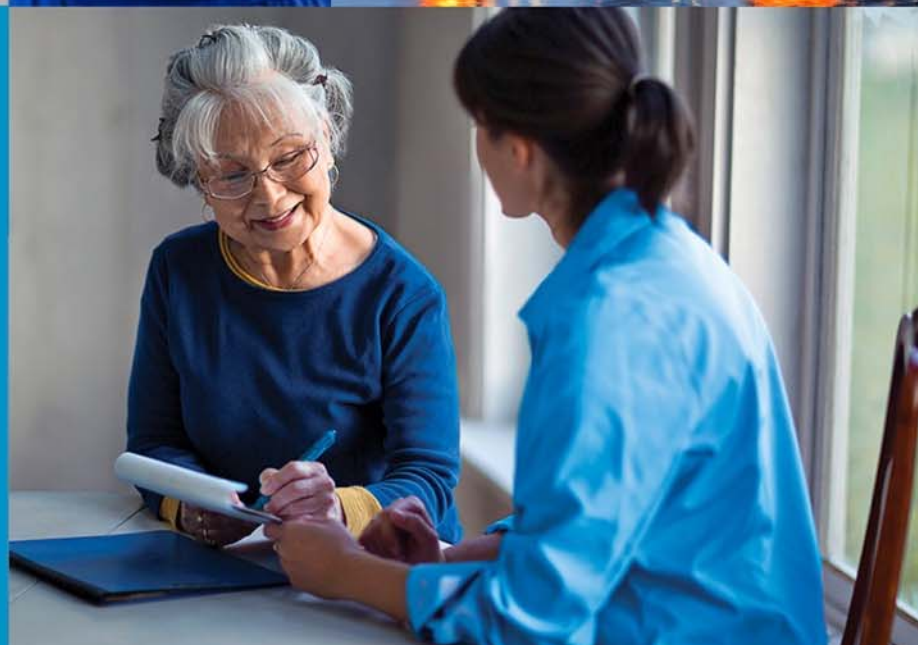
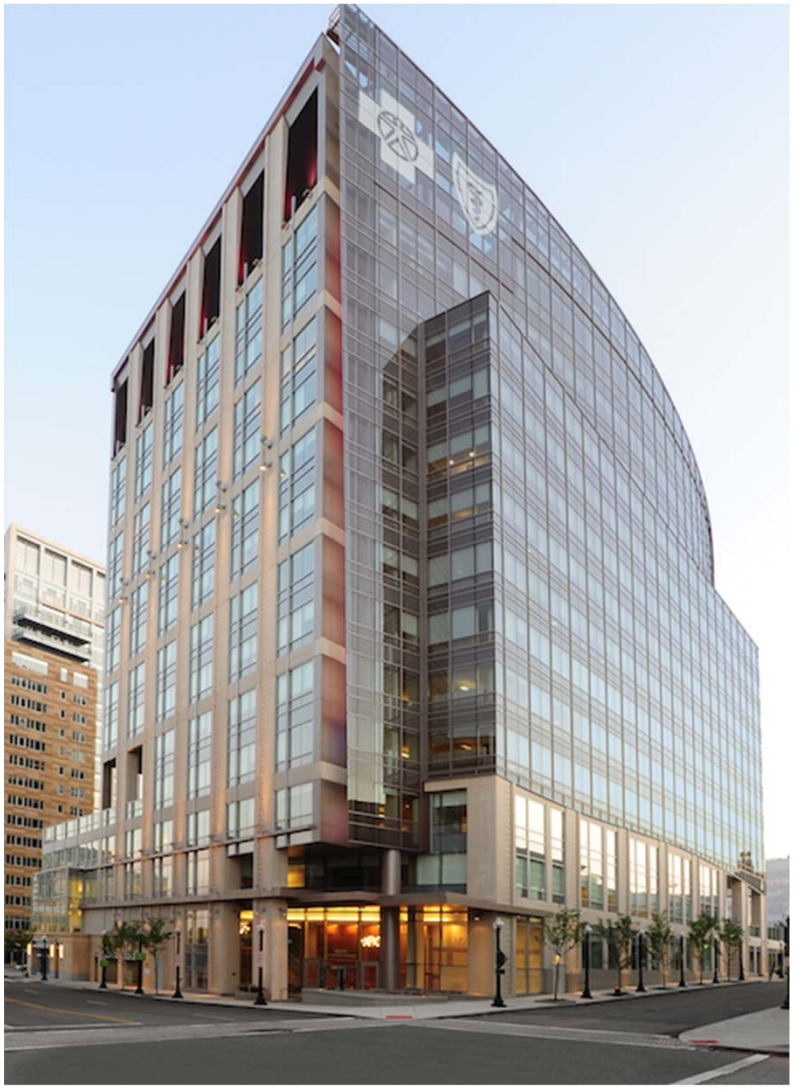
City of Providence/Providence School Retiree

2020 Group Medicare
Benefits Overview





At Blue Cross & Blue Shield of Rhode Island,

we've been serving the local community since 1939, with responsive service and a broad network of affordable care to help our members make the most of their retirement years.

