2021 Individual Medicare Plan Change Request Form

Section 1 - Please Provide Personal Information (Please Print)

Member Number

Last Name	First Name	Middle Initial (optional)

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 — P.O. box allowed)

City	State	ZIP Code

Billing Address (only if different from your Mailing Address)

City	State	ZIP Code

Home Phone Number ( )	Cell Phone Number ( )

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 ( )

*For all BlueCHiP for Medicare plans, you're required to select a primary care provider (PCP). If you're enrolled in our BlueCHiP for Medicare Advance plan, you must select a PCP from the BlueCHiP for Medicare Advance PCP network. If you do not select a PCP, BCBSRI may assign one for you. HealthMate for Medicare (PPO) does not require you to select a PCP.

Section 3 – Choose Your Medical Plan

(You only need to complete this section if you are changing your plan or adding BlueCHiP for Medicare Dental.)

I want to transfer from my current plan to the plan I have selected below. I understand that if this form is received by the end of any month, my new plan will generally be effective the first of the following month.

Plan Options: If you'd like to change your plan, check the box above your plan choice:	**Medical and Prescription Drug Plans**		
	☐ BlueCHiP for Medicare Advance (HMO)	☐ BlueCHiP for Medicare Value (HMO-POS)	☐ BlueCHiP for Medicare Standard with Drugs (HMO)
Monthly Premium:	$0	$0	$61
PCP Office Visit Copay:	$0	$0 PCMH/ $35 Non-PCMH	$0 PCMH/ $20 Non-PCMH
Specialist Office Visit Copay:	$35	$30	$35
Emergency Room Copay:	$90	$90	$90
Inpatient Hospital Copay:	$375 per day; Days 1-5	$360 per day; Days 1-5	$290 per day; Days 1-5
In-Network Out-of-Pocket Maximum:	$5,000	$5,000	$4,500
Prescription Drug Coverage:	$2/$9/$47/$100/29% Preferred Retail $10/$17/$47/$100/29% Standard Retail ($200 deductible for Tiers 3,4,5)	$0/$0/$47/$100/33% Preferred Retail $8/$16/$47/$100/33% Standard Retail (No deductible)	$1/$8/$47/$100/31% Preferred Retail $9/$16/$47/$100/31% Standard Retail ($100 deductible for Tiers 3,4,5)
Point-of-Service Out-of-Network Benefit:	Not Covered	20% coinsurance for most covered services	Not Covered
Point-of-Service Out-of-Pocket Maximum:		$5,000	
	Dental Benefits		
If you'd like to add the dental rider, check the applicable box to the right.	☐ I have the dental rider and want to keep it ☐ I do not have the dental rider and want to add it	Included in Medical Plan	Included in Medical Plan
Monthly Premium	$19.60	$0	$0
Calendar Year Coverage Limit	$1,000	$1,000	$1,500
Preventive Services	Covered at 100%	Covered at 100%	Covered at 100%
Comprehensive Services	Covered at 50%	Covered at 50%	Covered at 80%

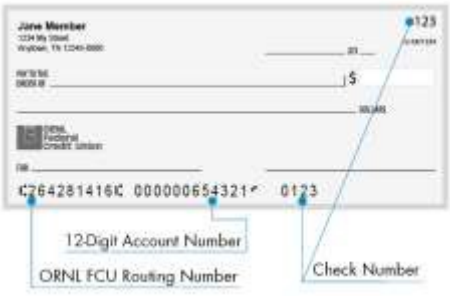
Medical and Prescription Drug Plans			Medical Only
☐ BlueCHiP for Medicare Extra (HMO-POS)	☐ BlueCHiP for Medicare Plus (HMO)	☐ BlueCHiP for Medicare Preferred (HMO-POS)	☐ BlueCHiP for Medicare Core (HMO)
$99	$161	$266	$0
$0 PCMH/ $10 Non-PCMH	$0 PCMH/ $5 Non-PCMH	$0 PCMH/ $5 Non-PCMH	$0 PCMH/ $5 Non-PCMH
$25	$25	$25	$25
$90	$75	$75	$90
$275 per day; Days 1-5	$190 per day; Days 1-5	$180 per day; Days 1-5	$180 per day; Days 1-5
$4,125	$2,800	$2,250	$3,500
$0/$4/$47/$100/33% Preferred Retail $8/$12/$47/$100/33% Standard Retail (No deductible)	$3/$6/$47/$100/33% Preferred Retail $11/$14/$47/$100/33% Standard Retail (No deductible)	$3/$6/$47/$100/33% Preferred Retail $11/$14/$47/$100/33% Standard Retail (No deductible) Tier 1 & 2 gap coverage	Not Covered
20% coinsurance for most covered services	Not Covered	20% coinsurance for most covered services	Not Covered
$5,000		$5,000	
Dental Benefits			
Included in Medical Plan	Included in Medical Plan	Included in Medical Plan	☐ I have the dental rider and want to keep it ☐ I do not have the dental rider and want to add it
$0	$0	$0	$19.60
$1,500	$1,500	$1,500	$1,000
Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Covered at 100%	Covered at 100%	Covered at 100%	Covered at 50%

