO) plans with a Point of Service Option (POS) with a Medicare contract. **HealthMate for Medicare** is a Medicare Advantage Preferred Provider Organization (PPO) plan with a Medicare contract. Enrollment in these plans depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "**Evidence of Coverage.**"

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.

BlueCHiP for Medicare Value and **BlueCHiP for Medicare Extra** have a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services. These plans also require you to get referrals for some specialist visits from your PCP.

For BlueCHiP for Medicare Value and **BlueCHiP for Medicare Extra** you can use providers that are not in our network for some services.

HealthMate for Medicare (PPO) has a newtwork of doctors, hospitals, pharmacies, and other providers. Using services in-network can cost less than using out-of-network services, except for emergency or urgently needed services or out-of-area dialysis services. This plan does not require you to get referrals for services.

To join **BlueCHiP for Medicare Value**, **BlueCHiP for Medicare Extra**, and **HealthMate for Medicare**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Rhode Island: Providence, Kent, Washington, Bristol, and Newport.

This information is available for free in other languages and alternate formats including Spanish and large print.

For more information, interested prospects can contact the Medicare Sales team at 1-800-505-BLUE (2583) (TTY: 711). Hours: Monday through Friday, 8:00 a.m. to 8:00 p.m. (Open seven days a week, 8:00 a.m. to 8:00 p.m., from October 1 – March 31.) You can use our automated answering system outside of these hours.

If you are a member of our plan and would like more information, please call the Medicare Concierge team at (401) 277-2958 or 1-800-267-0439 (TTY: 711). Hours: October 1 – March 31, you can call us seven days a week, 8:00 a.m. to 8:00 p.m. From April 1 – September 30, you can call us Monday through Friday, 8:00 a.m. to 8:00 p.m. Saturday, 8:00 a.m. to noon. You can use our automated answering system outside of these hours.

You can see our plan's provider and pharmacy directories at **bcbsri.com/medicare**.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **bcbsri.com/medicare**.

Premiums and Benefits	BlueCHiP for Medicare Value (HMO-POS)	BlueCHiP for Medicare Value ACCESS (HMO-POS)
Monthly Plan Premium	$0 You must continue to pay your Medicare Part B premium.	$0 You must continue to pay your Medicare Part B premium.
Annual Medical Deductible	This plan does not have a medical deductible.	This plan does not have a medical deductible.
Maximum Out-of-Pocket Amount (does not include prescription drugs)	• $5,000 annually for services you receive from in-network providers • $5,000 annually for services you receive from out-of-network providers	• $5,000 annually for services you receive from in-network providers • $5,000 annually for services you receive from out-of-network providers
Inpatient Hospital Coverage*	• In-network: $375 copay per day for days 1-5 Our plan covers an unlimited number of days for an in-network inpatient hospital stay. • Out-of-network: 20% of the cost Out-of-network stays are limited to 90 days. Copays for hospital benefits are based on benefit periods. You pay these amounts each benefit period until you reach the in-network or out-of-network out-of-pocket maximum.	• In-network: $0 copay per day for days 1-5 Our plan covers an unlimited number of days for an in-network inpatient hospital stay. • Out-of-network: 20% of the cost Out-of-network stays are limited to 90 days. Copays for hospital benefits are based on benefit periods. You pay these amounts each benefit period until you reach the in-network or out-of-network out-of-pocket maximum.
Outpatient Hospital Coverage*	• In-network: $300 copay per visit • Out-of-network: 20% of the cost	• In-network: $0 • Out-of-network: 20% of the cost
Doctor's Office Visits: • Primary care	• In-network: $0 PCMH or $35 non-PCMH copay per visit • Out-of-network: 20% of the cost	• In-network: $0 copay per visit • Out-of-network: 20% of the cost
• Specialist	• In-network: $30 copay per visit • Out-of-network: 20% of the cost Referral is required for specialist visits.	• In-network: $0 copay per visit • Out-of-network: 20% of the cost Referral is required for specialist visits.