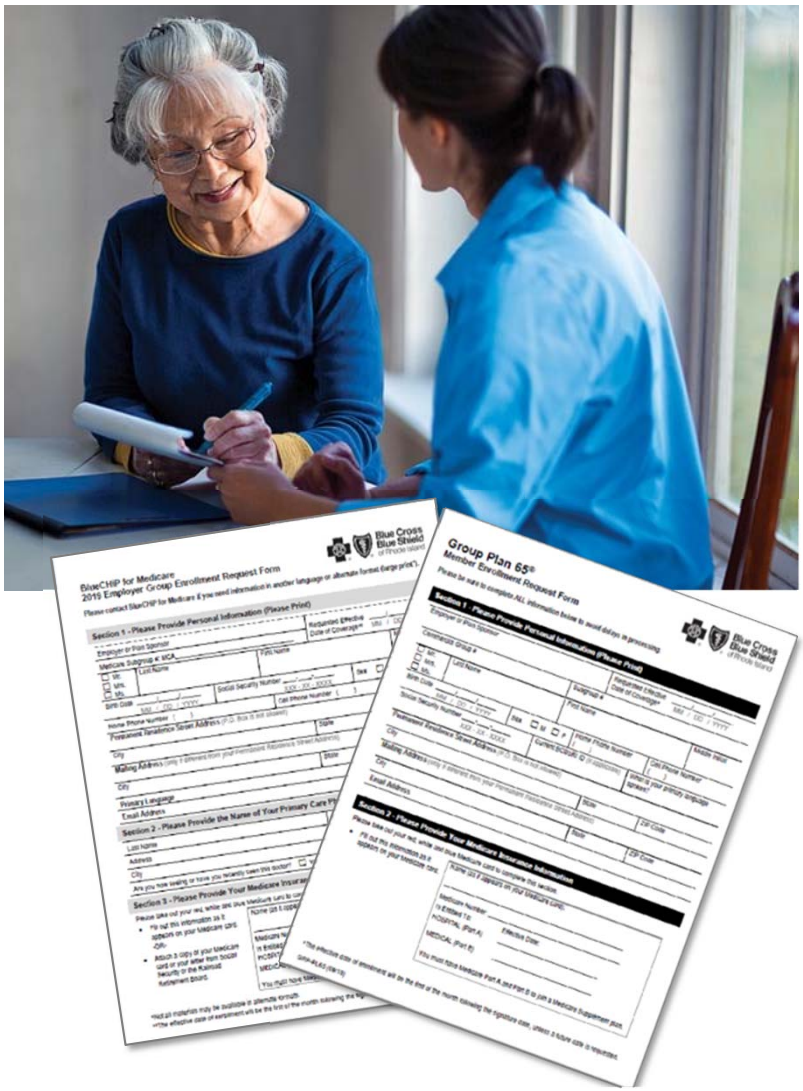
How We Help You Get the Most Out of Retirement

1. Extensive coverage: medical, dental, vision, over-the-counter, and fitness benefits
2. Leading local choice for health coverage
3. Dedicated support and service in-person and over the phone
4. Extensive provider and pharmacy network

Eligibility and Enrollment

If you turn 65 or become Medicare-eligible, you must:

- Apply for Medicare Part A and Part B
- Sign up for Medicare through Social Security
- Sign up any-time between 3 months before your birth month, the month of your birthday, or 3 months after your birth month

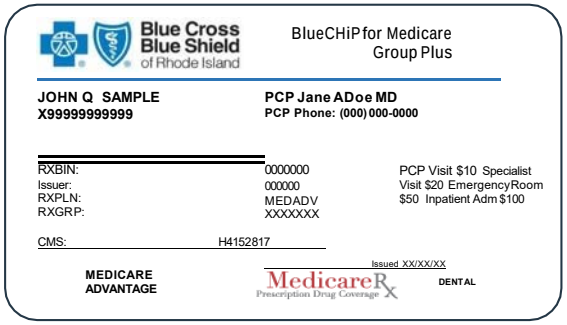


Completing Your Application

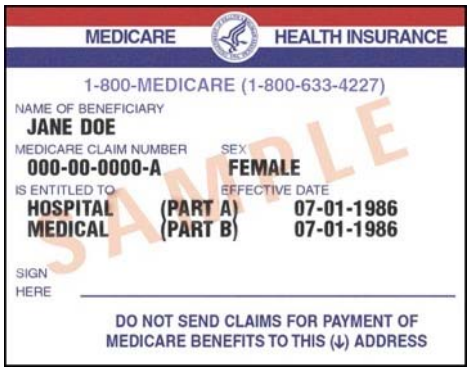
- Enter your full name and address
- Include all of your Medicare information
  - Located on your new red, white, and blue Medicare ID card
- Sign and date your application
  - If your form is completed by someone else, please include a copy of your executed healthcare power of attorney document
- Give completed application to the City prior to the effective date of coverage

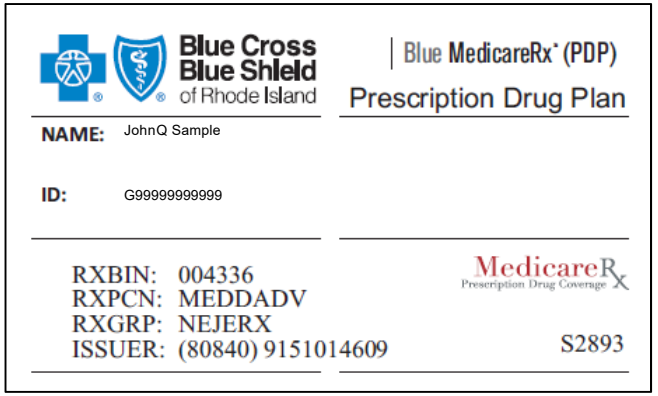
ID Cards

If you have BlueCHiP for Medicare Group Plus (HMO):



If you have Group Plan 65 and Blue MedicareRx (optional):

