

























































































































































































































































































































































































---

## **Chapter 10. Ending your membership in the plan**

<b>SECTION 1</b>	<b>Introduction.....</b>	<b>186</b>
Section 1.1	This chapter focuses on ending your membership in our plan .....	186
<b>SECTION 2</b>	<b>When can you end your membership in our plan?.....</b>	<b>186</b>
Section 2.1	You can end your membership at any time .....	186
Section 2.2	Where can you get more information about when you can end your membership? .....	187
<b>SECTION 3</b>	<b>How do you end your membership in our plan?.....</b>	<b>187</b>
Section 3.1	Usually, you end your membership by enrolling in another plan.....	187
<b>SECTION 4</b>	<b>Until your membership ends, you must keep getting your medical services and drugs through our plan.....</b>	<b>189</b>
Section 4.1	Until your membership ends, you are still a member of our plan.....	189
<b>SECTION 5</b>	<b>Medicare Choice HMO SNP must end your membership in the plan in certain situations .....</b>	<b>189</b>
Section 5.1	When must we end your membership in the plan? .....	189
Section 5.2	We <u>cannot</u> ask you to leave our plan for any reason related to your health.....	190
Section 5.3	You have the right to make a complaint if we end your membership in our plan .....	191

---

## SECTION 1 Introduction

---

<b>Section 1.1</b>	<b>This chapter focuses on ending your membership in our plan</b>
--------------------	---

Ending your membership in Medicare Choice HMO SNP may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
  - You can end your membership in the plan at any time. Section 2 tells you about the types of plans you can enroll in and when your enrollment in your new coverage will begin.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

---

## SECTION 2 When can you end your membership in our plan?

---

<b>Section 2.1</b>	<b>You can end your membership at any time</b>
--------------------	--

You can end your membership in Medicare Choice HMO SNP at any time.

- **When can you end your membership?** Most people with Medicare can end their membership only during certain times of the year. However, because you get assistance from Medicaid, **you can end your membership in Medicare Choice HMO SNP at any time.**
- **What type of plan can you switch to?** If you decide to change to a new plan, you can choose any of the following types of Medicare plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.

- If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

**Note:** If you disenroll from Medicare prescription drug coverage and go without “creditable” prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

Contact your State Medicaid Office to learn about your Medicaid plan options (telephone numbers are in Chapter 2, Section 6 of this booklet).

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

<b>Section 2.2</b>	<b>Where can you get more information about when you can end your membership?</b>
--------------------	---

If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can find the information in the *Medicare & You 2012* Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

---

## **SECTION 3**      **How do you end your membership in our plan?**

---

<b>Section 3.1</b>	<b>Usually, you end your membership by enrolling in another plan</b>
--------------------	--

Usually, to end your membership in our plan, you simply enroll in another Medicare plan. However, if you want to switch from our plan to Original Medicare but you have not selected a separate 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 Member Services 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, 7 days a week. TTY users should call 1-877-486-2048.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"> <li>• Another Medicare health plan.</li> </ul>	<ul style="list-style-type: none"> <li>• Enroll in the new Medicare health plan.  You will automatically be disenrolled from Medicare Choice HMO SNP when your new plan’s coverage begins.</li> </ul>
<ul style="list-style-type: none"> <li>• Original Medicare <i>with</i> a separate Medicare prescription drug plan.</li> </ul>	<ul style="list-style-type: none"> <li>• Enroll in the new Medicare prescription drug plan.  You will automatically be disenrolled from Medicare Choice HMO SNP when your new plan’s coverage begins.</li> </ul>
<ul style="list-style-type: none"> <li>• Original Medicare <i>without</i> a separate Medicare prescription drug plan.                         <ul style="list-style-type: none"> <li>○ If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.</li> <li>○ If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Send us a written request to disenroll.</b> Contact Member Services if you need more information on how to do this (phone numbers are on the back cover of this booklet).</li> <li>• You can also contact <b>Medicare</b>, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.</li> <li>• You will be disenrolled from Medicare Choice HMO SNP when your coverage in Original Medicare begins.</li> </ul>

**If you would like to switch from our plan to:**

**This is what you should do:**

pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 6, Section 10 for more information about the late enrollment penalty.

---

## **SECTION 4      Until your membership ends, you must keep getting your medical services and drugs through our plan**

---

<b>Section 4.1      Until your membership ends, you are still a member of our plan</b>
--

If you leave Medicare Choice HMO SNP, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

---

## **SECTION 5      Medicare Choice HMO SNP must end your membership in the plan in certain situations**

---

<b>Section 5.1      When must we end your membership in the plan?</b>
---

**Medicare Choice HMO SNP must end your membership in the plan if any of the following happen:**

- If you do not stay continuously enrolled in Medicare Part A and Part B.

- If you are no longer eligible for Medicaid. As stated in Chapter 1, section 2.1, our plan is for people who are eligible for both Medicare and Medicaid.
- If you move out of our service area for more than six months.
  - If you move or take a long trip, you need to call Member Services 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 medical 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 medical care.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

### Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are on the back cover of this booklet).

<b>Section 5.2</b> <b>We <u>cannot</u> ask you to leave our plan for any reason related to your health</b>
--

### What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

---

<b>Section 5.3</b>	<b>You have the right to make a complaint if we end your membership in our plan</b>
--------------------	---

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 11 for information about how to make a complaint.