* A prior authorization may be required

BlueCHiP for Medicare Extra (HMO-POS)	HealthMate for Medicare (PPO)
$109 per month You must continue to pay your Medicare Part B premium.	$132 per month You must continue to pay your Medicare Part B premium.
This plan does not have a medical deductible.	This plan does not have a medical deductible.
• $4,500 annually for services you receive from in-network providers • $5,000 annually for services you receive from out-of-network providers	• $4,250 annually, combined, for services you receive from in-network providers • $4,250 annually, combined, for services you receive from out-of-network providers
• In-network: $300 copay per day for days 1-5 Our plan covers an unlimited number of days for an in-network inpatient hospital stay. • Out-of-network: 20% of the cost Out-of-network stays are limited to 90 days. Copays for hospital benefits are based on benefit periods. You pay these amounts each benefit period until you reach the in-network or out-of-network out-of-pocket maximum.	• In-network: $300 copay per day for days 1-5 Our plan covers an unlimited number of days for an in-network inpatient hospital stay. • Out-of-network: 20% of the cost Out-of-network stays are limited to 90 days. Copays for hospital benefits are based on benefit periods. You pay these amounts each benefit period until you reach the combined in-network and out-of-network out-of-pocket maximum.
• In-network: $250 copay per visit • Out-of-network: 20% of the cost	• In-network: $250 copay per visit • Out-of-network: $500 copay per visit
• In-network: $0 PCMH or $10 non-PCMH copay per visit • Out-of-network: 20% of the cost	• In-network: $0 PCMH or $10 non-PCMH copay per visit • Out-of-network: $25 copay per visit
• In-network: $25 copay per visit • Out-of-network: 20% of the cost Referral is required for specialist visits.	• In-network: $25 copay per visit • Out-of-network: $50 copay per visit

Premiums and Benefits	BlueCHiP for Medicare Value (HMO-POS)	BlueCHiP for Medicare Value ACCESS (HMO-POS)
Preventive Care	• In-network: $0 • Out-of-network: 20% of the cost Any additional preventive services approved by Medicare during the contract year will be covered.	• In-network: $0 • Out-of-network: 20% of the cost Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$90 copay per visit If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Coverage" section of this booklet for other costs.	$0 copay per visit See the "Inpatient Hospital Coverage" section of this booklet for other costs.
Urgently Needed Services	$60 copay per visit	$0 copay per visit
Diagnostic Services/ Labs/Imaging:* • High-tech diagnostic radiology services (such as MRIs, CT scans, etc.)	• In-network: $150 copay per visit • Out-of-network: 20% of the cost	• In-network: $0 copay per visit • Out-of-network: 20% of the cost
• Lab services	• In-network: $0 • Out-of-network: 20% of the cost	• In-network: $0 • Out-of-network: 20% of the cost
• Outpatient X-rays and diagnostic tests and procedures	• In-network: $0 • Out-of-network: 20% of the cost	• In-network: $0 • Out-of-network: 20% of the cost
• Therapeutic radiology	• In-network: $10 copay per visit • Out-of-network: 20% of the cost	• In-network: $0 • Out-of-network: 20% of the cost
Hearing Services: • Hearing exam - routine	• In-network: $0 • Out-of-network: 20% of the cost Limit one visit per year.	• In-network: $0 • Out-of-network: 20% of the cost Limit one visit per year.
• Hearing exam - diagnostic/non-routine	• In-network: $30 copay per visit • Out-of-network: 20% of the cost	• In-network: $0 copay per visit • Out-of-network: 20% of the cost
• Hearing aid	You pay $200-$1,675 for each hearing aid. Coverage is for 2 hearing aids every 3 years.	You pay $200-$1,675 for each hearing aid. Coverage is for 2 hearing aids every 3 years.