Section 4 – Paying Your Plan Premium

For plans with a premium, you can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by selecting one of the options below. If you choose a plan without a premium, and we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how would prefer to pay it. You can choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month, quarterly, or you can choose one of the options below.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.



If you don't select a payment option, you will get a bill each month.

☐ Option 1 - Electronic funds transfer (EFT) from your bank account each month.

1. Fill out the information below:
   Account Holder Name: _____

   Bank Routing Number: _____

   Bank Account Number: _____

   Account Type: ☐ Checking ☐ Savings
2. Attach a voided check to this form. Write "VOID" on the blank check from the account you would like the EFT payments withdrawn from. Do NOT send a deposit slip, blank check, or canceled check.

☐ Option 2 - Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

The Social Security or RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

☐ Option 3 - Direct bill

Please select a premium payment option: ☐ Receive a bill monthly ☐ Receive a bill quarterly

Section 5 – Race/Ethnicity & Alternate Formats *(This section is optional)*

1. Select one if you want us to send you information in a language other than English.

   ☐ Spanish
   ☐ Portuguese

2. Select one if you want us to send you information in an accessible format.

   ☐ Large Print
   ☐ Braille
   ☐ Audio CD

3. What's your race? Select all that apply.

   ☐ White
   ☐ Asian Indian
   ☐ Japanese
   ☐ Other Asian
   ☐ Guamanian or Chamorro
   ☐ Black or African American
   ☐ Chinese
   ☐ Korean
   ☐ Native Hawaiian
   ☐ Other Pacific Islander
   ☐ American Indian or Alaska Native
   ☐ Filipino
   ☐ Vietnamese
   ☐ Samoan
   ☐ Portuguese

4. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

   ☐ No, not of Hispanic, Latino/a, or Spanish origin
   ☐ Yes, Puerto Rican
   ☐ Yes, another Hispanic, Latino, or Spanish origin
   ☐ Yes, Mexican, Mexican American, Chicano/a
   ☐ Yes, Cuban

   ☐ I choose not to answer

Section 6 – Please Sign Below

Call the Medicare Concierge team at 1-800-267-0439 (TTY users should call 711), seven days a week from October 1 to March 31, 8:00 a.m. to 8:00 p.m. From April 1 to September 30, you can call Monday through Friday, from 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.

I want to transfer my current plan to the plan I have selected on this form. I understand that if I make the change as part of the Medicare Annual Enrollment Period and I don't have a Special Election, my new plan will be effective on January 1, 2021. If I do have a Special Election, and if this form is received by the end of any month, my new plan will generally be effective on the first of the following month.

Signature: _____ Today's Date: _____

If you are the member, please ensure you have signed above.

If you are signing on behalf of the member, please sign above AND complete the authorized representative section below.

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

Please mail this form to:
Blue Cross & Blue Shield of Rhode Island
Attn: Medicare Membership Department
500 Exchange Street
Providence, RI 02903-2699

Internal Use Only – To Be Completed by Agent

☐ AEP ☐ SEP ☐ SEP (County Change) ☐ OEP ☐ OEPI (Institutionalized)	
Sales Agent Signature (if assisted in enrollment)	Agent Received Date
Print Sales Agent Name	Broker ID#
Effective Date of Plan Change_____/_____/_____(MM / DD / YYYY)	

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

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