BlueCHiP for Medicare
2018 Plan Change Request Form

Please contact BlueCHiP for Medicare if you need information in another language or alternate format (large print*).

Section 1 - Please Provide Personal Information (Please Print)

Member Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Last Name	First Name	Middle Initial

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

Billing Address (only if different from your Mailing Address)

City	State	ZIP Code

Home Phone Number ( )	Cell Phone Number ( )	Alternate Phone Number ( )

Email Address

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

Last Name	First Name

Address

City	State	ZIP Code

Are you now seeing or have you recently seen this doctor? ☐ Yes ☐ No	Phone ( )

*Not all materials may be available in alternate formats.
**For all BlueCHiP for Medicare plans, you're required to select a primary care physician (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 will assign one for you.

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.)

Plan Options: If you'd like to change your plan, check the box next to 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	$23; $33 Newport County Only*	$58
PCP Office Visit Copayment:	$10	$5 PCMH/ $35 Non-PCMH	$0 PCMH/ $20 Non-PCMH
Specialist Office Visit Copayment:	$45	$50	$40
Emergency Room Copayment:	$75	$75	$75
Inpatient Hospital Copayment:	$360 per day; Days 1-5	$360 per day; Days 1-5	$290 per day; Days 1-5
In-Network Out-of-Pocket Maximum:	$5,100	$5,900	$4,500
Prescription Drug Coverage:	$1/$8/$47/$100/29% Preferred Retail $9/$16/$47/$100/29% Standard Retail ($200 deductible for Tiers 3,4,5)	$1/$8/$47/$100/27% Preferred Retail $9/$16/$47/$100/27% Standard Retail ($290 deductible for Tiers 3,4,5)	$3/$7/$47/$100/31% Preferred Retail $11/$15/$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:		$10,000	

*Newport County Zip Codes: 02801, 02835, 02837, 02840, 02841, 02842, 02871, 02878

Medical and Prescription Drug Plans			Medical Plan Only
☐ BlueCHiP for Medicare Extra (HMO-POS)	☐ BlueCHiP for Medicare Plus HMO)	☐ BlueCHiP for Medicare Preferred (HMO-POS)	☐ BlueCHiP for Medicare Core (HMO)
$97	$168	$257	$0
$0 PCMH/ $10 Non-PCMH	$0 PCMH/ $5 Non-PCMH	$0 PCMH/ $5 Non-PCMH	$0 PCMH/ $10 Non-PCMH
$35	$30	$30	$40
$75	$65	$65	$75
$275 per day; Days 1-5	$190 per day; Days 1-5	$180 per day; Days 1-5	$180 per day; Days 1-5
$3,750	$2,800	$2,250	$3,950
$0/$5/$47/$100/29% Preferred Retail $8/$13/$47/$100/29% Standard Retail ($200 deductible for Tiers 3,4,5)	$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
$10,000		$5,000	

Section 4 — Choose Your Optional Supplemental Benefits	BlueCHiP for Medicare Dental
If you'd like to add the dental rider, check the box to the right.	☐
Monthly Premium	$22.70
Calendar Year Coverage Limit	$1,000
Annual exam, cleanings, & X-rays	Covered at 100%
Basic Services: Fillings, palliative treatment, repairs to existing partial or complete dentures, simple extractions	50%
Major Restorative Services: Crowns over natural teeth, build ups, posts and cores, surgical periodontal services, prosthodontics (bridges, implants, dentures), root canals, oral surgery	Not Covered

Please see your Evidence of Coverage (EOC) for full benefit details on the optional BlueCHiP for Medicare Dental plan.

Section 5 – Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) using any of the payment 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 co-insurance. 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 this 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.

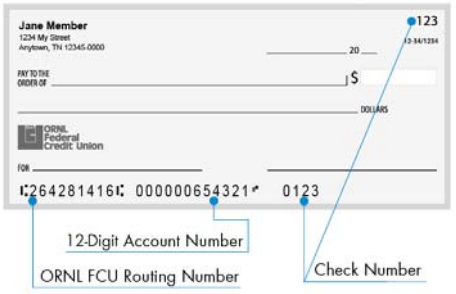
☐ Option 1 - Electronic Funds Transfer (EFT) from your bank account each month.

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

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (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 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 February 14, 8:00 a.m. to 8:00 p.m. From February 15 to September 30, you can call Monday through Friday, from 8:00 a.m. to 8:00 p.m. On Saturday and Sunday, call from 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, 2018. 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 ( )	

Internal Use Only – To Be Completed by Agent

☐ AEP ☐ SEP ☐ SEP (County Change) ☐ 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)	

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

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

Blue Cross Blue Shield of Rhode Island

07/17 BMED-175076.1329

H4152_2018planchngform Approved