

2012 PLAN OPTION CHANGE FORM



CARE IMPROVEMENT PLUS
Specialized Care for Medicare Beneficiaries

Please Provide the Following Information:

First Name:	Last Name:	MI:
Date:	Member ID Number:	

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 Provide the Following Information:

	CSNP (Chronic Conditions)	DSNP (Full Medicaid)	MAPD
RPPO	<input type="checkbox"/> Silver Rx \$33.60 per month Annual out-of-pocket maximum: \$6,700 Inpatient Hospital: In 2011 the deductible for each benefit period was \$1,132 Days 1-60: \$0 Days 61-90: \$283 per day Days 91-150: \$566 per lifetime reserve day These amounts will change in 2012. Primary Care Physician Visit: 20% coinsurance Specialist Visit: 20% coinsurance Cost sharing for Medicare-covered services is generally paid for those who have full Medicaid <hr/> <input type="checkbox"/> Gold Rx \$0 per month Annual out-of-pocket maximum: \$6,700 Inpatient Hospital: NO deductible Days 1-15: \$165 Days 16-90: \$0 Days 91-150: \$0 Primary Care Physician Visit: \$30 copayment Specialist Visit: \$50 copayment	<input type="checkbox"/> Dual Advantage \$0 per month Annual out-of-pocket maximum: \$6,700 Inpatient Hospital: NO deductible Days 1-15: \$0 Days 16-90: \$0 Days 91-150: \$0 Primary Care Physician Visit: \$0 copayment Specialist Visit: \$0 copayment	<input type="checkbox"/> Medicare Advantage \$70 per month Annual out-of-pocket maximum: \$6,700 Inpatient Hospital: NO deductible Days 1-15: \$175 Days 16-90: \$0 Days 91-150: \$0 Primary Care Physician Visit: \$35 copayment Specialist Visit: \$50 copayment

Please Provide the Following Information:

	CSNP (Chronic Conditions)	DSNP (Full Medicaid)	MAPD
LPPO (select counties)	<input type="checkbox"/> Silver Rx Georgia \$31.20 per month Annual out-of-pocket maximum: \$6,700 Inpatient Hospital: In 2011 the deductible for each benefit period was \$1,132 Days 1-60: \$0 Days 61-90: \$283 per day Days 91-150: \$566 per lifetime reserve day These amounts will change in 2012. Primary Care Physician Visit: 20% coinsurance Specialist Visit: 20% coinsurance Cost sharing for Medicare- covered services is generally paid for those who have full Medicaid	<input type="checkbox"/> Dual Advantage Georgia \$0 per month Annual out-of-pocket maximum: \$6,700 Inpatient Hospital: NO deductible Days 1-15: \$0 Days 16-90: \$0 Days 91-150: \$0 per lifetime reserve day Primary Care Physician Visit: \$0 copayment Specialist Visit: \$0 copayment	<input type="checkbox"/> Medicare Advantage Georgia \$38 per month Annual out-of-pocket maximum: \$6,700 Inpatient Hospital: NO deductible Days 1-15: \$175 Days 16-90: \$0 Days 91-150: \$0 per lifetime reserve day Primary Care Physician Visit: \$35 copayment Specialist Visit: \$50 copayment
	<input type="checkbox"/> Gold Rx Georgia \$0 per month Annual out-of-pocket maximum: \$6,700 Inpatient Hospital: NO deductible Days 1-15: \$175 Days 16-90: \$0 Days 91-150: \$0 per lifetime reserve day Primary Care Physician Visit: \$30 copayment Specialist Visit: \$50 copayment	<input type="checkbox"/> Dual Advantage South Carolina \$0 per month Annual out-of-pocket maximum: \$6,700 Inpatient Hospital: NO deductible Days 1-15: \$0 Days 16-90: \$0 Days 91-150: \$0 per lifetime reserve day Primary Care Physician Visit: \$0 copayment Specialist Visit: \$0 copayment	<input type="checkbox"/> Medicare Advantage South Carolina \$42 per month Annual out-of-pocket maximum: \$6,700 Inpatient Hospital: NO deductible Days 1-15: \$175 Days 16-90: \$0 Days 91-150: \$0 per lifetime reserve day Primary Care Physician Visit: \$35 copayment Specialist Visit: \$50 copayment

Please Provide the Following Information:

	CSNP (Chronic Conditions)	DSNP (Full Medicaid)	MAPD
LPPO (select counties)	<p><input type="checkbox"/> Silver Rx South Carolina \$36.20 per month</p> <p>Annual out-of-pocket maximum: \$6,700</p> <p>Inpatient Hospital: In 2011 the deductible for each benefit period was \$1,132</p> <p>Days 1-60: \$0</p> <p>Days 61-90: \$283 per day</p> <p>Days 91-150: \$566 per lifetime reserve day</p> <p>These amounts will change in 2012.</p> <p>Primary Care Physician Visit: 20% coinsurance</p> <p>Specialist Visit: 20% coinsurance</p> <p>Cost sharing for Medicare-covered services is generally paid for those who have full Medicaid</p> <hr/> <p><input type="checkbox"/> Gold Rx South Carolina \$0 per month</p> <p>Annual out-of-pocket maximum: \$6,700</p> <p>Inpatient Hospital: NO deductible</p> <p>Days 1-15: \$175</p> <p>Days 16-90: \$0</p> <p>Days 91-150: \$0 per lifetime reserve day</p> <p>Primary Care Physician Visit: \$30 copayment</p> <p>Specialist Visit: \$50 copayment</p>		

Paying Your Plan Premium

If we determine that you owe a late enrollment penalty, or if you currently have a late enrollment penalty, we need to know how you would prefer to pay it. If you have a monthly premium (including any late enrollment penalty that you currently have or may owe), you can pay by mail or Electronic Funds Transfer (EFT). You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. **DO NOT** pay Care Improvement Plus the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay 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 part of this premium, we will bill you for the amount that Medicare doesn't cover.

Please indicate your choice of billing (select only one billing method):

Automatic deduction of funds from your bank account each month. Please enclose a VOIDED check or a savings deposit ticket and provide the following:

Account holder name: _____

Bank routing number: _____ Bank account number: _____

Account type: Checking Savings

Monthly paper statement bill

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/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.)

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

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format: Other: _____

Please contact Care Improvement Plus at 1-800-204-1002 (TTY users should call 711) if you need information in another format or language than what is listed above. A representative is available to help you 7 days a week, 8:00 am – 8:00 pm.

Signature: _____ Today's Date: _____

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

Name: _____

Address: _____

Phone Number: _____

Relationship to Enrollee: _____

Please mail this form to: Care Improvement Plus
P.O. Box 691350
San Antonio, TX 78269-1350

Fax number: 1-866-686-2508

Licensed Agent Use Only: Licensed Agent Name (print): _____

Licensed Agent ID #: _____ Date: _____

ICEP/IEP AEP SEP (type): _____

Requested effective date of coverage: _____