Summary of Benefits

January 1, 2022 - December 31, 2022

BlueCHiP for Medicare Advance (HMO)

BlueCHiP for Medicare Standard with Drugs (HMO)

BlueCHiP for Medicare Plus (HMO)

BlueCHiP for Medicare Preferred (HMO-POS)

BlueCHiP for Medicare Core (HMO)

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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 Advance, BlueCHiP for Medicare Standard with Drugs, BlueCHiP for Medicare Plus, BlueCHiP for Medicare Preferred, and BlueCHiP for Medicare Core.

BlueCHiP for Medicare Advance, **BlueCHiP for Medicare Standard with Drugs**, **BlueCHiP for Medicare Plus** and **BlueCHiP for Medicare Core** are Medicare Advantage Health Maintenance Organization (HMO) plans with a Medicare contract. **BlueCHiP for Medicare Preferred** (HMO-POS) is a Medicare Advantage HMO plan with a Point of Service Option (POS) 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 Advance, **BlueCHiP for Medicare Standard with Drugs**, **BlueCHiP for Medicare Plus**, **BlueCHiP for Medicare Preferred**, and **BlueCHiP for Core** 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 Preferred, you can use providers that are not in our network for some services.

BlueCHiP for Medicare Core does not cover Part D prescription drugs.

To join **BlueCHiP for Medicare Advance**, **BlueCHiP for Medicare Standard with Drugs**, **BlueCHiP for Medicare Plus**, **BlueCHiP for Medicare Preferred**, and **BlueCHiP for Medicare Core**, 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 Advance (HMO)	BlueCHiP for Medicare Standard with Drugs (HMO)
Monthly Plan Premium	$0 per month You must continue to pay your Medicare Part B premium	$61 per month 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	$4,500 annually for services you receive from in-network providers
Inpatient Hospital Coverage*	• $375 copay per day for days 1-5 • $0 copay per day for days 6 and beyond Our plan covers an unlimited number of days for an in-network inpatient hospital stay.	• $290 copay per day for days 1-5 • $0 copay per day for days 6 and beyond Our plan covers an unlimited number of days for an in-network inpatient hospital stay.
	Copays for hospital benefits are based on benefit periods. You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum.	Copays for hospital benefits are based on benefit periods. You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum.
Outpatient Hospital Coverage*	$350 copay per visit	$275 copay per visit
Doctor's Office Visits: • Primary care	$0 copay per visit	$0 PCMH or $20 non-PCMH copay per visit

* A prior authorization may be required

BlueCHiP for Medicare Plus (HMO)	BlueCHiP for Medicare Preferred (HMO-POS)	BlueCHiP for Medicare Core (HMO)
$153 per month You must continue to pay your Medicare Part B premium	$266 per month You must continue to pay your Medicare Part B premium	$0 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.	This plan does not have a medical deductible.
$2,800 annually for services you receive from in-network providers	• $2,250 annually for services you receive from in-network providers • $5,000 annually for services you receive from out-of-network providers	$3,500 annually for services you receive from in-network providers
• $190 copay per day for days 1-5 • $0 copay per day for days 6 and beyond Our plan covers an unlimited number of days for an in-network inpatient hospital stay.	• In-network: $180 copay per day for days 1-5 • $0 copay per day for days 6 and beyond 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.	• $180 copay per day for days 1-5 • $0 copay per day for days 6 and beyond Our plan covers an unlimited number of days for an in-network inpatient hospital stay.
Copays for hospital benefits are based on benefit periods. You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum.	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.	Copays for hospital benefits are based on benefit periods. You pay these amounts each benefit period until you reach the in-network out-of-pocket maximum.
$150 copay per visit	• In-network: $150 copay per visit • Out-of-network: 20% of the cost	$150 copay per visit
$0 PCMH or $5 non-PCMH copay per visit	• In-network: $0 PCMH or $5 non-PCMH copay per visit • Out-of-network: 20% of the cost	$0 PCMH or $5 non-PCMH copay per visit

Premiums and Benefits	BlueCHiP for Medicare Advance (HMO)	BlueCHiP for Medicare Standard with Drugs (HMO)
• Specialist	$35 copay per visit Referral is required for specialist visits.	$35 copay per visit Referral is required for specialist visits.
Preventive Care	$0 Any additional preventive services approved by Medicare during the contract year will be covered.	$0 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.	$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.
Urgently Needed Services	$60 copay per visit	$50 copay per visit
Diagnostic Services/ Labs/Imaging:* • High-tech diagnostic radiology services (such as MRIs, CT scans, etc.)	$200 copay per visit	$125 copay per visit
• Lab services	$0	$0
• Outpatient X-rays and diagnostic tests and procedures	$0	$0
• Therapeutic radiology	$20 copay per visit	$5 copay per visit
Hearing Services: • Hearing exam - routine	$0 Limit one visit per year.	$0 Limit one visit per year.