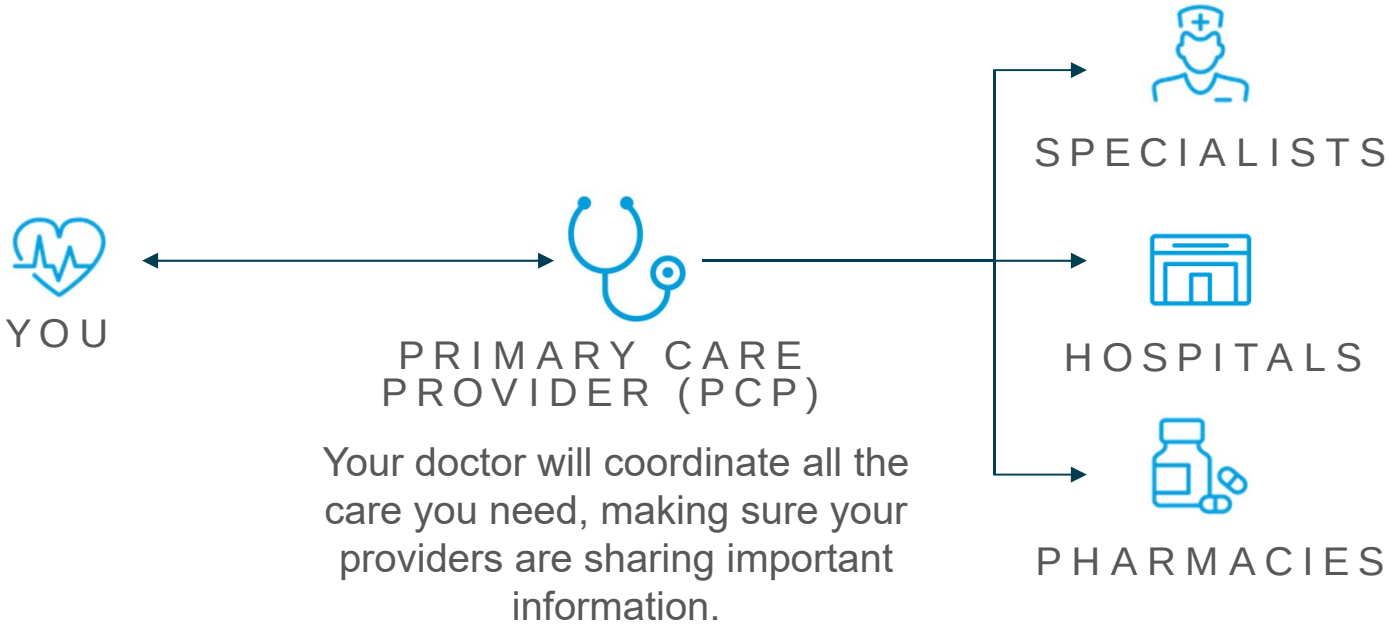




GROUP BLUECHiP BENEFITS

MEDICARE ADVANTAGE

How Group BlueCHiP for Medicare works



Group BlueCHiP for Medicare

MEDICAL BENEFITS OVERVIEW	
PCP copayment	**$0** PCMH/**$10** non-PCMH
Specialist copayment	**$30**
Hospitalization per admission per benefit period	**$250**
Skilled nursing facility	**$0/day** for day(s) 1-29; **$50/day** for day(s) 30-100
Home healthcare	**$0**
Durable medical equipment	**$0**
Diagnostic lab / X-ray services	**$0**
MRI, CT scan, PET scan, nuclear cardiology*	**$50**
Outpatient hospitalization	**$150**
Emergency room visit**	**$65**
Urgent care	**$40**

*Pre-authorization is required for MRIs, MRAs, CT scans, PET scans, and nuclear cardiology. **Waived if admitted in one day

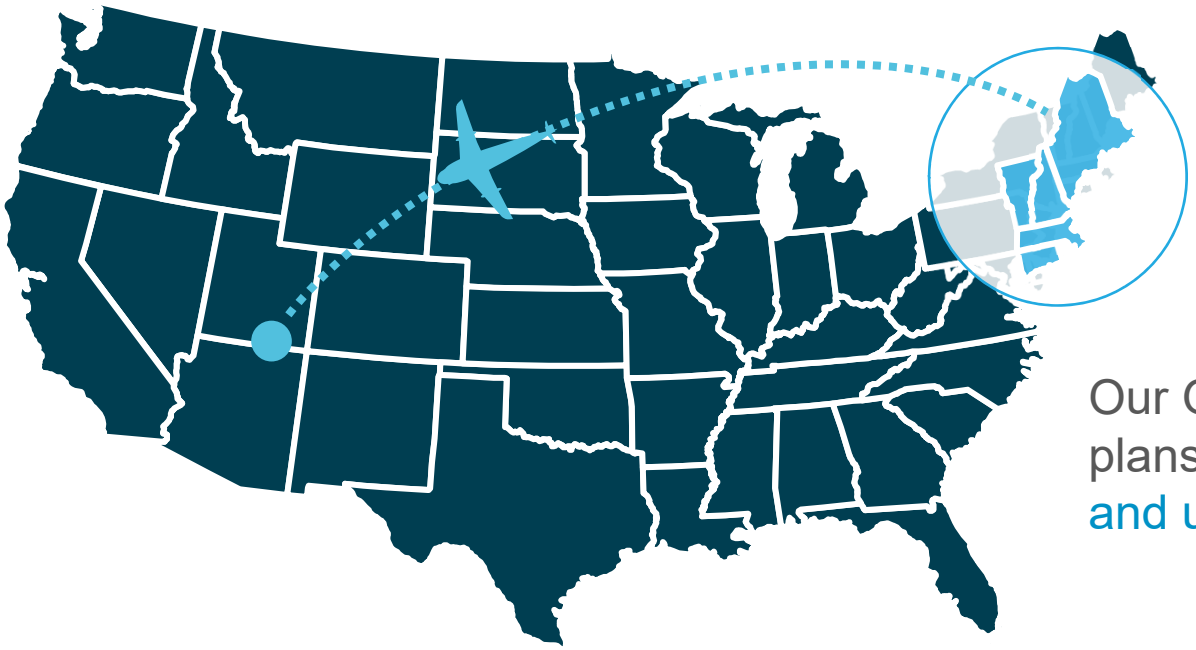
Controlling Your Healthcare Expenses

MAXIMUM OUT-OF-POCKET FOR YOUR PLAN:

$3,000

- You will not pay more than this in a calendar year for Medicare-covered services
- Services not covered by Medicare and prescription drug copays do not count toward the out-of-pocket maximum

Coverage Wherever You Are



Our Group Medicare Advantage plans offer worldwide emergency and urgent care coverage

BlueCHiP for Medicare Group Prescription Drug Benefits

2020 Retail Pharmacy (30-Day Supply)

- Tier 1 – Generic: $8
- Tier 2 – Preferred brand: $24
- Tier 3 – Non-preferred brand: $52
- Tier 4 – Specialty: 25%

2020 Mail Order Pharmacy (90-Day Supply)

- Tier 1 – Generic: $0
- Tier 2 – Preferred brand: $60
- Tier 3 – Non-preferred brand: $130
- Tier 4 – Specialty: N/A

Note: No coverage through the coverage gap

Your pharmacy benefit: how it works!

