YOURPLANCHOICE, LLC. TELEPHONIC MULTIPLAN IB/OB SALES SCRIPT 2025

PURPOSE: This is a telephonic sales script provided by YourPlanChoice, LLC (YPC). Agents and agencies who are contracted in the YPC hierarchy are permitted to use this script to provide Medicare Beneficiaries with information about available Medicare Advantage plans and Medicare Prescription Drug plans for the Health Plans they are contracted with through YPC. It can be used as an inbound and outbound script with the necessary additions for each.

Verbatim sections are in Red; Agent notes are in Blue

1. **GREETING**

   a. **INBOUND GREETING:**

Thank you for calling ***[AGENCY NAME]*** a licensed sales agency not affiliated with the government. My name is ***[AGENT NAME]*** and I am a Licensed Insurance Agent**.** I need to let you know that this call is being recorded for quality assurance. Is it okay if I continue?

If beneficiary objects, end the call using the "COURTESY CLOSE 2" scripting near the end of this document.

How may I help you today? **(Agent to acknowledge the inquiry if the caller would like to learn about Medicare plan options and express willingness to assist by stating):** I'll be happy to help you with that.

> **If not a sales call: (Do not continue to probe for sales opportunities but connect them with the appropriate area stating the following):** I'm sorry but you've reached the sales department. Let me transfer you to ***[Dept.]*** where they can help you.
>
> **If sales call: CONTINUE TO DEMOGRAPHIC INFORMATION**

   b. **OUTBOUND GREETING:**

Hi, is ***[CLIENT NAME]*** available?

> **If not client:** When is a good time to call back to speak with ***[CLIENT/AUTHORIZED REPRESENTATIVE NAME]***?
>
> > I will call ***[CLIENT/AUTHORIZED REPRESENTATIVE NAME]*** on ***[DATE AND TIME]*** Thank you for your time.
>
> **If client:** Hi ***[CLIENT NAME]***, my name is ***[AGENT NAME]*** and I am a licensed Insurance agent with ***[AGENCY NAME]*** a licensed sales agency, not affiliated with the

government. I need to let you know that we are on a recorded line for quality assurance. Is it ok if I continue?

If beneficiary objects, end the call using the "COURTESY CLOSE 2" scripting near the end of this document.

I am calling today because you requested information about Medicare options, and if we can assist you with your Medicare questions. How can I help you today? **(Agent to acknowledge the inquiry if the caller would like to learn about Medicare plan options and express willingness to assist by stating):** I'll be happy to help you with that.

If not a sales call: (Do not continue to probe for sales opportunities but connect them with the appropriate area stating the following): I'm sorry but you've reached the sales department. Let me transfer you to ***[Dept.]*** where they can help you.

If sales call: CONTINUE TO DEMORAPHIC INFORMATION

2. DEMOGRAPHIC INFORMATION

AGENT WILL COLLECT THIS INFORMATION FROM THE CALLER. THIS INFORMATION IS VOLUNTARY, AND IF THE CALLER DOES NOT WISH TO PROVIDE, THEN AGENT MUST MOVE FORWARD.

a. INBOUND:

If the TPMO does not sell for all MA organizations in the service area: Please note, we do not offer every plan available in your area. Currently we represent ***[INSERT NUMBER OF ORGANIZATIONS]*** organizations which offer ***[INSERT NUMBER OF PLANS]*** products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all your options.

If the TPMO sells for all MA organizations in the service area: Currently we represent ***[INSERT NUMBER OF ORGANIZATIONS]*** organizations which offer ***[INSERT NUMBER OF PLANS]*** products in your area. You can always contact Medicare.gov, 1–800–MEDICARE, or your local State Health Insurance Program for help with plan choices.

May I please have your first and last name? **(Spell to verify.)** Thank you.

Do I have your permission to contact you at this number if we get disconnected? Is this the best phone number to reach you on? **(Notate prospect's best contact number.)**

Can ***[AGENCY NAME AGENT/I]*** follow-up with you afterward at the phone number and/or email address you provided? We would like to ensure you have all the information you need and to answer any other questions you may have regarding Medicare Advantage and Prescription Drug (Part D) Plans. Your consent is voluntary and allows us to contact you via text messaging

or automatic dialing. You may contact us to change your preferences at any time. Changing your preferences will not affect your eligibility for ***[CARRIER NAME]*** enrollment or benefits. Data use charges and rates from your cellular carrier may apply. **(Notate.)** Thank you.

b. OUTBOUND:

If the TPMO does not sell for all MA organizations in the service area: Please note, we do not offer every plan available in your area. Currently we represent ***[INSERT NUMBER OF ORGANIZATIONS]*** organizations which offer ***[INSERT NUMBER OF PLANS]*** products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all your options.

If the TPMO sells for all MA organizations in the service area: Currently we represent ***[INSERT NUMBER OF ORGANIZATIONS]*** organizations which offer ***[INSERT NUMBER OF PLANS]*** products in your area. You can always contact Medicare.gov, 1–800–MEDICARE, or your local State Health Insurance Program for help with plan choices.

