Blue Cross Blue Shield of Rhode Island

500 Exchange Street, Providence, Rhode Island 02903-2699
(401) 459-1000 bcbsri.com

February 20, 2023

Dear Medicare Member,

Thank you for being a part of our Blue Cross & Blue Shield of Rhode Island (BCBSRI) family. We are reaching out with important information about changes to your Medicare Part B benefit through your BCBSRI Medicare Advantage plan. These changes may lower your Part B drug costs due to the Inflation Reduction Act.

Starting April 1, 2023, certain Part B drugs may be subject to a lower coinsurance. This means that the coinsurance you pay for some Part B drugs may be less than what is listed in your Evidence of Coverage (EOC). This amount may vary depending on the drug and when you fill the prescription, but will never exceed the coinsurance listed in your EOC.

Also, starting July 1, 2023, you will pay no more than $35 for a one-month supply of Part B insulin, such as insulin administered via a pump. The $35 limit applies to the insulin itself, not the pump or pump supplies. This change is in addition to the $35 Part D insulin cap which was implemented in January 2023. If your plan includes the Insulin Savings Program, you may already have an insulin cost share less than $35 per one-month supply.

You do not need to take any action. These benefits will automatically begin on the dates noted above.

If you have any questions, please call the Medicare Concierge team at (401) 277-2958 or 1-800-267-0439 (TTY:711). Hours are Monday through Friday, 8:00 a.m. to 8:00 p.m.; Saturday, 8:00 a.m. to noon. (Open seven days a week, 8:00 a.m. to 8:00 p.m., October 1 – March 31.) You can use our automated answering system outside of these hours. The Medicare Concierge team also has free language interpreter services available for non-English speakers.

As always, thank you for putting your trust in us.

Sincerely,

Michael Menard
Vice President, Medicare

Blue Cross & Blue Shield of Rhode Island is an HMO & PPO 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

Y0146_PartBIRA_C

Summary of Benefits

January 1, 2023 - December 31, 2023

BlueCHiP for Medicare Extra (HMO-POS)

BlueCHiP for Medicare Standard with Drugs (HMO)

BlueCHiP for Medicare Plus (HMO)

BlueCHiP for Medicare Preferred (HMO-POS)

BlueCHiP for Medicare Core (HMO)

Blue Cross Blue Shield of Rhode Island

Summary of Benefits

This is a summary of drug and health services covered by BlueCHiP for Medicare Extra, BlueCHiP for Medicare Standard with Drugs, BlueCHiP for Medicare Plus, BlueCHiP for Medicare Preferred, and BlueCHiP for Medicare Core.

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 Extra** and **BlueCHiP for Medicare Preferred** (HMO-POS) are Medicare Advantage HMO plans 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 Extra, **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 Extra** and **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 Extra**, **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 Standard with Drugs (HMO)	BlueCHiP for Medicare Extra (HMO-POS)
Monthly Plan Premium	$57 per month You must continue to pay your Medicare Part B premium	$107 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)	$4,500 annually for services you receive from in-network providers	• $4,500 annually for services you receive from in-network providers • $5,000 annually for services you receive from out-of-network providers
Inpatient Hospital Coverage*	• $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.	• In-network: $300 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. 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/ Ambulatory Surgical Center (ASC)*	$275 copay per visit	• In-network: $250 copay per visit • Out-of-network: 20% of the cost

* A prior authorization may be required

BlueCHiP for Medicare Plus (HMO)	BlueCHiP for Medicare Preferred (HMO-POS)	BlueCHiP for Medicare Core (HMO)
$151 per month You must continue to pay your Medicare Part B premium	$264 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. 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.	• 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. 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.	• $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.
$150 copay per visit	• In-network: $150 copay per visit • Out-of-network: 20% of the cost	$150 copay per visit

Premiums and Benefits	BlueCHiP for Medicare Standard with Drugs (HMO)	BlueCHiP for Medicare Extra (HMO-POS)
Doctor's Office Visits: • Primary care	$0 PCMH or $20 non-PCMH copay per visit	• In-network: $0 PCMH or $10 non-PCMH copay per visit • Out-of-network: 20% of the cost
• Specialist	$35 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.
Preventive Care	$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.
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	$50 copay per visit	$50 copay per visit
Diagnostic Services/ Labs/Imaging:* • High-tech diagnostic radiology services (such as MRIs, CT scans, etc.)	$125 copay per visit	• In-network: $150 copay per visit • Out-of-network: 20% of the cost