* A prior authorization may be required

BlueCHiP for Medicare Extra (HMO-POS)	HealthMate for Medicare (PPO)
• In-network: $0 • Out-of-network: 20% of the cost Any additional preventive services approved by Medicare during the contract year will be covered.	• In-network: $0 • Out-of-network: $25 copay per visit Any additional preventive services approved by Medicare during the contract year will be covered.
$90 copay per visit If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Coverage" section of this booklet for other costs.	$90 copay per visit If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Coverage" section of this booklet for other costs.
$50 copay per visit	$50 copay per visit
• In-network: $150 copay per visit • Out-of-network: 20% of the cost	• In-network: $100 copay per visit • Out-of-network: $200 copay per visit
• In-network: $0 • Out-of-network: 20% of the cost	• In-network: $0 copay per visit • Out-of-network: $10 copay per visit
• In-network: $0 • Out-of-network: 20% of the cost	• In-network: $0 • Out-of-network: $10 copay per visit
• In-network: $0 • Out-of-network: 20% of the cost	• In-network: $0 • Out-of-network: $10 copay per visit
• In-network: $0 • Out-of-network: 20% of the cost Limit one visit per year.	• In-network: $0 • Out-of-network: $50 copay per visit Limit one visit per year.
• In-network: $25 copay per visit • Out-of-network: 20% of the cost	• In-network: $25 copay per visit • Out-of-network: $50 copay per visit
You pay $200-$1,675 for each hearing aid. Coverage is for 2 hearing aids every 3 years.	• You pay $200-$1,675 for each hearing aid. Coverage is for 2 hearing aids every 3 years. • Out-of-network: You pay 50% coinsurance for hearing aids and services. The plan will cover up to $300 per ear. Coverage is for 2 hearing aids every 3 years.

Premiums and Benefits	BlueCHiP for Medicare Value (HMO-POS)	BlueCHiP for Medicare Value ACCESS (HMO-POS)
Dental Services* • Medicare covered	• In-network: 20% of the cost • 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).	• In-network: $0 • 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).
• Preventive	$0 cost for covered services	$0 cost for covered services
• Comprehensive	50% of the cost for covered services	$0 cost for covered services
• Annual benefit maximum	$1,000 limit on all covered dental services for preventive and comprehensive Dental Services	$1,000 limit on all covered dental services for preventive and comprehensive dental services
Vision Services: • Vision exam - routine	• In-network: $0 • Out-of-network: 20% of the cost Limit one visit per year.	• In-network: $0 • Out-of-network: 20% of the cost Limit one visit per year.
• Vision exam - diagnostic/non-routine	• In-network: $30 copay per visit • Out-of-network: 20% of the cost	• In-network: $0 • Out-of-network: 20% of the cost
• Vision eyewear	Our plan pays up to $150 every year for eyewear.	Our plan pays up to $150 every year for eyewear.
Mental Health Services:* • Inpatient visit	• In-network: $375 copay per day for days 1-4 • Out-of-network: 20% of the cost Our plan covers an unlimited number of days for an in-network inpatient hospital stay. Out-of-network stays are covered for 90 days.	• In-network: $375 copay per day for days 1-4 • Out-of-network: 20% of the cost Our plan covers an unlimited number of days for an in-network inpatient hospital stay. Out-of-network stays are covered for 90 days.
• Outpatient group/ individual therapy visit	• In-network: $35 copay per visit • Out-of-network: 20% of the cost	• In-network: $0 copay per visit • Out-of-network: 20% of the cost

* A prior authorization may be required

BlueCHiP for Medicare Extra (HMO-POS)	HealthMate for Medicare (PPO)
• In-network: 20% of the cost • 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).	• In-network: 20% of the cost • Out-of-network: 50% of the cost Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).
$0 cost for covered services	• In-network: $0 cost for covered services • Out-of-network: 50% of the cost
$0 cost for covered services	• In-network: $0 cost for covered services • Out-of-network: 50% of the cost
$1,500 limit on all covered dental services for preventive and comprehensive dental services	$2,000 limit on all covered dental services for preventive and comprehensive dental services
• In-network: $0 • Out-of-network: 20% of the cost Limit one visit per year.	• In-network: $0 • Out-of-network: $50 copay per visit Limit one visit per year.
• In-network: $25 copay per visit • Out-of-network: 20% of the cost	• In-network: $25 copay per visit • Out-of-network: $50 copay per visit
Our plan pays up to $150 every year for eyewear.	Our plan pays up to $200 every year for eyewear.
• In-network: $300 copay per day for days 1-4 • Out-of-network: 20% of the cost Our plan covers an unlimited number of days for an in-network inpatient hospital stay. Out-of-network stays are covered for 90 days.	• In-network: $300 copay per day for days 1-4 • Out-of-network: 20% of the cost Our plan covers an unlimited number of days for an in-network inpatient hospital stay. Out-of-network stays are covered for 90 days.
• In-network: $25 copay per visit • Out-of-network: 20% of the cost	• In-network: $25 copay per visit • Out-of-network: $50 copay per visit