Now, just to make sure I have the right information, I have your name as ***[CLIENT NAME]*** **(spell to verify)** correct? Great!

Is this the best number to reach at if we get disconnected? **(Notate prospect's best contact number.)** Thank you.

FOR BOTH INBOUND AND OUTBOUND:

Can you confirm your State and Zip code (county if applicable)? **(Repeat back to confirm.)** Is that Correct? **(Notate.)** Thank you.

3. PRIVACY STATEMENT

[CLIENT NAME], Please be aware that you are not required to give any health-related information unless it will be used to determine your enrollment eligibility in the plan. If you choose not to provide the health information that is necessary to determine enrollment eligibility, then you may not be able to enroll. Any information disclosed will be used to determine the plan that best fits your needs.

4. POWER OF ATTORNEY

Are you interested in discussing Medicare options for yourself or for someone else?

If calling on behalf of someone else: Ok, may I have your name, and what is your relationship to the beneficiary? Are you the legal representative or someone who is legally authorized to act on behalf of the beneficiary under the applicable state law? And can you provide written document evidencing your authority if requested by CMS? For example, do you have a durable Power of Attorney, or a court appointed guardianship? **(Notate.)**

If not legal rep: Ok, no problem. I can give you general information about the Medicare plans, but we'll need to bring the beneficiary on the phone if they decide they want to enroll, ok?

If calling on behalf of self: Do you usually have help making your healthcare decisions?

If No: **CONTINUE TO NEXT QUALIFIER QUESTION.**

EVEN IF THE BENEFICIARY INDICATES THEY DO NOT HAVE A GUARDIAN OR POA, THROUGHOUT THE CALL, BE SURE TO BE ON THE LOOKOUT FOR COMPETENCY ISSUES OR OTHER STATEMENTS OR QUESTIONS THAT INDICATE THAT THE INDIVIDUAL GENERALLY CONSULTS WITH OTHERS TO MAKE THIS TYPE OF DECISION. IF SO, AND EVEN IF THAT INDIVIDUAL IS NOT THE POA, FOLLOW SCRIPTING BELOW TO INVITE THE PERSON TO JOIN THE CALL.

FOR EXAMPLE: **If the member indicates another family member helps them with Dr appointments, getting prescriptions, etc. The agent should clarify if that person is the POA and a part of the member's decision-making process.**

If Yes: Would you like to have that person on this call to help discuss plans today?

If No: We will be shopping for Medicare plans and the plan you select could change your health insurance coverage. If ***[AUTHORIZED REPRESENTATIVE NAME]*** helps you make healthcare decisions, are you sure you would not like ***{HIM/HER}*** on the line to help you decide what is best for you?

If client does not want person on the line: CONTINUE

If Yes: Are they available now or should we discuss later when they are available?

If available and person joins the call: Are you the legal representative or someone who is legally able to act on behalf of the beneficiary? For example, do you have a durable Power of Attorney or court appointed guardianship that allows you to make medical and insurance decisions for them?

If Yes: Ok, may I have your name, and what is your relationship to the beneficiary? Are you the legal representative or someone who is legally authorized to act on behalf of the beneficiary under the applicable state law? And can you provide written document evidencing your authority if requested by CMS? For

example, do you have a durable Power of Attorney, or a court appointed guardianship?

If No: Okay, great. You can both stay on the line, and we can continue our conversation, but if ***[CLIENT NAME]*** decides to enroll in a plan today, they will need to remain on the call and complete the enrollment themselves.

If No (calling for someone else): Ok, no problem. I can give you general information about the Medicare plans, but we'll need to bring the beneficiary on the phone if they decide they want to enroll, ok?

If client wants to have person on the line but they are unavailable: (Offer to set a call back or an appointment for a time in which the person will be able to be on the call.)

5. SCOPE OF APPOINTMENT

FOR OUTBOUND CALLS, THE AGENT MUST HAVE A VALID PTC OR BRC ALREADY COMPLETED BY THE BENEFICIARY, AS WELL AS A COMPLETED SOA, DATED AT LEAST 48 HOURS PRIOR TO THE OUTBOUND CALL/APPOINTMENT.

Before we begin, we are required to complete a document called a Scope of Appointment. This will allow me to share specific details about Medicare plans in your area. Before we begin, let me tell you a little bit about ***[AGENCY NAME]*** so you know who you are speaking with, and how we can help you find a Medicare plan with the benefits you are looking for.

(Proceed to provide 3-4 statements about agency to clearly explain that agency is not a government agency, is not a health insurance carrier. The agent will help beneficiary look at a variety of Medicare plan options and help find a plan right for their needs and can help beneficiary enroll in a plan if they are eligible and find a plan they like.)

