

Dear Member:

Thank you for your recent inquiry into the other Medicare Advantage plans we offer in your area. Once you have chosen your new plan, please complete the enclosed plan selection form and return it to us in the postage paid envelope by December 7, 2011. If we receive your completed selection form by December 7, 2011, your new benefit plan will begin January 1, 2012. **If you decide you want to stay in the plan you have – you do not need to do anything.**

To make a change in the Medicare Advantage plan you have with Priority Health, fill out the enclosed plan selection form to make your choice. Check off the plan you want, and sign the form. Then mail the completed form back to us in the postage-paid envelope by December 7, 2011.

Please be aware that you can change health plans only at certain times during the year. Between October 15th and December 7th each year, anyone can join our plan. In addition, from January 1 through February 14, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same time. Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join in your area with a 5-star rating, or qualify for extra help paying for prescription drug coverage.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

If you select another plan and we receive your completed selection form by December 7, 2011, your new benefit plan will begin in January 2012. Your monthly plan premium will be \$0 - \$119 and you may continue to see any Priority Health Medicare name primary care doctors and specialists.

Complete the attached form only if you wish to change plans.

To help you with your decision, we have also included 2012 Summary of Benefits for the available options.

If you have any questions, please call Priority Health at toll-free at 888 389-6648. TTY users should call 711. We are open 8 a.m. - 8 p.m., 7 days a week. You can also visit us online at prioritymedicare.com to find additional plan information or to access tools and resources that can help make your life a little easier. Thank you.

Sincerely,

Medicare Sales Department

H2320_2000_2038_5 CMS approved 09222011

Priority Health Medicare Plan Selection Form



PriorityMedicare ValueSM (HMO-POS)

PriorityMedicareSM (HMO-POS)

Last name	First name	M.I.	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Member number		Date	

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 1st of the following month.

Please check the appropriate box below:

<input type="checkbox"/> PriorityMedicare Value	<ul style="list-style-type: none"> • \$15 doctor visits and physicals • \$40 specialist visits • \$600 for each Medicare-covered hospital stay • \$65 worldwide emergency and \$40 urgent care • \$3,400 maximum out of pocket limit every year (in-network)
<input type="checkbox"/> PriorityMedicare	<ul style="list-style-type: none"> • \$10 doctor visits and physicals • \$30 specialist visits • \$75 each day for day(s) 1-5, \$0 for additional hospital days • \$65 worldwide emergency and \$40 urgent care • \$3,400 maximum out of pocket limit every year (in-network)

Your plan premium

You can pay your monthly plan premium, if you have one, (including any late enrollment penalty you have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium 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 pay for 75% or more of 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 this 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/TTD 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 payment option, you will receive a bill each month.

Please select a premium payment option:

- Receive a bill monthly.
- Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check.
- Automatic deduction from your monthly Social Security or 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.)
- Please check the box if you would prefer us to send you information in another format (like Braille, audio tape or large print), and contact Priority Health Medicare toll-free at 888 389-6648 (TTY users should call 711), 8 a.m. - 8 p.m., 7 days a week.

Your signature: _____ Today's date: ____/____/____

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

Name : _____

Address: _____

Phone number: () _____ Relationship to enrollee: _____

Please mail this form to:

Priority Health Medicare
MS 1175
1231 East Beltline NE
Grand Rapids, MI 49502-0472