Premiums and Benefits	BlueCHiP for Medicare Value (HMO-POS)	BlueCHiP for Medicare Value ACCESS (HMO-POS)
Skilled Nursing Facility (SNF)*	In-network • $0 copay per day for days 1-20 • $180 copay per day for days 21-45 • $0 copay per day for days 46-100 Out-of-network: 20% of the cost Our plan covers up to 100 days in a SNF. Copays for SNF benefits are based on benefit periods. You pay these amounts each benefit period until you reach the in-network or out-of-network out-of-pocket maximum.	In-network • $0 copay per day for days 1-20 • $0 copay per day for days 21-45 • $0 copay per day for days 46-100 Out-of-network: 20% of the cost Our plan covers up to 100 days in a SNF. Copays for SNF benefits are based on benefit periods. You pay these amounts each benefit period until you reach the in-network or out-of-network out-of-pocket maximum.
Physical therapy (PT), occupational therapy (OT), and speech and language therapy (ST) visit	• In-network: $35 copay per provider per visit • Out-of-network: 20% of the cost Referral is required for PT/OT/ST visits.	• In-network: $0 copay per provider per visit • Out-of-network: 20% of the cost Referral is required for PT/OT/ST visits.
Ambulance*	$150 copay per trip	$0 copay per trip
Transportation	$0 copay per trip (some restrictions apply)	$0 copay per trip (some restrictions apply)
Medicare Part B Drugs*	• In-network: 20% of the cost • Out-of-network: 20% of the cost	• In-network: $0 • Out-of-network: 20% of the cost
Ambulatory Surgery Center*	• In-network: $300 copay per visit • Out-of-network: 20% of the cost	• In-network: $0 copay per visit • Out-of-network: 20% of the cost
Prescription Drug Benefits		
Stage 1: Annual Prescription Deductible	No Prescription Drug Deductible	No Prescription Drug Deductible
Stage 2: Initial Coverage	You will pay the following until your total yearly drug costs reach $4,430. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You pay $35 for select insulins through the coverage gap for a 30 day supply. You may get your drugs at network retail pharmacies and mail order pharmacies.	You will pay the following until your total yearly drug costs reach $4,430. 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.

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BlueCHiP for Medicare Extra (HMO-POS)	HealthMate for Medicare (PPO)
In-network • $0 copay per day for days 1-20 • $150 copay per day for days 21-45 • $0 copay per day for days 46-100 Out-of-network: 20% of the cost Our plan covers up to 100 days in a SNF. Copays for SNF benefits are based on benefit periods. You pay these amounts each benefit period until you reach the in-network or out-of-network out-of-pocket maximum.	In-network • $0 copay per day for days 1-20 • $150 copay per day for days 21-45 • $0 copay per day for days 46-100 Out-of-network: 20% of the cost Our plan covers up to 100 days in a SNF. Copays for SNF benefits are based on benefit periods. You pay these amounts each benefit period until you reach the in-network or out-of-network out-of-pocket maximum.
• In-network: $25 copay per provider per visit • Out-of-network: 20% of the cost Referral is required for PT/OT/ST visits.	• In-network: $25 copay per provider per visit • Out-of-network: $50 copay per provider per visit
$150 copay per trip	$150 copay per trip
$0 copay per trip (some restrictions apply)	$0 copay per trip (some restrictions apply)
• In-network: 20% of the cost • Out-of-network: 20% of the cost	• In-network: 20% of the cost • Out-of-network: 30% of the cost
• In-network: $250 copay per visit • Out-of-network: 20% of the cost	• In-network: $250 copay per visit • Out-of-network: $500 copay per visit
No Prescription Drug Deductible	No Prescription Drug Deductible
You will pay the following until your total yearly drug costs reach $4,430. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You pay $35 for select insulins through the coverage gap for a 30 day supply. You may get your drugs at network retail pharmacies and mail order pharmacies.	You will pay the following until your total yearly drug costs reach $4,430. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You pay $35 for select insulins through the coverage gap for a 30 day supply.