Ok, ***[CLIENT NAME]*** I work for ***[AGENCY NAME]***, and in your area, we have a wide variety of plans such as ***[MEDICARE ADVANTAGE PLANS, MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS, STAND-ALONE PRESCRIPTION DRUG PLANS, MEDICARE SUPPLEMENTS INSURANCE PLANS, OPTIONAL SUPPLEMENTAL BENEFITS (OSBS), STAND-ALONE VISION, STAND-ALONE DENTAL]***. **(Agent to list out all product types available.)**

Would you like to discuss all these options or are you only interested in certain ones**? (Wait for response and proceed accordingly based on beneficiary's choice.)**

I can give you a brief overview of each of these plans ***["TODAY"/or ON {INSERT DATE OF APPOINTMENT}],*** then you can decide which plan might be best for you based on your needs. Would that be okay? **(Agent to wait for response.)**

This conversation has no effect on your current or future health coverage unless you enroll in a plan today. Talking to me does not obligate you to enroll or automatically enroll you in a plan.

[CLIENT NAME] if you understand the statements I just read to you, and you are ready to proceed with the call on ***[TODAY'S MONTH/DATE/YEAR}]*** please say "Yes". **(Must obtain clear confirmation to proceed. If individual states no, or that they would want to discuss other plans, go to "COURTESY CLOSE 1" or refer to other approved processes/scripts.)**

6. **MEDICARE:**

Before we continue, I have a few questions for you to ensure you are eligible for the types of plans available in your area. You aren't required to provide an answer; however, your responses will help me determine which type of plan may best fit your needs.

Do you currently have, or will soon have, Medicare Parts A & B?

If Yes: CONTINUE

If No: I'm sorry, but you do not qualify for a Medicare health plan currently. Please feel free to give us a call back around three months before your Medicare benefits go into effect. **(Go to "COURTESY CLOSE 1".)**

If consumer only has Part A or B: I'm sorry, but right now you don't qualify for a Medicare health plan; however, you may qualify for a Part D plan which only requires Medicare Part A and/or B. **CONTINUE**

7. **PERMANENT RESIDENCE**

Would you please provide me with your permanent home address? **(Notate.)**

If No: CONTINUE

8. **OTHER COVERAGE/RETIREMENT BENEFITS**

Do you have any current coverage through an employer, individual major medical, employer group Medicare plan, retirement benefits for healthcare, VA benefits, or Tricare for Life/ChampVA?

Retiree coverage through you or your spouse: (Inform prospect how their current coverage would be affected by enrollment in a ma plan.)

If Union: Enrolling in a Medicare Advantage Plan with Drug coverage or a Medicare Prescription Drug plan may impact your ability to keep your Union Medical or Drug coverage. You may want to talk with your Union before proceeding with enrollment to learn if enrolling in this plan will impact your current Union Medical or Drug Plan.

Active employment coverage through you or your spouse: When does that coverage end? When would you like your new plan to start?

Military insurance such as Tricare for Life, or CHAMP/VA? (Inform prospect how their current coverage would be affected by enrollment in a ma plan.)

If VA Medical benefits: (Discuss use of VA facility (or not) to determine type of plan that may or may not be needed.) VA Healthcare and Medicare Advantage are separate. VA Healthcare cannot bill Medicare Advantage and Medicare Advantage cannot bill the VA. Having a Medicare Advantage plan will not disrupt VA healthcare services. An MA plan may be helpful to consider for those with VA as it would allow access to additional civilian providers within the MA plan network. **(VA healthcare benefits are different from TRICARE for Life and ChampVA.)**

If Tricare for Life/ChampVA: (Explain that benefits with TRICARE for Life/ChampVA are generally "richer" than most other types of coverage available. Agent should explain to the beneficiary how enrolling in a plan will affect their TRICARE for Life/ChampVA (i.e. how the claims will pay differently, TRICARE for Life/ChampVA will become the secondary insurance if an MAPD plan is selected etc.). Explain that is not recommended to enroll in MA/MAPD plan if they have TRICARE for Life/ChampVA benefits and they will lose their TRICARE for Life/ChampVA benefits if they do.

ONLY CONTINUE WITH THE SCRIPT IF THE PROSPECT UNDERSTANDS HOW THEIR CURRENT COVERAGE WOULD BE IMPACTED AND WOULD LIKE TO PROCEED. IF THE PROSPECT DOES NOT WANT TO PROCEED, GO TO "COURTESY CLOSE 1".

9. VERIFY CURRENT SUBSIDY

Before we discuss your plan options and with your permission, it's always good to check your current coverage as well as any subsidies that you may currently have, like Medicaid or Extra Help. Your status will help us determine what plans you may be eligible to enroll into. Please note that the status is based on current information available and is not guaranteed. Do I have your consent to check your eligibility status and your current coverage? **(Agent must explain what information may be available to them if they look up the consumer's information.)**

If Yes: (verify subsidy status.)

If No: That is not a problem, but I will only be able to give you general details on co-pays, co-insurance, deductibles, and drug costs. These figures may change based on your personal information, including not being eligible for some plans that I may discuss.