Medicare Part D benefit stages

STAGE 1

INITIAL COVERAGE

The initial coverage limit is **$4,020**

STAGE 2

COVERAGE GAP

25% of the plan's costs for generic and brand name drugs

Coverage gap limit is **$6,350**

STAGE 3

CATASTROPHIC COVERAGE

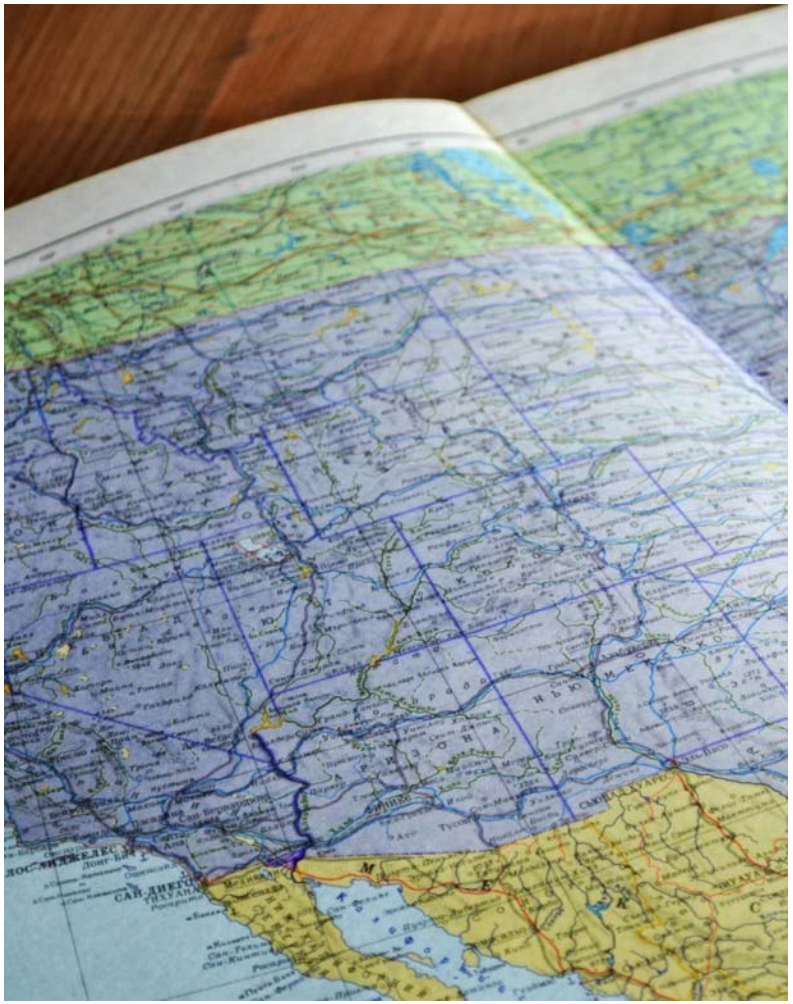
$3.60 copay for generic drugs and **$8.95** copay for brand name drugs or **5%** coinsurance, whichever is more

Group BlueCHiP for Medicare 2020 Benefits:

- **NEW!** Silver&Fit®: $0 national gym membership
- $0 copay for routine hearing and vision screenings
- $50 per quarter over-the-counter benefit
- Flat dollar outpatient hospital copay of $150
- Dental:
  - $1,500 annual benefit maximum
  - 2 cleanings per year
  - 80% for comprehensive dental services
- Eyewear allowance - $150 per year
- Wig coverage - $350 every 3 years

GROUP PLAN 65 BENEFITS

MEDICARE SUPPLEMENT



Group Plan 65

General Overview

- You have nationwide coverage:
  - Any doctor or facility that accepts Medicare is covered
- Group Plan 65 coverage follows Original Medicare
- Part D prescription drug coverage is available for an additional cost
- Emergency care outside the U.S.:
  - $250 deductible
  - You pay 20% after deductible during the first 60 days of each trip
  - $50,000 lifetime maximum

Group Plan 65

MEDICAL BENEFITS OVERVIEW	
PCP visits	**$0**
Specialist visits	**$0**
Hospitalization	**$0**
Home health services (Medicare-covered)	**$0**
Durable medical equipment	**$0**
Skilled nursing facility	**$0/day** for day(s) 1-20; **$170.50/day*** for day(s) 21-100; You pay all costs for days 101+
Diagnostic lab / X-ray services	**$0**

*This amount may change for 2020

GROUP BLUE MEDICARERX

PART D PRESCRIPTION DRUG COVERAGE

Group Blue MedicareRx

- Group Blue MedicareRx monthly premium: $209
  - No premium change from previous year
  - No deductible
- Group Blue MedicareRx includes standard Medicare Part D benefits
- Premium is billed directly (not through the City)
- You will receive your monthly premium invoice about 15 days prior to the month of coverage
- The due date will be the 1st of the month for each month of coverage (e.g., January 2020 premium invoice will be mailed mid-December and due January 1, 2020).
- Payment address is:
  Blue MedicareRx (PDP)
  P.O. Box 30016
  Pittsburgh, PA 15220-0330
- Separate prescription drug card

Group Blue MedicareRx: $10/$20 Plan

2020 Retail Pharmacy (30-Day Supply)

- Tier 1 – Generic: $10
- Tier 2 – Brand: $20
- Tier 2 – Specialty: $20

2020 Mail Order (90-Day Supply)

- Tier 1 – Generic: $10
- Tier 2 – Brand: $40
- Tier 2 – Specialty: N/A

After your yearly out-of-pocket drug costs reach $6,350, you pay greater of:

- $3.60 - generics or brands treated like generics
- $8.95 - all other drugs

THIS PLAN HAS UNLIMITED COVERAGE FOR PRESCRIPTION DRUGS

INDIVIDUAL BLUE MEDICARERX

PART D PRESCRIPTION DRUG COVERAGE

2020 Individual Blue MedicareRx Plans

Drug Tier	Blue MedicareRx Value Plus What you pay: $42.50 $435 deductible on Tiers 3, 4, and 5			Blue MedicareRx Premier What you pay: $128.00 $0 deducible		
Initial Coverage Level	A copayment or coinsurance for covered prescription drugs, until the annual cost of prescription drug expenses you pay and we pay reaches $4,020. Any deductible, copayments, or coinsurance you pay counts towards the $4,020.					
Supply	Network Retail Pharmacy 30-day supply		90-day Supply Mail Order	Network Retail Pharmacy 30-day supply		90-day Supply Mail Order
	Preferred Cost-Sharing	Standard Cost-Sharing		Preferred Cost-Sharing	Standard Cost-Sharing	
Tier 1: Preferred Generic Tier 2: Generic Tier 3: Preferred Brand Tier 4: Non-Preferred Tier 5: Specialty	Tier 1: $2 Tier 2: $8 Tier 3: $37 Tier 4: 40% Tier 5: 25%	Tier 1: $7 Tier 2: $19 Tier 3: $47 Tier 4: 50% Tier 5: 25%	Tier 1: $2 Tier 2: $16 Tier 3: $74 Tier 4: 40% Tier 5: N/A	Tier 1: $1 Tier 2: $7 Tier 3: $30 Tier 4: 35% Tier 5: 33%	Tier 1: $6 Tier 2: $12 Tier 3: $40 Tier 4: 45% Tier 5: 33%	Tier 1: $1 Tier 2: $14 Tier 3: $60 Tier 4: 35% Tier 5: N/A
Gap Coverage	After you reach the coverage gap, you pay 25% or the plan's cost for covered medications until your costs reach $6,350, which is the end of the coverage gap.			After you reach the coverage gap you receive continuous coverage for Tier 1 and 2 medications, and you pay 25% of the plan's cost for Tier 3, 4, and 5 medications until your costs reach $6,350, which is the end of the coverage gap.		
Catastrophic Coverage Level	After your yearly out-of-pocket drug costs reach $6,350, you pay the greater of 5% of the cost or a $3.60 copay for generic medications or a $8.95 copay for all other medications, whichever is greater.					

What to Expect After Enrolling

If you enroll in Group BlueCHiP for Medicare

You will receive:

- A letter saying how much your plan costs
  - It is NOT a bill—Medicare requires us to tell you, but the City actually pays the bill
- A plan member ID card
- A welcome kit of plan materials

If you enroll in Group Plan 65 and Blue MedicareRx

You will receive:

- Plan member ID cards
- A welcome kit of plan materials


LOCAL SUPPORT

Your Membership Provides You With Additional Services at No Additional Cost:

- Medicare Concierge Team: Great local service
- Your Blue Store℠ retail locations:
  - Weekly fitness and health-education classes (our most popular and well-attended member benefit!)
  - Nurses and dietitians on staff
  - Community service activities and events
  - Friendship and fun

Service as Close as Your Phone

Available 7 days a week

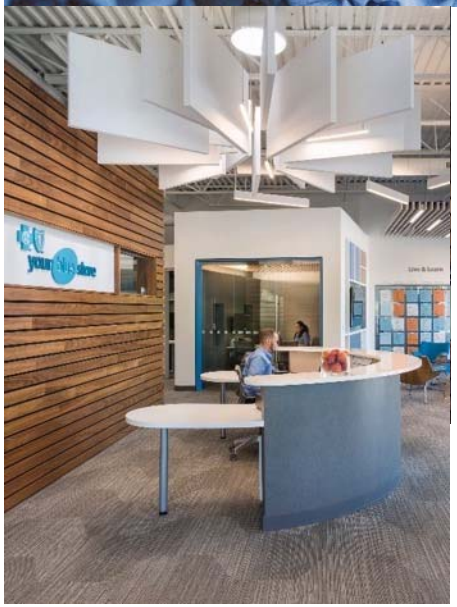
GROUP BLUECHiP FOR MEDICARE

You can speak with the Medicare Concierge team at:

1-800-267-0439

(TTY:711)

Hours: Monday through Friday, 8:00 a.m. to 8:00 p.m.; Saturday & Sunday, 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.



GROUP PLAN 65

You can speak with the Medicare Concierge team at:

1-800-267-0439

(TTY:711)

INDIVIDUAL BLUE MEDICARERX

(Prescription drug coverage)

You can speak with a Blue MedicareRx representative at:

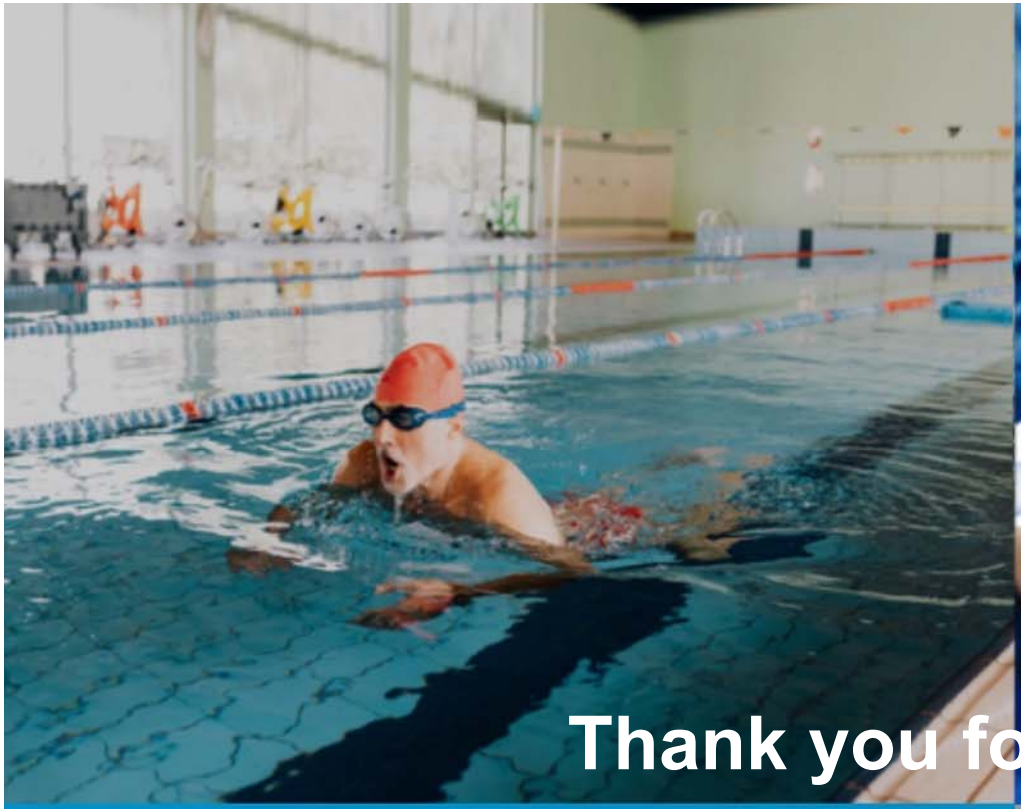
1-888-543-4917

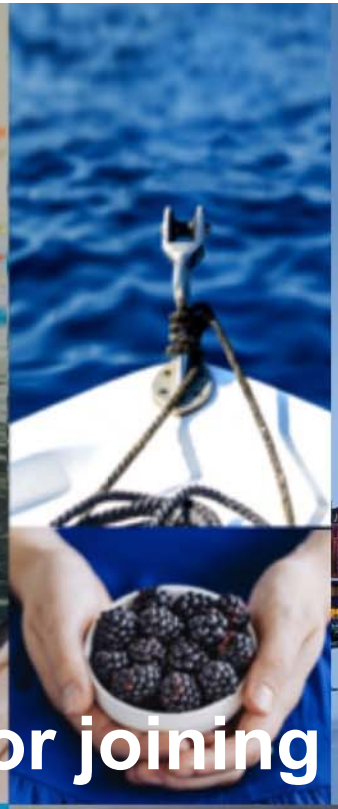
GROUP BLUE MEDICARERX

(Prescription drug coverage)