* A prior authorization may be required

BlueCHiP for Medicare Plus (HMO)	BlueCHiP for Medicare Preferred (HMO-POS)	BlueCHiP for Medicare Core (HMO)
$25 copay per visit Referral is required for specialist visits.	• In-network: $25 copay per visit • Out-of-network: 20% of the cost Referral is required for specialist visits.	$25 copay per visit Referral is required for specialist visits.
$0 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.	$0 Any additional preventive services approved by Medicare during the contract year will be covered.
$75 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.	$75 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	$50 copay per visit
$150 copay per visit	• In-network: $150 copay per visit • Out-of-network: 20% of the cost	$130 copay per visit
$0	• In-network: $0 • Out-of-network: 20% of the cost	$0
$0	• In-network: $0 • Out-of-network: 20% of the cost	$0
$0	• In-network: $0 • Out-of-network: 20% of the cost	$0
$0 Limit one visit per year.	• In-network: $0 • Out-of-network: 20% of the cost Limit one visit per year.	$0 Limit one visit per year.

Premiums and Benefits	BlueCHiP for Medicare Advance (HMO)	BlueCHiP for Medicare Standard with Drugs (HMO)
• Hearing exam - diagnostic/non-routine	$35 copay per visit	$35 copay per visit
• 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.
Dental Services* • Medicare covered	20% of the cost Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	20% of the cost Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).
• Preventive	Not covered	$0 cost for covered services
• Comprehensive	Not covered	20% of the cost for covered services
• Annual benefit maximum	Not covered	$1,500 limit on all covered dental services for preventive and comprehensive dental services
Vision Services: • Vision exam - routine	$0 Limit one visit per year.	$0 Limit one visit per year.
• Vision exam - diagnostic/non-routine	$35 copay per visit	$35 copay per visit
• Vision eyewear	Our plan pays up to $100 every year for eyewear.	Our plan pays up to $125 every year for eyewear.
Mental Health Services:* • Inpatient visit	• $375 copay per day for days 1-4 Our plan covers an unlimited number of days for an in-network inpatient hospital stay.	• $290 copay per day for days 1-4 Our plan covers an unlimited number of days for an in-network inpatient hospital stay.

* A prior authorization may be required

BlueCHiP for Medicare Plus (HMO)	BlueCHiP for Medicare Preferred (HMO-POS)	BlueCHiP for Medicare Core (HMO)
$25 copay per visit	• In-network: $25 copay per visit • Out-of-network: 20% of the cost	$25 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.	You pay $200-$1,675 for each hearing aid. Coverage is for 2 hearing aids every 3 years.
20% of the cost Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	• In-network: 20% of the cost • Out-of-network: 20% of the cost Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	20% of the cost Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).
$0 cost for covered services	$0 cost for covered services	Not covered
$0 cost for covered services	$0 cost for covered services	Not covered
$1,500 limit on all covered dental services for preventive and comprehensive dental services	$1,500 limit on all covered dental services for preventive and comprehensive dental services	Not covered
$0 Limit one visit per year.	• In-network: $0 • Out-of-network: 20% of the cost Limit one visit per year.	$0 Limit one visit per year.
$25 copay per visit	• In-network: $25 copay per visit • Out-of-network: 20% of the cost	$25 copay per visit
Our plan pays up to $150 every year for eyewear.	Our plan pays up to $200 every year for eyewear.	Our plan pays up to $200 every year for eyewear.
• $190 copay per day for days 1-4 Our plan covers an unlimited number of days for an in-network inpatient hospital stay.	In-network • $180 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.	• $180 copay per day for days 1-4 Our plan covers an unlimited number of days for an in-network inpatient hospital stay.