10. **SNP PLANS**

If Dual Special Needs Plan(s) are available in the caller's area: In your area, we do offer Dual Eligible Special Needs Plan(s). These are plans specifically designed for anyone who has both Medicare and Medicaid. Would you like to hear more about this plan?

If Chronic Special Needs Plan(s) are available in the caller's area: If you have certain conditions, you may be eligible for a Chronic Care Special Needs Plan. These are plans specifically designed for anyone who has been diagnosed with **(list conditions of available with according CCSNPs such as, Diabetes, Cardiovascular Disease, etc.).** Would you like to hear more about this plan?

11. **ELECTION PERIOD**

If during AEP: (Probe to determine if eligible for other election periods (IEP/ICEP or SEP) and if so, determine if the beneficiary desires an effective date earlier than January 1.)

If Yes: **(Determine the election period to which the beneficiary qualifies.)**

If No: CONTINUE

If NOT during AEP: Since we are currently outside the Medicare Advantage & Prescription Drug Plan Annual Enrollment Period, which run from October 15th to December 7th and the Open Enrollment Period from January 1st to March 31st each year, you will need to have a Special Election Period (SEP) to qualify for a Medicare Advantage or Prescription Drug Plan. There are several election periods for which you may qualify, based on your circumstances. I want to ask a few questions to determine if you are eligible to enroll today, ok? **(Refer to Medicare Managed Care Manual chapter 2 - Medicare advantage enrollment and disenrollment, section 30.4 - special election period (SEP).)**

Does the caller qualify for an election period now? (Ask the following questions until you receive a "yes" response. Once you receive a "yes", educate the caller about the relevant SEP. For example, if SEP "MOV", advise you have one month before and two months after to complete your enrollment.)

- Are you new to Medicare? **(ICEP-Initial Coverage Election Period)**
- Are you enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period **(MA OEP)**?

- Have you recently moved outside of your plan's service area, or have you moved, and this plan is a new option? If yes, what was the date?
- Have you recently been released from incarceration? If yes, what was the date?
- Have you recently returned to the United States after living permanently outside of the United States? If yes, what was the date?
- Have you recently obtained lawful presence status in the United States? If yes, what date did you obtain this status?
- Have you recently had a change in your Medicaid (new to Medicaid, had a change in level of Medicaid assistance, or lost Medicaid)? If yes, what date was this change?
- Have you recently had a change in your Extra Help paying for Medicare prescription drug coverage (newly received Extra Help, had a change in the level of Extra Help, or lost Extra Help)? If yes, what date was this change?
- Do you have both Medicare and Medicaid or is your state helping to pay for Medicare premiums or do you get Extra Help paying for your Medicare prescription drug coverage, but you haven't had a change?
- Are you moving into, live in, or recently moved out of a Long-Term Care Facility (example, nursing home)? If yes, as of what date?
- Have you recently left a Program of All-Inclusive Care for the Elderly (PACE)? If yes, when did you leave?
- Have you recently involuntarily lost creditable prescription drug coverage (as good as Medicare's)? If yes, what was the date?
- Are you losing or leaving coverage you had from an employer or union? If yes, what was the date?
- Do you belong to a pharmacy assistance program provided by your state?
- Were you enrolled in a plan by Medicare (or your state) and you want to choose a different plan? If yes, what date did your enrollment in that plan start on?
- Is your plan ending its contract with Medicare or is Medicare ending its contract with your plan?
- Have you been affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity? Or have one of the other statements applied to you, but you were unable to make your enrollment request because of the disaster?
- Are you in plan that's had a star rating of less than 3 stars for the last 3 years and want to join a plan with a star rating of 3 stars or higher?
- Are you in a plan that was recently taken over by the state because of financial issues and want to switch to another plan?
- Were you enrolled in a Special Needs Plan but have lost the Special Needs qualification requirement to be in that plan? If yes, when?
- If none of these statements applies to you, is there another reason you believe you may be eligible to enroll?

If SEP is determined: Based on the information you've provided, it appears you do qualify for an election period to enroll now.

If SEP is not determined: I'm sorry but currently it does not appear that you qualify for a special election period to enroll in a plan now. The Annual Enrollment Period is from October 15 through December 7 when you can change plans. Please feel free to contact us once the Annual Enrollment Period begins. **(Go to "Courtesy Close 1".)**

12. DISCOVERY

To help me find a plan that may be the right fit your needs, would you mind if I ask you detailed questions about your personal situation? Of course, this is optional. But the more information I have to work with, the better our chances of finding a plan that fits your needs. **(Ask appropriate questions. You don't have to ask all.)**

What are 3 things that are important to you, in a plan? **(Give examples if needed. Notate.)**

Do you feel that you should be able to participate in a plan with more benefits than you have now? **(Notate.)**

Many Medicare beneficiaries feel it is important to have lower copays because they see their doctor (s) regularly. Would you benefit from lower copays? **(Notate.)**