* A prior authorization may be required

BlueCHiP for Medicare Plus (HMO)	BlueCHiP for Medicare Preferred (HMO-POS)	BlueCHiP for Medicare Core (HMO)
$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
$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

Premiums and Benefits	BlueCHiP for Medicare Standard with Drugs (HMO)	BlueCHiP for Medicare Extra (HMO-POS)
• Lab services	$0	• In-network: $0 • Out-of-network: 20% of the cost
• Outpatient X-rays and diagnostic tests and procedures	$0	• In-network: $0 • Out-of-network: 20% of the cost
• Therapeutic radiology	$5 copay per visit	• In-network: $0 • Out-of-network: 20% of the cost
Hearing Services: • Hearing exam - routine	$0 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	$35 copay per visit	• In-network: $25 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.
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).	• 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).
• Preventive	$0 of the cost for covered services	$0 of the cost for covered services
• Comprehensive	20% of the cost for covered services	$0 of the cost for covered services
• Annual benefit maximum	$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
Vision Services: • Vision exam - routine	$0 Limit one visit per year.	• In-network: $0 • Out-of-network: 20% of the cost 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)
$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.
$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 of the cost for covered services	$0 of the cost for covered services	$0 of the cost for covered services
$0 of the cost for covered services	$0 of the cost for covered services	50% of the cost for covered services
$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	$1,500 limit on all covered dental services for preventive and comprehensive dental services
$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 Standard with Drugs (HMO)	BlueCHiP for Medicare Extra (HMO-POS)
• Vision exam - diagnostic/non-routine	$35 copay per visit	• In-network: $25 copay per visit • Out-of-network: 20% of the cost
• Vision eyewear	Our plan pays up to the amount on your Flexible Benefit Card.	Our plan pays up to the amount on your Flexible Benefit Card.
Mental Health Services:* • Inpatient visit	• $290 copay per day for days 1-4 Our plan covers an unlimited number of days for an in-network inpatient hospital stay.	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.
• Outpatient group/ individual therapy visit	$35 copay per visit	• In-network: $25 copay per visit • Out-of-network: 20% of the cost
Skilled Nursing Facility (SNF)*	• $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.	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.

* 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
Our plan pays up to the amount on your Flexible Benefit Card.	Our plan pays up to the amount on your Flexible Benefit Card.	Our plan pays up to the amount on your Flexible Benefit Card.
• $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.
$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.

Premiums and Benefits	BlueCHiP for Medicare Standard with Drugs (HMO)	BlueCHiP for Medicare Extra (HMO-POS)
Physical therapy (PT), occupational therapy (OT), and speech and language therapy (ST) visit	$35 copay per provider per visit Referral is required for PT/OT/ST visits.	• In-network: $25 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	$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	• In-network: 20% of the cost • Out-of-network: 20% of the cost
Prescription Drug Benefits		
Stage 1: Annual Prescription Drug Deductible	No Prescription Drug Deductible	No Prescription Drug Deductible
Stage 2: Initial Coverage	After you pay your annual prescription deductible, you pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You pay $20 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 $4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You pay $20 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.

BlueCHiP for Medicare Plus (HMO)	BlueCHiP for Medicare Preferred (HMO-POS)	BlueCHiP for Medicare Core (HMO)
$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
No Prescription Drug Deductible	No Prescription Drug Deductible	Not covered
After you pay your annual prescription deductible, you pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You pay $20 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 $4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You pay $20 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

Premiums and Benefits	BlueCHiP for Medicare Standard with Drugs (HMO)		BlueCHiP for Medicare Extra (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	$8 copay
Tier 2: Generic	$0 copay	$16 copay	$4 copay	$12 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	33% of the cost	33% of the cost	33% of the cost	33% 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 $50.00 for select insulins through the coverage gap for a 90-day mail order supply.		You pay $50.00 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)	
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 You pay $50.00 for select insulins through the coverage gap for a 90-day mail order supply.		$0 copay $0 copay $117.50 copay $250 copay N/A You pay $50.00 for select insulins through the coverage gap for a 90-day mail order supply.		Not covered	

Premiums and Benefits	BlueCHiP for Medicare Standard with Drugs (HMO)		BlueCHiP for Medicare Extra (HMO-POS)	
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 $4,660. After you enter the coverage gap, you pay 25% of the plan’s cost for generic and brand name drugs until your costs total $7,400, 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 $4,660. After you enter the coverage gap, you pay 25% of the plan’s cost for generic and brand name drugs until your costs total $7,400, 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	

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<table>
<tr><th colspan="2">BlueCHiP for Medicare Plus (HMO)</th><th colspan="2">BlueCHiP for Medicare Preferred (HMO-POS)</th><th colspan="2">BlueCHiP for Medicare Core (HMO)</th></tr>
<tr><td colspan="2">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 $4,660.