Premiums and Benefits	BlueCHiP for Medicare Value (HMO-POS)		BlueCHiP for Medicare Value ACCESS (HMO-POS)	
Pharmacy Network	**Preferred Retail 30-day supply**	**Standard Retail 30-day supply**	**Preferred Retail 30-day supply**	**Standard Retail 30-day supply**
Tier 1: Preferred Generic	$0 copay	$8 copay	$0 copay	Follow LIS copays
Tier 2: Generic	$0 copay	$16 copay	$0 copay	Follow LIS copays
Tier 3: Preferred Brand	$47 copay	$47 copay	Follow LIS copays	Follow LIS copays
Tier 4: Non-Preferred Drug	$100 copay	$100 copay	Follow LIS copays	Follow LIS copays
Tier 5: Specialty	33% of the cost	33% of the cost	Follow LIS copays	Follow LIS copays
	Mail Order 90-day supply		**Mail Order 90-day supply**	
Tier 1: Preferred Generic	$0 copay		$0 copay	
Tier 2: Generic	$0 copay		$0 copay	
Tier 3: Preferred Brand	$117.50 copay		Follow LIS copays	
Tier 4: Non-Preferred Drug	$250 copay		Follow LIS copays	
Tier 5: Specialty	N/A You pay $87.50 for select insulins through the coverage gap for a 90-day mail order supply.		Follow LIS copays	
Stage 3: 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 $4,430. After you enter the coverage gap, you pay 25% of the plan’s cost for generic and brand name drugs until your costs total $7,050, 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 $4,430. After you enter the coverage gap, you pay 25% of the plan’s cost for generic and brand name drugs until your costs total $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.	

* A prior authorization may be required

BlueCHiP for Medicare Extra (HMO-POS)		HealthMate for Medicare (PPO)
Preferred Retail 30-day supply	**Standard Retail 30-day supply**	**Standard Retail 30-day supply**
$0 copay	$8 copay	$0 copay
$4 copay	$12 copay	$0 copay
$47 copay	$47 copay	$47 copay
$100 copay	$100 copay	$100 copay
33% of the cost	33% of the cost	33% of the cost
Mail Order 90-day supply		**Mail Order 90-day supply**
$0 copay		$0 copay
$0 copay		$0 copay
$117.50 copay		$117.50 copay
$250 copay		$250 copay
N/A		N/A
You pay $87.50 for select insulins through the coverage gap for a 90-day mail order supply.		You pay $87.50 for select insulins through the coverage gap for a 90-day mail order supply.
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 $4,430.		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 $4,430.
After you enter the coverage gap, you pay 25% of the plan’s cost for generic and brand name drugs until your costs total $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.		After you enter the coverage gap, you pay 25% of the plan’s cost for generic and brand name drugs until your costs total $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you have additional coverage in the gap. You will pay the lesser of the gap coverage coinsurance or the Tier 1 & Tier 2 copays from the chart below.

Premiums and Benefits	BlueCHiP for Medicare Value (HMO-POS)		BlueCHiP for Medicare Value ACCESS (HMO-POS)	
Pharmacy Network	**Preferred Retail 30-day supply**	**Standard Retail 30-day supply**	**Preferred Retail 30-day supply**	**Standard Retail 30-day supply**
Tier 1: Preferred Generic Tier 2: Generic	Refer to Coverage Gap amounts	Refer to Coverage Gap amounts	Follow LIS copay amounts	Follow LIS copay amounts
	Mail Order		**Mail Order**	
Tier 1: Preferred Generic Tier 2: Generic	Refer to Coverage Gap amounts		Follow LIS copays copay	
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: 5% of the cost, or $3.95 copay for generic (including brand drugs treated as generic) and $9.85 copay for all other drugs.		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: 5% of the cost, or $3.95 copay for generic (including brand drugs treated as generic) and $9.85 copay for all other drugs.	
Additional Benefits				
Chiropractic Office Visits	• In-network: $20 copay per visit • Out-of-network: 20% of the cost Referral is required for specialist visits.		• In-network: $0 copay per visit • Out-of-network: 20% of the cost Referral is required for specialist visits.	
Fitness Benefit - Silver&Fit	$0 per month		$0 per month	
Foot Care (podiatry services): • Foot exams and treatment	• In-network: $30 copay per visit • Out-of-network: 20% of the cost Referral is required for specialist visits.		• In-network: $0 copay per visit • Out-of-network: 20% of the cost Referral is required for specialist visits.	
• Routine foot care for members with certain medical conditions	• In-network: $30 copay per visit • Out-of-network: 20% of the cost Referral is required for specialist visits.		• In-network: $0 copay per visit • Out-of-network: 20% of the cost Referral is required for specialist visits.	
Medical Equipment/ Supplies:* • Durable medical equipment and prosthetics	• In-network: 20% of the cost • Out-of-network: 20% of the cost		• In-network: $0 • Out-of-network: 20% of the cost	
• Diabetes monitoring supplies	• In-network: $0 • Out-of-network: 20% of the cost You must use OneTouch plan-designated monitors and test strips.		• In-network: $0 • Out-of-network: 20% of the cost You must use OneTouch plan-designated monitors and test strips.	