Several of our Prospects want to make sure that the bigger bills such as hospitalization have a lower cost. Would that be important to you? **(Notate.)**

Some people struggle with the cost of their medications because they are expensive. Would it be important to you to have your medication cost reduced? **(Notate.)**

Do you require hearing, dental, and/or vision coverage? **(Notate.)**

Do you have any other health care needs, such as needing durable medical equipment, physical therapy? **(Notate.)**

Is there anything else that is important to you or that you would like to be different? **(Notate.)**

Thank you for answering my questions. So here is what I believe you are wanting in a plan; and let me know if I've missed anything, please: **(Summarize all prospect's answers to prospect. Notate.)**

13. VERIFICATION OF ABSOLUTES

Do you give me permission to review your providers and prescription medications to see if they are in network or covered by the plans, we look at today?

If No: Not a problem. But before we continue, I would like you to know that not all providers or prescriptions are covered by all plans and cost may differ between plans as well. So, if you change your mind and would like me to look something up let me know.

If Yes: Okay great, we will go over your providers and prescription medications you would like covered so we can give you an estimate of how much these items would cost for the plan(s) we discuss.

(Check for PCP, specialist, nurse practitioners, clinics, etc. Network status of providers needs to be disclosed and explain to the member that they will either need to select new providers or must pay out of pocket. This applies to preferred hospitals and facilities as well.) –

(Document medications, generic or brand, quantity and dosage; discuss Rx cost in summary of benefits, notify them of quantity limitations, prior authorization, and step therapy give prospect date and code for medicare.gov so they can access their information. Explain to member that if the prescriptions are not on the formulary the member may have to pay full price.)

14. **PHARMACY**

Do you have a local pharmacy that you would like to make sure is in Network?

If Yes: (Notate.)

If No: Would you like some help finding a pharmacy that is in Network with the Plan you choose?

(Provide the pharmacy status to the member and explain that if it is not in network, they will need to choose a new pharmacy or may have to pay full price for prescriptions.)

15. **CHRONIC CARE SNP**

(IF APPLICABLE): THE FOLLOWING ALSO NEEDS TO BE INCLUDED: ITEMS ONLY APPLICABLE TO CERTAIN PLAN TYPES:

- Review PPO or PFFS out-of-network coverage.
- Review need to have Medicaid to qualify for D-SNP
- Review need to remain in institutional skilled nursing facility in order to qualify for I-SNP
- Review need to maintain trust/custodial account in order to remain enrolled in MSA. (UHC does not offer MSAs)

READ ONLY IF ELIGIBLE OR A C-SNP IS AVAILABLE. SKIP TO "LEAD IN" IF THEY WANT A PDP ONLY.

Based on what you mentioned earlier, you have ***[NAME OF CHRONIC CONDITION]*** which means you may be eligible for a Chronic Care Special Needs Plan.

(DISCLAIMER): These plans are available to individuals with certain chronic diseases.

In your area we do offer <Chronic Care and/or Dual Eligible> Special Needs Plan(s). These are plans specifically designed for anyone who:

If Chronic Care SNP is available: has been diagnosed with <list conditions of available CC SNPs such as, Diabetes, Cardiovascular Disease, etc.>. Would you like to hear more about this plan?

If Dual Eligible SNP is available: has both Medicare and Medicaid. Would you like to hear more about this plan?

If there is a Chronic Special Need plan available to you and you decide to enroll, your doctor will need to complete a verification form sent to either you or them from ***[CARRIER NAME]*** as part of the qualification process. You will need to make an appointment with your treating physician within the first month of coverage to have them fill out the form, sign it and fax it over to ***[CARRIER NAME]***

16. **LEAD IN**

It looks like I have found a plan that may fit your needs through ***[CARRIER NAME/PLAN NAME/PLAN NUMBER]*** with a premium of ***[PREMIUM]*** per month because: **(Explain why the plan seems like the most suitable option.)**

17. **SUMMARY OF BENEFITS**

REVIEW PLAN OF INTEREST IN MORE DETAIL BY READING THE BENEFITS HIGHLIGHTS ON *[CMS/CARRIER APPROVED ENROLLMENT PLATFORM]* AND USE THE SUMMARY OF BENEFITS. YOU MUST READ ALL APPLICABLE DISCLOSURES INCLUDED IN THE SUMMARY OF BENEFITS INCLUDING THE PRE-ENROLLMENT CHECK LIST.

BENEFIT HIGHLIGHTS:

REVIEW COVERAGE FOR OUT-OF-NETWORK PROVIDERS AND SERVICES (E.G., EXCEPT IN EMERGENCY OR URGENT SITUATIONS, PLAN DOES NOT COVER SERVICES BY OUT-OF-NETWORK PROVIDERS (I.E., DOCTORS WHO ARE NOT LISTED IN THE PROVIDER DIRECTORY).

