

2027 Plan Selection Form



Section 1 – Personal Information (Please Print)

Member ID

Last Name

First Name

Middle Initial (optional)

Has your address changed recently? ☐ No ☐ Yes (If yes, please write the new address below):

Section 2 – Medicaid Information (Required for BlueRI for Duals Members Only)

To confirm your eligibility for Medicaid coverage, the information below is **required** to process your plan selection form:

Social Security Number

Are you experiencing housing insecurity or homelessness? ☐ No ☐ Yes

Please use your Rhode Island **Medicaid** “Anchor” Card to fill out this section:

Name (as it appears on your Medicaid card): _____

Medicaid ID number (MID): _____

Section 3 – Choose Your Medical Plan⁽¹⁾

Plan Options: To change your plan, check the box of your plan choice	Medical and Prescription Drug Plans		
	☐ BlueCHiP for Medicare Essential (HMO-POS)	☐ BlueCHiP for Medicare Enhanced (HMO-POS)	☐ BlueCHiP for Medicare Extra (HMO-POS)
Monthly Premium	\$0	\$39	\$159
PCP Office Visit	\$0	\$0	\$0
Specialist Office Visit	\$0-\$50	\$0-\$40	\$0-\$35
Emergency Room	\$130	\$130	\$130
Inpatient Hospital	\$458 per day, days 1-6	\$400 per day, days 1-6	\$325 per day, days 1-6
Out-of-Pocket Maximum (In-Network)	\$6,750	\$6,750	\$6,000
Out-of-Network Point-of- Service (POS) Benefit	40% coinsurance for most covered services	30% coinsurance for most covered services	20% coinsurance for most covered services

Section 3 – Choose Your Medical Plan⁽¹⁾ (Continued)

Plan Options: To change your plan, check the box of your plan choice	☐ BlueRI for Duals (HMO D-SNP)	☐ BlueCHiP for Medicare Access (HMO-POS)	☐ BlueCHiP for Medicare Core (HMO)
Monthly Premium	\$0	\$31.30/\$0 ⁽²⁾	\$0
PCP Office Visit	\$0	\$0	\$0
Specialist Office Visit	\$0	\$0-\$35 ⁽³⁾	\$0-\$30
Emergency Room	\$0	\$130	\$130
Inpatient Hospital	\$0	\$400/\$150 ⁽³⁾ per day, days 1-6	\$275 per day, days 1-6
Out-of-Pocket Maximum (In-Network)	\$9,850	\$6,000	\$5,000
Out-of-Network Point-of- Service (POS) Benefit	Not Covered	20% coinsurance for most covered services	Not Covered

⁽¹⁾ Please see your Evidence of Coverage (EOC) for full benefit details.

⁽²⁾ Premium displayed is for members who qualify for Extra Help, also known as Low-Income Subsidy

⁽³⁾ You may be eligible for lower cost sharing, which is part of Special Supplemental Benefits for the Chronically Ill (SSBCI) if you are living with one or more qualifying chronic condition(s), as defined by CMS, including but not limited to chronic heart failure, chronic lung diseases, dementia, diabetes mellitus, and frailty & fall risk, you receive a Low-Income Subsidy (also called Extra Help), and have selected a High Value Provider as your Primary Care Provider. Receiving this benefit is not solely determined by your condition(s); all relevant eligibility criteria must be satisfied before benefit is available for use. Please see your Evidence of Coverage for full details.

Section 4 – Alternate Formats

We are asking for this **optional** information to help us better understand our members' needs. Your responses or choice not to respond will not affect your benefits, coverage, or costs.

1. We try to accommodate a member's preferred language to receive BCBSRI correspondence when possible.
Do you have a preferred 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 ☐ Data CD
3. Would you like to receive the following materials electronically as they become available?
☐ Plan material (e.g. Medical Explanation of Benefits, Annual Notice of Change, Premium Invoice)

Email Address: _____

Cellphone (text communications only): _____

Section 5 – Payment Options

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail, Electronic Funds Transfer (EFT), credit card, or check each month or quarterly. You can also choose to pay by automatic deduction from your Social Security or Railroad Retirement Board Check each month.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance.

Additionally, those who qualify will not be subject to 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 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048.

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

If you don't select a new payment option, or cancel your current selection, your existing payment method will remain in effect. If you do not have a payment option on file, you will continue to receive a monthly bill.

☐ 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



☐ 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 monthly bill ☐ Receive a quarterly bill

Section 6 – Please Sign Below

I want to transfer from my current plan to the plan I have selected on this form. I understand that if I make a change during the Medicare Annual Enrollment Period, my plan will be effective January 1, 2027. If this form is received by the end of any month, my new plan will generally be effective the 1st of the following month.

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

If you are the authorized representative, you must sign above AND provide the following information below:

Last Name	First Name
Address	
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

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form

Signature (if assisted in enrollment)		Received Date
Print Name	Broker ID#	Broker/Agent National Producer Number (NPN)
Effective Date of Coverage ____/____/____ MM / DD / YYYY	Relationship to Member	
☐ AEP	☐ SEP	☐ OEP
☐ OEPI (Institutionalized)		

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