After you enter the coverage gap, you pay 25% of the plan’s cost for generic and brand name drugs until your costs total $7,400, which is the end of the coverage gap. Not everyone will enter the coverage gap.</td><td colspan="2">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 $4,660.

After you enter the coverage gap, you pay 25% of the plan’s cost for generic and brand name drugs until your costs total $7,400, 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.</td><td colspan="2">Not covered</td></tr>
<tr><td>Preferred Retail 30-day supply</td><td>Standard Retail 30-day supply</td><td>Preferred Retail 30-day supply</td><td>Standard Retail 30-day supply</td><td>Preferred Retail 30-day supply</td><td>Standard Retail 30-day supply</td></tr>
<tr><td>Refer to Coverage Gap amounts</td><td>Refer to Coverage Gap amounts</td><td>$3 copay

$6 copay</td><td>$11 copay

$14 copay</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td colspan="2">Mail Order</td><td colspan="2">Mail Order</td><td colspan="2">Mail Order</td></tr>
<tr><td colspan="2">Refer to Coverage Gap amounts</td><td colspan="2">$0 copay

$0 copay</td><td colspan="2">Not covered</td></tr>
</table>

Premiums and Benefits	BlueCHiP for Medicare Standard with Drugs (HMO)	BlueCHiP for Medicare Extra (HMO-POS)
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of: 5% of the cost, or $4.15 copay for generic (including brand drugs treated as generic) and $10.35 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 $7,400, you pay the greater of: 5% of the cost, or $4.15 copay for generic (including brand drugs treated as generic) and $10.35 copay for all other drugs.
Additional Benefits		
Chiropractic Office Visits	$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.
Fitness Benefit - Silver&Fit	$0 per month	$0 per month
Foot Care (podiatry services): • Foot exams and treatment	$35 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.
• Routine foot care for members with certain medical conditions	$35 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.
Medical Equipment/ Supplies:* • Durable medical equipment and prosthetics	20% of the cost	• In-network: 20% of the cost • Out-of-network: 20% of the cost

* A prior authorization may be required

BlueCHiP for Medicare Plus (HMO)	BlueCHiP for Medicare Preferred (HMO-POS)	BlueCHiP for Medicare Core (HMO)
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of: 5% of the cost, or $4.15 copay for generic (including brand drugs treated as generic) and $10.35 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 $7,400, you pay the greater of: 5% of the cost, or $4.15 copay for generic (including brand drugs treated as generic) and $10.35 copay for all other drugs.	Not covered 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

Premiums and Benefits	BlueCHiP for Medicare Standard with Drugs (HMO)	BlueCHiP for Medicare Extra (HMO-POS)
• Diabetes monitoring supplies	$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.
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*	$275 copay per visit	• In-network: $250 copay per visit • Out-of-network: 20% of the cost
Over-the-Counter (OTC) Benefit	$90 per quarter to use on approved health products	$75 per quarter to use on approved health products
Flexible Benefit Card	$200 per year to use on dental/vision/hearing services and vision hardware	$200 per year to use on dental/vision/hearing services and vision hardware
In-home Support Services	60 hours per year of in-home support services	60 hours per year of in-home support services
Wellness Reimbursement	Not Covered	$100 per year to use on approved services
Caregiver Reimbursement	Not Covered	$50 per year
Post Discharge Meal Benefit	$0 Benefit is for 7 days (14 meals) per inpatient or SNF discharge	$0 Benefit is for 7 days (14 meals) per inpatient or SNF discharge

* A prior authorization may be required

BlueCHiP for Medicare Plus (HMO)	BlueCHiP for Medicare Preferred (HMO-POS)	BlueCHiP for Medicare Core (HMO)
$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)
$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
$200 per year to use on dental/vision/hearing services and vision hardware	$200 per year to use on dental/vision/hearing services and vision hardware	$200 per year to use on dental/vision/hearing services and vision hardware
60 hours per year of in-home support services	60 hours per year of in-home support services	60 hours per year of in-home support services
Not Covered	Not Covered	Not Covered
Not Covered	Not Covered	Not Covered
$0 Benefit is for 7 days (14 meals) per inpatient or SNF discharge	$0 Benefit is for 7 days (14 meals) per inpatient or SNF discharge	$0 Benefit is for 7 days (14 meals) per inpatient or SNF discharge

Notes

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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