- Premium **PLAN PREMIUM IS IN ADDITION TO THE PART B PREMIUM, *[INSERT DOLLAR AMOUNT]* PER MONTH/QUARTER/YEAR. THIS ONE ONLY APPLIES IF THERE IS A PREMIUM >$0.**

- Part B premium reduction (If applicable)
- Medical deductible (If applicable)
- Part B deductible (If applicable)
- Pharmacy (Part D) deductible and tiers (If applicable)
- Maximum out-of-pocket (MOOP) both in and out-of-Network (OON)
- In Network Benefits (and out-of-network if PPO/PFFS plans) for:
    - Acute Inpatient Hospital Care
    - Hospital Care
    - Doctor Office Visits
    - Primary care provider (PCP)
    - Specialists
    - Preventive care
    - Emergency room (Including the explanation)
    - Urgently needed services (including the definition)
    - Inpatient Mental Health services
    - Outpatient Mental Health services
    - Coverage outside the United States
- Other mandatory and optional supplemental benefits that may be available included but not limited to the following:
    - Hearing Benefits
    - Dental Benefits
    - Vision Benefits

EXPLAIN THESE BENEFITS ARE NOT A RIDER BUT ARE PART OF ENROLLEE'S NEW MEDICAL PLAN. SPECIFICALLY ASK IF CONSUMER WOULD LIKE TO REVIEW THESE BENEFITS IF THEY WERE NOT ALREADY REVIEWED PREVIOUSLY IN THE CONVERSATION.

THE AGENT SHOULD INQUIRE AS TO WHETHER THE BENEFICIARY IS INTERESTED IN REVIEWING ANY OTHER PLAN BENEFITS.

<u>UPON REQUEST FROM THE BENEFICIARY</u>, ADDITIONAL BENEFITS SHOULD BE REVIEWED:

- Costs/limitations on dental, vision, and hearing
- Review coverage outside the United States.
- Diagnostic Services/Labs/Imaging Benefits
- Podiatry Benefits
- Chiropractic Benefits
- Medical Equipment Benefits
- Rehabilitation Benefits
- Coverage Gap/Catastrophic Coverage
- Skilled Nursing Facility Benefits
- Physical Therapy Benefits

- Ambulance Benefits
- Transportation Benefits
- Maximum out-of-pocket (MOOP) both in and out-of-Network (OON)

If stand-alone PDP plan: (Are there MAPD plans in their area that seem like they may meet their needs?)

If No: I will be happy to go over the benefits our PDP plans offer with you in more detail.

(Review Monthly Premium and plan stages including any Rx deductible, tiers, and cost-shares (at least for 30-day retail), coverage gap and catastrophic level.)

(If not done so already, offer to lookup any medications to determine coverage under the plan. If they decline the offer to look up their prescriptions, remind them): I suggest we look them up since, it is possible they may not be covered or require prior authorization and may lead to higher than expected out of pocket costs.

If Yes: **(Review the advantages of a MAPD plan. For example, "I will be happy to review our PDP plans with you. We also have plans in your area called Medicare Advantage Prescription Drug plans which combine both medical and prescription drug coverage. Do you mind me asking what you have in place for medical coverage? May I tell you more about our Medicare Advantage plans to see if we have anything that meets all your needs?"**

If Yes: (Compare the premiums of a PDP and the MAPD plans in their area. If the caller has medical coverage other than Medicare and tells you how much they pay for their premium, add the cost of their premium to what our PDP premium would be and compare that total to the premium of our MAPD plans in their area.)

If No: (Continue with PDP plan discussion.)

(Ask the caller if they have any questions or if they'd like to discuss any other specific benefits of the plan in more detail.)

If No: **CONTINUE.**

If Yes: (Answer questions and/or provide details as requested and then continue.)

(AGENT NOTE: THE PROMPT TO PROVIDE OTHER PLAN DETAILS MAY BE INDIRECT, SUCH AS A MEMBER TELLING YOU THEY NEED OXYGEN OR TRANSPORTATION. IF ADDITIONAL BENEFITS ARE REVIEWED, ALL LIMITATIONS SHOULD BE REVIEWED AS WELL, SUCH AS ALLOWANCES AND FREQUENCIES ON SERVICES FOR DENTAL OR VISION.)

18. CALLER CHOOSES PLAN

If During AEP:

If discussing a plan that will not be renewing for the upcoming plan year for a beneficiary with IEP/ICEP or SEP for current plan year, state verbatim: ***[CARRIER NAME, PLAN TYPE, CONTRACT/PBP NUMBER]*** will not be available in this area effective January. You may choose to enroll in the plan, but the coverage will automatically end on December 31. You are entitled to enroll into a new Medicare Advantage or Prescription Drug plan between October 15th and the end of February. However, if you want the new plan to be effective January 1st, your completed application must be submitted and received by December 31st. If you do not enroll into a Medicare Advantage or Prescription Drug plan by December 31st, you will be disenrolled from your current plan and only have Original Medicare as of January 1st.