You can speak with a Group Blue MedicareRx representative at:

1-888-620-1748





Blue Cross Blue Shield of Rhode Island

Thank you for joining us!

For more plan information, please visit:
bcbsri.com/medicare.

H4152_2020COP_M **BMED-348884 10/19**

Group Plan65® Plan C without SNF

Blue Cross Blue Shield of Rhode Island

Our Group Plan 65 Plan C is a Medicare Supplement "Medigap" plan that picks up where Medicare leaves off, making it easier for you to budget your healthcare expenses. You can get care from Original Medicare-participating providers of your choice nationwide. This plan pays for Original Medicare's cost-sharing deductibles and coinsurance. It does not cover services beyond what Original Medicare provides, unless otherwise noted.

Benefit Features	With Original Medicare, you pay:	With Medicare and Group Plan 65 C, you pay:
Part A Services		
Hospitalization • First 60 days	$1,408 per benefit period	$0
• Days 61 - 90	$352 per day	
• Days 91 and after while using 60 lifetime reserve days	$704 per day	
• Once lifetime reserve days are used, an additional 365 days	All costs	
Skilled nursing facility care • First 20 days	$0	
• Days 21 - 100	$176 per day	Up to $176 per day
• Days 101 and after	All costs	All costs
Part B Services		
Part B excess charges	All costs	All costs
Immunizations & Screenings • Immunizations	$0	$0
• Bone mass measurement		
• Colorectal screening exams		
• Diabetes screening		
• Annual mammography screening		
• Pap tests and pelvic exams		
• Prostate cancer screening exams		
Lab services (Medicare-covered)		
Home health care (Medicare-covered)		
Hospice care	Medicare copay/coinsurance	
Office visits • Doctor visits	20% of Medicare-approved amounts after $198 annual deductible	
• Non-routine hearing services		
• Non-routine vision care		
• Non-routine podiatry services		
• Chiropractic services (limited)		
Emergency room	20% of Medicare-approved amounts after $198 annual deductible	$0
Outpatient surgery		
Diagnostic tests and X-rays		
Durable medical equipment and prosthetics		
Urgently needed care		
Ambulance services		
Foreign travel care	All costs	20% after $250 deductible[1]

1. $250 deductible is annual. There is a $50,000 lifetime maximum for the foreign travel care benefit.

Recent changes in federal law prohibit BCBSRI from offering Plan C to anyone who is eligible for Medicare on or after January 1, 2020. For more information about how this change may affect your employees, contact Mark Thomas at the number on the back of this page.

Enrolling in Group Plan65® C?

Contact Mark Thomas, Group Medicare Account Executive, at (401) 459-2409 for more information.

Already a Group Plan65® C Member?

Contact the Medicare Concierge team at 1-800-267-0439 (TTY: 711) for more information.

Hours: Monday through Friday, 8:00 a.m. to 8:00 p.m.; Saturday & Sunday, 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.

500 Exchange Street • Providence, RI 02903-2699 • bcbsri.com/medicare

IT'S WHAT WE LIVE FOR℠

Blue Cross Blue Shield of Rhode Island

12/19 PL65-385504.7721

Group Plan 65®
Member Enrollment Request Form

Blue Cross Blue Shield of Rhode Island

Please be sure to complete ALL information below to avoid delays in processing.

Section 1 - Employer Information (To be completed by plan administrator.)

Group Name	Effective Date _____/_____/_____ MM / DD / YYYY
Group #	Subgroup #

Section 2 - Please Provide Personal Information (Please Print)

☐ Mr. ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial

Birth Date _____/_____/_____ MM / DD / YYYY	Sex ☐ M ☐ F	Home Phone Number ( )	Cell Phone Number ( )

Social Security Number* ____-____-_____ XXX - XX - XXXX	Current BCBSRI ID (if applicable)	What is your primary language spoken?

Permanent Residence Street Address (P.O. Box is not allowed)

City	State	ZIP Code

Mailing Address (only if different from your Permanent Residence Street Address)

City	State	ZIP Code

Email Address

Section 3 - Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is Entitled To:	Effective Date:
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

You must have Medicare Part A and Part B to join a Medicare Supplement plan.

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/

Section 4 - Please Provide Your Current or Prior Insurance Information

What is the name of your current or prior health insurance carrier?	When will your medical coverage end? _____/_____/_____ MM / DD / YYYY
_____	Please attach a copy of your Certificate of Creditable Coverage showing the coverage end date, unless you are enrolled with BCBSRI or are new to Medicare Part B. **Application will not be processed until received.**

Section 5 - Eligibility

1. Are you transferring from an out-of-state Blue Cross Blue Shield plan? ☐ Yes ☐ No
   If yes, please include: the state, company name, and subscriber ID:
   State: _____
   Company Name: _____
   Subscriber ID: _____

2. Are you enrolled in another health insurance plan? ☐ Yes ☐ No
   If yes, please answer the following questions:
   Name of policy holder with other insurance: _____
   Relationship: _____
   Policy/contract number: _____
   Name of employer who offers this coverage: _____
   Address of employer who offers this coverage: _____
   Name of other insurance company: _____
   Address of other insurance company: _____

Section 6 - Please Read and Sign Below

By completing this enrollment application, I certify and agree that:

By signing this form, I certify the information is true and complete to the best of my knowledge.

