



Disenrollment Rights and Responsibilities

Voluntary Disenrollment

You can change your plan from October 15 through December 7 each year. You can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year at that time. Generally, you may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as if you move out of the plan's service area.

Medicare Advantage plan members have the opportunity to make *one* change to their health coverage during the annual Medicare Advantage Disenrollment Period. This happens every year from January 1 to February 14. During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods. However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. (Contact Customer Service if you need more information on how to do this.)
- --or-- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

In certain situations, members may be eligible to end their membership at other times of the year.

If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- If you have moved out of your plan's service area.
- If you have Medicaid.
- If you are eligible for Extra Help with paying for your Medicare prescriptions.



People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, 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 won't have a coverage gap or a late enrollment penalty. Many people qualify 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 will be changing to Original Medicare you might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right.

Federal law requires the protections described above. Your State may have laws that provide more Medigap protections. If you have questions about Medigap or Medigap rights in your State, you should contact your State Health Insurance Program. You can also call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information. TTY users should call 1-877-486-2048.

Involuntary Disenrollment

The plan must end your membership if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A or Part B (or both).
- If you move out of our service area for more than 6 months for Medicare Advantage plans and 12 months for standalone Prescription Drug plans.
 - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan.



- We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get prescription drugs.
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for two full calendar months.
 - We must notify you in writing that you have two months to pay the plan premium before we end your membership.
- If you do not get “Extra Help” and you do not pay your premium.

Potential for Contract Termination or Plan Non-Renewal

What are my protections in this plan if the plan contract is terminated by Medicare or the plan does not renew its contract?

Medicare Advantage Plans

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

Prescription Drug Plans & Medicare Advantage Plans featuring Prescription Drug Coverage

The Center for Medicare and Medicaid Services (“CMS”) must periodically terminate (either through mutual agreement or at its own initiative to protect beneficiaries) an organization’s contract. When this occurs, CMS’ primary concern is to protect the impacted beneficiaries. Any actions which may be taken are done so to consider beneficiary choice while recognizing that a situation may compel CMS to assign a member to another plan. When we or CMS make an assignment, we aim to move beneficiaries to a plan in which their best interests are primary. CMS will implement a beneficiary transition plan based upon the particular circumstances involved and local conditions, so the elements of these plans can vary. However, all beneficiary transition plans will follow these guiding principles:

- **Beneficiary Choice:** Members of terminating plans will be afforded a special election period (SEP) during which they may choose to join a new plan available in their service area.



- **Beneficiary Education:** Terminating sponsors must send a notice to members that informs them of the termination and includes a full discussion of their rights under the transition (including special election periods when appropriate) and information on other available plans in the service area. CMS may also require the terminating plan to take one or more of the following steps: conduct media advertising & outreach; issue notices to providers, outreach community organizations, and state and local governments; and conduct additional mailings or phone calls to impacted members.
- **Assuring Continuity of Care:** If the sponsor of a terminated plan does not make an alternate election for members, or the need for immediate termination does not allow time for members to make an advance election; CMS will establish a default option where CMS will move those members to another plan. In such circumstances, CMS will select a sponsor that:
 1. Operates in the same service area as the terminating plan;
 2. Has a plan product similar to that of the terminating plan (benefits, cost sharing, premiums, and formulary);
 3. Has the capacity to absorb additional members;
 4. Has a compliance and performance history that gives CMS confidence that the selected sponsor can serve the potential new members.
 5. Agrees to and signs terms and conditions with respect to how it will conduct the transition, including strict requirements around promoting beneficiary choice, conducting beneficiary education, and administering the CMS-approved formulary transition period for affected members.

A Coordinated Care plan with a Medicare Advantage contract and a Medicare-approved Part D sponsor.