[CLIENT NAME], it sounds like we found a plan that offers what you were looking for. It has **(list benefits and services beneficiary previously identified interest in and inform beneficiary of participating physicians).**

If client has current coverage: I can enroll you today over the telephone in this ***[CARRIER AND PLAN NAME].*** Enrolling in this plan today may replace the current ***[EXISTING COVERAGE TYPE, IF APPLICABLE]*** coverage that you have today. Once approved by Medicare, your new ***[NEW PLAN COVERAGE TYPE]*** plan coverage will begin on ***[EFFECTIVE DATE].*** So, are you ready to enroll in ***[CARRIER AND PLAN NAME]*** today?

If Yes: (Have prospect write down carrier name, plan name and number before continuing.) Are you ready to enroll in ***[CARRIER AND PLAN NAME]?***

If No: (Address questions and concerns.)

If prospect does not wish to continue, state: Do you give me permission to follow up with you within the next week?

If No: Go to "COURTESY CLOSE 1"

If Yes: I have your appointment set for ***[DATE AND TIME]***. **Go to "COURTESY CLOSE 1"**

(IF THEY WANT TO RESCHEDULE THE ENROLLMENT, SET APPOINTMENT AND GO TO "COURTESY CLOSE 1".)

If Medicare Advantage: ***[CLIENT NAME]***, I do want to clarify that this is not a Medicare Supplement plan, which supplements Original Medicare benefits. You are enrolling into a Medicare Advantage plan which is an alternative to Original Medicare.

Medicare Supplement Insurance helps fill "gaps" in Original Medicare. Original Medicare is a fee-for-service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles) and is sold by private companies. Original Medicare pays for much, but not all, of the cost for covered health care services and supplies. A Medicare Supplement Insurance (Medigap) policy can help pay some of the remaining health care costs, like:

- Copayments
- Coinsurance
- Deductibles

A Medigap policy is different from a Medicare Advantage Plan. Those plans are ways to get Medicare benefits, while a Medigap policy only supplements your Original Medicare benefits. Do you understand that this is a Medicare Advantage plan? **(Must obtain clear confirmation. If the prospect is unsure or has further questions explain in more detail the differences between a Medicare supplement and a Medicare advantage plan.)**

19. HOW TO FILE A COMPLAINT

Before we proceed, I must inform you that you are permitted to file a complaint with the Plan if needed. You may use the Medicare Complaint Form found on Medicare.gov or follow the instructions in your plan membership materials to submit a complaint about your Medicare health or drug plan. Generally, you can find your plan's contact information on your plan membership card.

20. RIGHT TO CANCEL

You can also cancel your plan prior to the effective date should you wish to do so. You may call the Plan directly or review your Plan documents, which you will be receiving soon, for more information.

21. CALL BACK INSTRUCTIONS FOR OUTBOUND CALLS. FOR INBOUND CALLS GO TO #24, "INBOUND ENROLLMENT SCRIPT ON *[SUNFIRE]* STARTS"

[CLIENT NAME], Now that we have determined that you are eligible, and have found a plan that fits your needs, we can proceed to the next step which is the Enrollment.
CMS requires that it take place on an inbound call. In order to fulfill that requirement, I will need you to call me back at ***[XXX-XXX-XXXX].***

(If client does not wish to complete enrollment via telephone, offer options for self-enroll via agency website, text message link, or email link.)

(If caller objects to enrollment. Overcome objections, answer questions & continue.)

If Yes: I'll hold my line open just for you, so you can call me right back, okay? **(Continue to "PROSPECT CALLS BACK IN".)**

If No: **(Ask to set appointment. Go to "COURTESY CLOSE 1".)**

PROSPECT CALLS INBOUND. THIS SECTION IS ONLY USED WHEN THE PROSPECT CALLS BACK IN. ENROLLMENTS ARE PROHIBITED ON AN OUTBOUND CALL!

22. PROSPECT CALLS BACK IN

Thank you for calling ***[AGENCY NAME]*** Medicare Enrollment Department. My name is ***[AGENT NAME]*** and I am a Licensed Insurance Agent**.** Who am I speaking with today?

Hi**,** ***[CLIENT NAME]***, Thank you for calling. Just to confirm, you are calling back in so that we may begin your enrollment, correct?

Do you know the name of the plan you would like to enroll in? **(Prompt if prospect doesn't remember.)**

Thank you. Okay, let's begin.

23. RECORDING NOTIFICATION

And just a reminder, this call is being recorded for quality assurance and training purposes. Do I have your permission to continue to record?

PROSPECT MUST PROVIDE CLEAR CONFIRMATION (I.E. YES, YEA, OF COURSE) BEFORE YOU START THE ENROLLMENT.

IF CALL ORIGINATED AS INBOUND, ASK PERMISSION TO RECORD FROM *[SUNFIRE]* ENROLLMENT PLATFORM.