Signature: _____ **Today's Date:** _____

Internal Use Only – To Be Completed by Agent

☐ New _____ ☐ TConv _____ ☐ Other: _____	
Sales Agent Signature (if assisted in enrollment)	Agent Received Date
Print Sales Agent Name	Broker ID#
	Effective Date of Coverage _____/_____/_____. (MM / DD / YYYY)

2020

BlueCHiP for Medicare

Group Plus (HMO) Summary of Benefits

Blue Cross Blue Shield of Rhode Island

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage" or visit us at www.bcbsri.com/medicare.

BlueCHiP for Medicare Group Plus (HMO): A Medicare Advantage Health Maintenance Organization (HMO) plan offered by Blue Cross & Blue Shield of Rhode Island with a Medicare contract. Enrollment in this plan depends on contract renewal.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan such as **BlueCHiP for Medicare Group Plus (HMO)**.

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **BlueCHiP for Medicare Group Plus (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or use the Medicare Plan Finder on www.medicare.gov.
- 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 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.

What this booklet tells you

- Things to know about **BlueCHiP for Medicare Group Plus (HMO)**
- Monthly premium, deductible, and limits on how much you pay for covered services
- Covered medical and hospital benefits
- Prescription drug benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-800-267-0439 (TTY: 711).

Este documento está disponible en otros formatos como sistema braille y en texto con letras grandes.

También puede estar disponible en otro idioma que no sea inglés. Para obtener información adicional, llámenos al 1-800-267-0439 (usuarios de TTY: 711).

Things to know about BlueCHiP for Medicare Group Plus (HMO)

Customer Service hours of operations

- October 1 - March 31, seven days a week, 8:00 a.m. to 8:00 p.m.
- April 1 - September 30, Monday through Friday, 8:00 a.m. to 8:00 p.m.; Saturday & Sunday, 8:00 a.m. to noon

  You can use our automated answering system outside of these hours.

BlueCHiP for Medicare Group Plus (HMO) phone numbers and website

- If you are a member of this plan, call (401) 277-2958 or 1-800-267-0439 (TTY: 711).
- If you are not a member of this plan, call (401) 351-2583 or 1-800-505-2583 (TTY: 711).
- Our website: www.bcbsri.com/medicare

Who can join?

To join **BlueCHiP for Medicare Group Plus (HMO)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes: Bristol, Kent, Newport, Providence, and Washington Counties in Rhode Island; all of Bristol County, Massachusetts; and the following ZIP codes in New London County, Connecticut: 06320, 06339, 06340, 06355, 06359, 06378, 06385, 06388.

Which doctors, hospitals, and pharmacies can I use?

BlueCHiP for Medicare Group Plus (HMO) has 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.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider & pharmacy listings on our website, bcbsri.org/FindDoctor.

Or call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers—and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

BlueCHiP for Medicare Group Plus (HMO) covers Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

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

How will I determine my drug costs?

BlueCHiP for Medicare Group Plus (HMO) groups each medication into one of four "tiers." You will need to use your formulary to locate what tier your drug is in to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Premiums and Benefits	BlueCHiP for Medicare Group Plus (HMO)
Monthly Plan Premium	$176 per month. You must continue to pay your Medicare Part B premium.
Annual Medical Deductible	This plan does not have a medical deductible.
Maximum Out-of-Pocket Amount (does not include prescription drugs)	$3,000 annually for services you receive from in-network providers.
Inpatient Hospital Coverage [1]	$250 copay per admission. This plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital Coverage	$150 copay per visit.
Doctor Office Visits: • Primary care	$0 PCMH or $10 non-PCMH copay per visit.
• Specialist	$30 copay per visit.
Preventive Care	$0. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$65 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 "Inpatient Hospital Coverage" (above) for other costs.
Urgently Needed Services	$40 copay per visit.
Diagnostic Services/Labs/Imaging: [1] • High-tech diagnostic radiology services (MRIs, CT scans, etc.)	$50 copay per visit.
• Lab services	$0.
• Outpatient X-rays and diagnostic tests and procedures	$0.
• Therapeutic radiology	$0.
Hearing Services: • Hearing exam - routine	$0. Limit one visit per year.
• Hearing exam - diagnostic/non-routine	$30 copay per visit.
• Hearing aid	Not covered.
Dental Services [1] • 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).
• Preventive	$0.
• Comprehensive	20% of the cost for covered services.
• Annual benefit maximum	$1,500 limit on all covered dental services for Preventive and Comprehensive Dental Services.

Premiums and Benefits	BlueCHiP for Medicare Group Plus (HMO)	
Vision Services: • Vision exam - routine	$0. Limit one visit per year.	
• Vision exam - diagnostic/non-routine	$30 copay per visit.	
• Vision eyewear	Our plan pays up to $150 every year for eyewear.	
Mental Health Services: (1) • Inpatient visit	• $250 copay per admission. This plan covers 90 days for an inpatient hospital stay.	
• Outpatient group/individual therapy visit	$0.	
Skilled Nursing Facility (SNF) (1)	• $0 per day for days 1-29; • $50 per day for days 30-100 • This 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, occupational therapy, and speech and language therapy visit	$0.	
Ambulance (1)	$50 copay per trip.	
Medicare Part B Drugs (1)	20% of the cost.	
Prescription Drug Benefits		
Stage 1: Annual Prescription Deductible	This plan does not have a prescription deductible.	
Stage 2: Initial Coverage	You pay the following until your total yearly drug costs reach $4,020. Total yearly drug costs are the total drug costs paid by both you and the Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	
	Retail Rx 30-day supply	**Mail Order 90-day supply**
Tier 1: Generic	$8 copay	$0 copay
Tier 2: Preferred brand	$24 copay	$60 copay
Tier 3: Non-preferred brand	$52 copay	$130 copay
Tier 4: Specialty	25% of the cost	N/A
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 the plan has paid and what you have paid) reaches $4,020. After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your costs reach $6,350 which is the end of the coverage gap. Not everyone will enter the coverage gap.	
	Retail Rx 30-day supply	**Mail Order 90-day supply**
Tier 1: Generic Tier 2: Preferred brand Tier 3: Non-preferred brand Tier 4: Specialty	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 $6,350, you pay the greater of: 5% of the cost, or $3.60 copay for generic (including brand drugs treated as generic) and $8.95 copay for all other drugs.	