Premiums and Benefits	BlueCHiP for Medicare Advance (HMO)	BlueCHiP for Medicare Standard with Drugs (HMO)
• Outpatient group/ individual therapy visit	$40 copay per visit	$35 copay per visit
Skilled Nursing Facility (SNF)*	• $0 copay per day for days 1-20 • $160 copay per day for days 21-45 • $0 copay per day for days 46-100 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 out-of-pocket maximum.	• $0 copay per day for days 1-20 • $140 copay per day for days 21-45 • $0 copay per day for days 46-100 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 out-of-pocket maximum.
Physical therapy (PT), occupational therapy (OT), and speech and language therapy (ST) visit	$40 copay per provider per visit Referral is required for PT/OT/ST visits.	$35 copay per provider per visit Referral is required for PT/OT/ST visits.
Ambulance*	$150 copay per trip	$150 copay per trip
Transportation	$0 copay per trip (some restrictions apply)	$0 copay per trip (some restrictions apply)
Medicare Part B Drugs*	20% of the cost	20% of the cost
Ambulatory Surgery Center*	$350 copay per visit	$275 copay per visit

* A prior authorization may be required

BlueCHiP for Medicare Plus (HMO)	BlueCHiP for Medicare Preferred (HMO-POS)	BlueCHiP for Medicare Core (HMO)
$25 copay per visit	• In-network: $25 copay per visit • Out-of-network: 20% of the cost	$25 copay per visit
• $0 copay per day for days 1-20 • $135 copay per day for days 21-45 • $0 copay per day for days 46-100 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 out-of-pocket maximum.	In-network • $0 copay per day for days 1-20 • $130 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.	• $0 copay per day for days 1-20 • $130 copay per day for days 21-45 • $0 copay per day for days 46-100 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 out-of-pocket maximum.
$15 copay per provider per visit Referral is required for PT/OT/ST visits.	• In-network: $15 copay per provider per visit • Out-of-network: 20% of the cost Referral is required for PT/OT/ST visits.	$15 copay per provider per visit Referral is required for PT/OT/ST visits.
$75 copay per trip	$75 copay per trip	$150 copay per trip
$0 copay per trip (some restrictions apply)	$0 copay per trip (some restrictions apply)	$0 copay per trip (some restrictions apply)
20% of the cost	• In-network: 20% of the cost • Out-of-network: 20% of the cost	20% of the cost
$150 copay per visit	• In-network: $150 copay per visit • Out-of-network: 20% copay per visit	$150 copay per visit

Premiums and Benefits	BlueCHiP for Medicare Advance (HMO)		BlueCHiP for Medicare Standard with Drugs (HMO)	
Prescription Drug Benefits				
Stage 1: Annual Prescription Drug Deductible	$0 per year for Tier 1 and Tier 2 $200 for Tier 3, Tier 4, and Tier 5 Part D prescription drugs		$0 per year for Tier 1 and Tier 2 $100 for Tier 3, Tier 4, and Tier 5 Part D prescription drugs	
Stage 2: Initial Coverage	After you pay your annual prescription deductible, you 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.		After you pay your annual prescription deductible, you 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.	
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	$2 copay	$10 copay	$1 copay	$9 copay
Tier 2: Generic	$9 copay	$17 copay	$8 copay	$16 copay
Tier 3: Preferred Brand	$47 copay	$47 copay	$47 copay	$47 copay
Tier 4: Non-Preferred Drug	$100 copay	$100 copay	$100 copay	$100 copay
Tier 5: Specialty	29% of the cost	29% of the cost	31% of the cost	31% of the cost
	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		$117.50 copay	
Tier 4: Non-Preferred Drug	$250 copay		$250 copay	
Tier 5: Specialty	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.	

* A prior authorization may be required

BlueCHiP for Medicare Plus (HMO)		BlueCHiP for Medicare Preferred (HMO-POS)		BlueCHiP for Medicare Core (HMO)	
No Prescription Drug Deductible		No Prescription Drug Deductible		Not covered	
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. You may get your drugs at network retail pharmacies and mail order pharmacies.		Not covered	
Preferred Retail 30-day supply	**Standard Retail 30-day supply**	**Preferred Retail 30-day supply**	**Standard Retail 30-day supply**	**Preferred Retail 30-day supply**	**Standard Retail 30-day supply**
$3 copay $6 copay $47 copay $100 copay 33% of the cost	$11 copay $14 copay $47 copay $100 copay 33% of the cost	$3 copay $6 copay $47 copay $100 copay 33% of the cost	$11 copay $14 copay $47 copay $100 copay 33% of the cost	Not covered	Not covered
Mail Order 90-day supply		**Mail Order 90-day supply**		**Mail Order 90-day supply**	
$0 copay $0 copay $117.50 copay $250 copay N/A		$0 copay $0 copay $117.50 copay $250 copay N/A		Not covered	
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.			