If Yes: Continue

If No: Go to "COURTESY CLOSE 1"

24. INBOUND ENROLLMENT SCRIPT ON *[SUNFIRE]* STARTS

Before we begin, do you have any questions about the plan that I can answer in more detail for you? **(Address questions and concerns.)**

START ENROLLMENT

IF ENROLLING IN A CHRONIC SNP, MAKE SURE TO READ ALL REQUIRED QUESTIONS ON THE CARRIER'S ON-LINE ENROLLMENT FORM.

We are going to start the enrollment now.

My name is ***[AGENT NAME]*** and I am a Licensed Insurance Agent**.** Today is ***[DATE] [FULL NAME OF PROSPECT]*** is it your intent to enroll in the ***[CARRIER & PLAN NAME & PLAN NUMBER]*** with an effective date of and a monthly premium of ***[$ MONTHLY PREMIUM]***?

If Yes: **Go to "AGENT ENROLLMENT INSTRUCTIONS"**

If No: At this time, you indicated that you do NOT intend to enroll in the ***[CARRIER & PLAN NAME]*** with a monthly premium of ***[$ MONTHLY PREMIUM]***, is this correct?

If Yes: Do you have any questions that I can answer for you?

If Yes: **(Answer all questions and ask):** Are you now ready to enroll in the ***[CARRIER & PLAN NAME]*** with an effective date of **<EFFECTIVE DATE>** and a monthly premium of ***[$ MONTHLY PREMIUM]***?

If Yes: **Go to "AGENT ENROLLMENT INSTRUCTIONS"**

If No: Would you like to schedule another time to complete your enrollment?

If Yes to completing enrollment now: **Go to "AGENT ENROLLMENT INSTRUCTIONS"**

If Yes to rescheduling: **(Set an appointment.)** I have your appointment set for ***[DATE AND TIME]***. Does ***[AGENCY NAME]*** have your permission to contact you to remind you of your appointment?

If Yes: **Go to "COURTESY CLOSE 1"**

If No: Not a problem, I look forward to your call on ***[DATE AND TIME]***. I will hold my phone line open for your appointment. **Go to "COURTESY CLOSE 1"**

If No to rescheduling: I'm sorry we couldn't help you today. **Go to "COURTESY CLOSE 1"**

25. AGENT ENROLLMENT INSTRUCTIONS

(PROCEED TO INBOUND ENROLLMENT SCRIPT ON *[SUNFIRE]* ENROLLMENT PLATFORM: <*MULTIPLAN_001_SUNFIRE_ENROLLMENT001_2025_M*>.)

ALL APPROVED ENROLLMENT LANGUAGE & DISCLAIMERS ARE IN *[SUNFIRE]* AND MUST BE READ VERBATIM.

26. AFTER APPLICATION IS COMPLETE

If confirmation number is available: Congratulations! Your application is complete and has been submitted to ***[CARRIER & PLAN NAME]***! I have your confirmation number if you are ready. Remember this number is not your plan identification number only a reference number for your enrollment. Your confirmation number is: **(Read confirmation number**.)

If confirmation number is not available: Congratulations! Your application is complete and has been submitted to ***[CARRIER & PLAN NAME]***! Because our normal system of enrollment is down at this time, I cannot provide you with a confirmation number at this time. After ***[CARRIER NAME]*** accepts your application and recorded attestation, I will call you within a week to give you the confirmation number.

27. CLOSING THE CALL

It's been a pleasure speaking with you today. If you have any family members or friends that would benefit by speaking with me, please give them my number and I would be happy to assist them too.

I have one last question, on a scale of 1 to 5 with 5 being completely satisfied with your experience, how well did ***[WE/I]*** meet your needs and expectations during this call?

Thank you!

28. COURTESY CLOSE 1

I am sorry that we were not able to help you today. The Medicare Advantage and Prescription Drug Annual Enrollment Period is from October 15th to December 7th. Do you give ***[AGENCY NAME]*** permission to contact you at the number you provided regarding your Medicare Plan options if anything changes?

> **If Yes:** By saying 'YES', you are requesting that a Licensed Insurance Agent contact you to at the telephone number and/or email address you provided to discuss Medicare Plan options such as Medicare Advantage and Prescription Drug (Part D).
>
> **If No: CONTINUE**

In the meantime, if there is anyone you know that needs help with their Medicare options, please have them call me at ***[XXX-XXX-XXXX]*** TTY/TDD users dial 711, any time between ***[9 A.M. TO 7 P.M., TIME ZONE, MONDAY THROUGH FRIDAY].***

Thank you very much and we look forward to speaking with you again in the future.

29. <u>COURTESY CLOSE 2</u>

Due to Centers for Medicare & Medicaid Services (CMS) and TCPA regulations, we are not permitted to continue with a call unless it is recorded. Should you decide to contact me for assistance for your healthcare needs in the future, please call me at ***[XXX-XXX-XXXX]*** TTY/TDD users dial 711, any time between ***[9 A.M. TO 7 P.M., TIME ZONE, MONDAY THROUGH FRIDAY].***

Thank you very much and have a great day.