* A prior authorization may be required

BlueCHiP for Medicare Extra (HMO-POS)		HealthMate for Medicare (PPO)
Preferred Retail 30-day supply	**Standard Retail 30-day supply**	**Standard Retail 30-day supply**
Refer to Coverage Gap amounts	Refer to Coverage Gap amounts	$0 copay $0 copay
Mail Order		**Mail Order**
Refer to Coverage Gap amounts		$0 copay $0 copay
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: 5% of the cost, or $3.95 copay for generic (including brand drugs treated as generic) and $9.85 copay for all other drugs.		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: 5% of the cost, or $3.95 copay for generic (including brand drugs treated as generic) and $9.85 copay for all other drugs.
• In-network: $20 copay per visit • Out-of-network: 20% of the cost Referral is required for specialist visits.		• In-network: $20 copay per visit • Out-of-network: $40 copay per visit
$0 per month		• In-network: $0 per month • Out-of-network: Fitness kits for home use
• In-network: $25 copay per visit • Out-of-network: 20% of the cost Referral is required for specialist visits.		• In-network: $25 copay per visit • Out-of-network: $50 copay per visit
• In-network: $25 copay per visit • Out-of-network: 20% of the cost Referral is required for specialist visits.		• In-network: $25 copay per visit • Out-of-network: $50 copay per visit
• In-network: 20% of the cost • Out-of-network: 20% of the cost		• In-network: 20% of the cost • Out-of-network: 30% of the cost
• In-network: $0 • Out-of-network: 20% of the cost You must use OneTouch plan-designated monitors and test strips.		• In-network: $0 • Out-of-network: $25 copay You must use OneTouch plan-designated monitors and test strips.

Premiums and Benefits	BlueCHiP for Medicare Value (HMO-POS)	BlueCHiP for Medicare Value ACCESS (HMO-POS)
Virtual Doctor's Visits (Telemedicine)	$0 copay per visit See a primary care or behavioral health provider using your computer or mobile device. (See EOC for more details)	$0 copay per visit See a primary care or behavioral health provider using your computer or mobile device. (See EOC for more details)
Outpatient Surgery*	• In-network: $300 copay per visit. • Out-of-network: 20% of the cost	• In-network: $0 copay per visit. • Out-of-network: 20% of the cost
Over-the-Counter (OTC) Benefit	$60 per quarter to use on approved health products	$200 per quarter to use on approved health products

* A prior authorization may be required

BlueCHiP for Medicare Extra (HMO-POS)	HealthMate for Medicare (PPO)
$0 copay per visit See a primary care or behavioral health provider using your computer or mobile device. (See EOC for more details)	$0 copay per visit See a primary care or behavioral health provider using your computer or mobile device. (See EOC for more details)
• In-network: $250 copay per visit. • Out-of-network: 20% of the cost	• In-network: $250 copay per visit. • Out-of-network: $500 copay per visit
$75 per quarter to use on approved health products	$75 per quarter to use on approved health products

Existing members can call the Medicare Concierge team at (401) 277-2958 or 1-800-267-0439 (TTY:711) for more information. Non-members can call the Medicare Sales team at 1-800-505-BLUE (2583) (TTY:711).

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Blue Cross Blue Shield of Rhode Island

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