Premiums and Benefits	BlueCHiP for Medicare Advance (HMO)		BlueCHiP for Medicare Standard with Drugs (HMO)	
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.	
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	Refer to Coverage Gap amounts	Refer to Coverage Gap amounts
	Mail Order		**Mail Order**	
Tier 1: Preferred Generic Tier 2: Generic	Refer to Coverage Gap amounts		Refer to Coverage Gap amounts	
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:		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:	

* A prior authorization may be required

BlueCHiP for Medicare Plus (HMO)		BlueCHiP for Medicare Preferred (HMO-POS)		BlueCHiP for Medicare Core (HMO)	
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. 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.		Not covered	
Preferred Retail 30-day supply	**Standard Retail 30-day supply**	**Preferred Retail 30-day supply**	**Standard Retail 30-day supply**	**Preferred Retail 30-day supply**	**Standard Retail 30-day supply**
Refer to Coverage Gap amounts	Refer to Coverage Gap amounts	$3 copay $6 copay	$11 copay $14 copay	Not covered	Not covered
Mail Order		**Mail Order**		**Mail Order**	
Refer to Coverage Gap amounts		$0 copay $0 copay		Not covered	
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:		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:		Not covered	

Premiums and Benefits	BlueCHiP for Medicare Advance (HMO)	BlueCHiP for Medicare Standard with Drugs (HMO)
	5% of the cost, or $3.95 copay for generic (including brand drugs treated as generic) and $9.85 copay for all other drugs.	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	$20 copay per visit Referral is required for specialist visits.	$20 copay per visit Referral is required for specialist visits.
Fitness Benefit - Silver&Fit	$0 per month	$0 per month
Foot Care (podiatry • Foot exams and treatment	$35 copay per visit Referral is required for specialist visits.	$35 copay per visit Referral is required for specialist visits.
• Routine foot care for members with certain medical conditions	$35 copay per visit Referral is required for specialist visits.	$35 copay per visit Referral is required for specialist visits.
Medical Equipment/ Supplies:* • Durable medical equipment and prosthetics	20% of the cost	20% of the cost
• Diabetes monitoring supplies	$0 You must use OneTouch plan-designated monitors and test strips.	$0 You must use OneTouch plan-designated monitors and test strips.
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)

* A prior authorization may be required

BlueCHiP for Medicare Plus (HMO)	BlueCHiP for Medicare Preferred (HMO-POS)	BlueCHiP for Medicare Core (HMO)
5% of the cost, or $3.95 copay for generic (including brand drugs treated as generic) and $9.85 copay for all other drugs.	5% of the cost, or $3.95 copay for generic (including brand drugs treated as generic) and $9.85 copay for all other drugs.	Not covered
$20 copay per visit Referral is required for specialist visits.	• In-network: $20 copay per visit • Out-of-network: 20% of the cost Referral is required for specialist visits.	$20 copay per visit Referral is required for specialist visits.
$0 per month	$0 per month	$0 per month
$25 copay per visit Referral is required for specialist visits.	• In-network: $25 copay per visit • Out-of-network: 20% of the cost Referral is required for specialist visits.	$25 copay per visit Referral is required for specialist visits.
$25 copay per visit Referral is required for specialist visits.	• In-network: $25 copay per visit • Out-of-network: 20% of the cost Referral is required for specialist visits.	$25 copay per visit Referral is required for specialist visits.
20% of the cost	• In-network: 20% of the cost • Out-of-network: 20% of the cost	20% of the cost
$0 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.	$0 You must use OneTouch plan-designated monitors and test strips.
$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)	$0 copay per visit See a primary care or behavioral health provider using your computer or mobile device. (See EOC for more details)

Premiums and Benefits	BlueCHiP for Medicare Advance (HMO)	BlueCHiP for Medicare Standard with Drugs (HMO)
Outpatient Surgery*	$350 copay per visit	$275 copay per visit
Over-the-Counter (OTC) Benefit	$25 per quarter to use on approved health products	$75 per quarter to use on approved health products
Optional Supplemental Dental Rider		
Monthly Premium	$21.80 per month	Included in medical
• Preventive	$0	
• Comprehensive	50% of the cost for covered services	
• Annual benefit maximum	$1,000 limit on all covered dental services for preventive and comprehensive dental services	

* A prior authorization may be required

BlueCHiP for Medicare Plus (HMO)	BlueCHiP for Medicare Preferred (HMO-POS)	BlueCHiP for Medicare Core (HMO)
$150 copay per visit	• In-network: $150 copay per visit • Out-of-network: 20% of the cost	$150 copay per visit
$100 per quarter to use on approved health products	$100 per quarter to use on approved health products	$75 per quarter to use on approved health products
Included in medical	Included in medical	$21.80 per month
		$0
		50% of the cost for covered services
		$1,000 limit on all covered dental services for preventive and comprehensive dental services

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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