---

**Chapter 11. Legal notices**

**SECTION 1 Notice about Governing Law ..... 193**

**SECTION 2 Notice about Nondiscrimination..... 193**

**SECTION 3 Notice about Third Party Liability.....233**

---

## **SECTION 1 Notice about governing law**

---

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

---

## **SECTION 2 Notice about nondiscrimination**

---

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

---

## **SECTION 3 Notice about Third Party Liability**

---

### **WHEN ANOTHER PARTY CAUSES YOUR INJURIES OR ILLNESS**

If another person or entity is legally responsible for causing your injury or illness (a "Liable Third Party"):

We agree to pay for covered services upon the condition that we will be able to recover the cost of those covered services from any payer of benefits, claims, and damages including, but not limited to, you and your insurance company and the Liable Third Party and the Liable Third Party's insurance company (all of which payers shall be referred to collectively as "Payer"), whether the Payer's obligation results from a settlement, judgment, award, or other process. This means that if you become entitled to receive payment from a Payer then we are entitled to recover the cost of the covered services we paid before you can recover any amounts. This applies even if you are not fully compensated for your injury or illness and even if the money to be paid is characterized as compensation for pain and suffering, lost wages, wrongful death or any other type of compensation. You agree that:

- Immediately upon our payment of covered services we will have an automatic subrogation lien against, and first-party and first priority rights in and to, any settlement, judgment, award or other payment that you or your Representative may be entitled to recover.
- We may bill the Payer directly or permit our contracted providers to pursue recovery from the Payer through any lawful means including, but not limited to, the filing of a hospital lien pursuant to C.R.S § 38-27-101.

- We have the right, but not the obligation, to pursue recovery from a Payer, at our sole discretion.
- You agree to the following:
  - Within 30 days of your becoming injured or ill, or as soon as is practical, you will tell us:
    - Whether a Liable Third Party caused your injury or illness.
    - The name of the Liable Third Party and any other potential Payer of your medical bills.
    - The name of the lawyer that you hired to collect from the Payer.
    - About any communications with, or lawsuits and other proceedings involving, the Payer; and you will provide us with regular and periodic updates of those events.
  - You or anyone acting on behalf of you or your estate including, but not limited to, your agent, attorney, power of attorney, assignee, proxy, parent, guardian, custodian, conservator, personal representative and administrator (all of whom shall be referred to collectively as “Representative”) will notify the Payer that:
    - We have, or are in the process of, making payment of your medical bills.
    - The Payer must contact us to discuss payment to us.
    - The Payer must pay us before it pays you or your Representative.
  - Neither you nor your Representative will do anything to hurt our ability to recover from a Payer including:
    - Make an agreement with a Payer that does not provide for payment to us.
    - Release any person or entity from liability or responsibility without our permission.
  - If the Payer pays you or your Representative but not us then you or your Representative will be personally obligated to repay to us, up to the amount of said payment, the amount of the covered services that we paid on your behalf. If we are unable to collect from the Payer because of a lack of help from, or interference by, you or your Representative then such lack of help or interference may result in your disenrollment from our plan.
  - If asked, you and your Representative agree to sign any papers, including but not limited to a release of medical records, that will help us collect from a Payer.
  - You and your Representative agree to cooperate fully with us in our attempts to be repaid for benefits paid on your behalf.
  - The costs of our legal representation will be paid solely by us except in a case where legal representation was necessary in order to collect from you or your Representative. The costs of legal representation for you and your Representative will always be paid solely by you or your Representative.

---

You agree that everything stated above will be binding upon you and your Representative and upon your successors, heirs, and assigns now and in the future. Medicare law may apply with respect to services covered by Medicare. If you have questions, please call our Member Services Department at (303) 602-2111.

#### **DISCLOSURE OF HEALTH AND BILLING INFORMATION TO THIRD PARTIES**

To the extent provided by law, we may disclose your health and billing information to your Representatives and Payers for the adjudication and subrogation of health benefit claims. This includes providing claim processing records, provider-billing records, and your medical records to your Representatives and Payers for determining the extent of any insurance, benefits, damages, compensation and other payments that may be available to cover your medical expenses.

**4822-8398-5418, v. 3**

---

## **Chapter 12. Definitions of important words**

**Ambulatory Surgical Center** – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

**Appeal** – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

**Balance Billing** – A situation in which a provider (such as a doctor or hospital) bills a patient more than the plan's cost-sharing amount for services. As a member of Medicare Choice HMO SNP, you only have to pay the plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" you. See Chapter 4, Section 1.6 for more information about balance billing.

**Benefit Period** – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

**Brand Name Drug** – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

**Catastrophic Coverage Stage** – The stage in the Part D Drug Benefit where you pay no *OR* a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$4,700 in covered drugs during the covered year.

**Centers for Medicare & Medicaid Services (CMS)** – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

**Coinsurance** – An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%).

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including















## Medicare Choice HMO SNP Member Services

<b>CALL</b>	303-602-2111  Or 1-877-956-2111 toll free  8 a.m. to 8 p.m., seven days a week. Member Services also has free language interpreter services available for non-English speakers.
<b>TTY</b>	303-602-2129  Or 1-866-538-5288 toll free  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  8 a.m. to 8 p.m., seven days a week.
<b>FAX</b>	303-602-2138
<b>WRITE</b>	777 Bannock Street, Mail Code 6000, Denver, CO 80204
<b>WEBSITE</b>	<a href="http://www.denverhealthmedicalplan.com">www.denverhealthmedicalplan.com</a>

## Colorado Senior Health Insurance Assistance Program

Colorado Senior Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

<b>CALL</b>	303-899-5151 or 1-800-544-918
<b>TTY</b>	Dial 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	1601 Lowell Blvd., Denver, CO 80204