Premiums and Benefits	BlueCHiP for Medicare Group Plus (HMO)
Additional Benefits	
Chiropractic Office Visits	$20 copay per visit.
Silver&Fit®	$0 per month.
Foot Care (podiatry services): • Foot exams and treatment	$30 copay per visit.
• Routine foot care for members with certain medical conditions	$30 copay per visit.
Medical Equipment/Supplies: • Durable medical equipment and prosthetics (1)	$0.
• Diabetes monitoring supplies (1)	$0. You must use OneTouch plan-designated monitors and test strips.
Virtual Doctor Visits (Telemedicine)	$0 PCMH or $10 non-PCMH copay per visit. Speak to a primary care provider using your computer or mobile device.
Outpatient Surgery/ Ambulatory Surgical Center (1)	$150 of the cost.
Over-the-counter (OTC) Benefit	$50 per quarter to use on approved health products.

(1) Prior Authorization may be required.

This information is not a complete description of benefits. Call the Medicare sales team at 1-800-505-BLUE (2583) (TTY: 711) for more information. Existing members can call the Medicare Concierge team at 1-800-267-0439 (TTY: 711).

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Blue Cross Blue Shield of Rhode Island

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12/19 BMED-334893•1377

Thank you for choosing Employer Medicare Advantage

Please tear off this card and insert between the pages when completing this enrollment form. Thank you.

<unique form ID>

Employer Group Medicare Advantage Enrollment Request Form

Please contact Blue Cross & Blue Shield of Rhode Island (BCBSRI) if you need information in another language or alternate format (large print*).

Section 1 - Please Provide Personal Information (Please Print)

Employer or Plan Sponsor Medicare Subgroup #: MCA_____			Effective Date _____/_____/_____ MM / DD / YYYY
☐ Mr. ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial
Birth Date _____/_____/_____ MM / DD / YYYY		Sex ☐ M ☐ F	
Home Phone Number ( )		Cell Phone Number ( )	
Permanent Residence Street Address (P.O. Box is not allowed)			
City	State	ZIP Code	
Mailing Address (only if different from your Permanent Residence Street Address)			
City	State	ZIP Code	
Primary Language			
Email Address			

Section 2 - Please Provide the Name of Your Primary Care Provider (PCP)

Last Name	First Name	
Address		
City	State	ZIP Code
Are you now seeing or have you recently seen this provider? ☐ Yes ☐ No	Phone ( )	

Section 3 - Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

  -OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is Entitled To:	Effective Date:
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

*Not all materials may be available in alternate formats.

**The effective date of enrollment will be the first of the month following the signature date, unless a future date is requested.

Section 4 - Please Read and Answer These Important Questions

1. Are you the retiree or employee of the plan sponsor (the "qualifying individual")? ☐ Yes ☐ No
   If you are a retiree of the plan sponsor please provide your retirement date (MM/DD/YYY)_____
   If you are not the qualifying individual, please provide their name: _____
2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
   If "yes", name of spouse: _____
   Name of dependents: _____
   Please note: If you are covering a spouse and/or dependent, they will need to submit a separate enrollment request form.
3. Do you or your spouse work? ☐ Yes ☐ No
4. Will the qualifying individual work for the plan sponsor while you are covered by this plan? ☐ Yes ☐ No
5. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No
   If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.
6. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs.
   Will you have other prescription drug coverage in addition to BlueCHiP for Medicare or HealthMate Coast-to-Coast for Medicare? ☐ Yes ☐ No
   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:
   Name of other coverage:_____
   ID # for this coverage:_____
7. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If "yes," please provide the following information:
   Name of institution:_____
   Address of institution:_____
   Phone number of institution:_____

To request future materials in Spanish or in large print, please contact the Medicare Concierge Team at 1-800-267-0439 (TTY users should call 711). Hours are October 1 – March 31, seven days a week, 8:00 a.m. to 8:00 p.m.; April 1 – September 30, Monday through Friday, 8:00 a.m. to 8:00 p.m.; Saturday & Sunday, 8:00 a.m. to noon. An automated answering system is available outside of these hours.

Section 5 – Please Read and Sign Below

By completing this enrollment application, I agree to the following:

BCBSRI contracts with the Federal government to offer two Medicare Advantage plans, BlueCHiP for Medicare and HealthMate for Medicare (each, individually, a "plan"). I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

Once I am a member of the plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from the plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

To obtain in-network coverage, I understand that beginning on the date my plan coverage begins, all services except for emergency or urgently needed services or out-of-area dialysis services must be obtained from providers participating in the network specific to the plan I have chosen. Services authorized by the plan and other services contained in my Evidence of Coverage document (also known as member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE PLAN WILL PAY FOR THE SERVICES**.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with the plan, he/she may be paid based on my enrollment in the plan.

Release of Information: By joining this Medicare Advantage plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that the plan will release my information including my prescription drug event data to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by the plan or from Medicare.

Signature: _____ **Today's Date:** _____

If you are the enrollee, please ensure you have signed above. If you are signing on behalf of the enrollee, please sign above AND complete the authorized representative section below.

Last Name	First Name	
Address		
City	State	ZIP Code
Relationship to Enrollee	Phone Number ( )	

Please keep the yellow copy for your own records. Thank you.

Internal Use Only – To Be Completed by Agent

☐ AEP ☐ ICEP ☐ IEP
☐ SEP ☐ OEPI (Institutionalized)
☐ Other SEP (SEP Reason): _____

Sales Agent Signature (if assisted in enrollment)	Agent Received Date
Print Sales Agent Name	Broker ID#
	Effective Date of Coverage _____/_____/_____. (MM / DD / YYYY)

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Blue Cross Blue Shield of Rhode Island

Post 65 Healthcare Rates

Medicare Eligible prior to 1/1/2020

Retiree Hired Before 7/1/2008

Plan	Monthly Cost	Annual Cost
Plan 65C *(No Rx or Dental)*	$0.00	$0.00
BlueCHiP *(Rx and Dental included, HMO network)*	$0.00	$0.00

Retiree Hired On or After 7/1/2008

Plan	Monthly Cost	Annual Cost
Plan 65C *(No Rx or Dental)*	$172.15	$2,065.80
BlueCHiP *(Rx and Dental included, HMO network)*	$176.00	$2,112.00

Spouse

Plan	Monthly Cost	Annual Cost
Plan 65C *(No Rx or Dental)*	$153.63	$1,843.56
BlueCHiP *(Rx and Dental included, HMO network)*	$176.00	$2,112.00