2024 Certification Training

Essence Healthcare-All Markets

ESSENCE HEALTHCARE™

A Healthy Tomorrow Starts Today.

Sales Information

Getting Ready to Sell

Thank you for choosing to represent Essence Healthcare in 2024.

Completing this certification will allow you to sell Essence in any state in which you are licensed.

Essence plans are available in Arkansas, Illinois, Indiana, Kentucky, Missouri and Ohio.

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Getting Ready to Sell

Completion of AHIP is required and Producers must receive a score of 85% or greater to pass Certification Exam.

Getting Ready to Sell

- Once you have completed all CMS and Plan requirements, you will be deemed **Ready to Sell (RTS)** and notified within the Producer Portal.
- **Do not** begin marketing or selling any plans until your Producer Portal reflects that you are RTS.
- Additionally, marketing for the next plan year cannot begin until October 1st.
- Your **National Producer Number (NPN)** is your writing code. Use this on all enrollment applications to ensure correct assignment of Agent of Record (AOR). Electronic applications through your Producer Portal will automatically populate your NPN.

Producer Services

Producer Support Unit

877-259-8657

Monday – Friday

8am – 6pm CT (9am – 7pm ET)

Saturday availability 10/7 to 12/9

9am-1pm CT (10am – 2pm ET)

Dedicated team to support our producers

One place to call with questions or issues

- Onboarding & Certification
- Benefits
- Commissions
- Technical support

Producer Phone Enrollment

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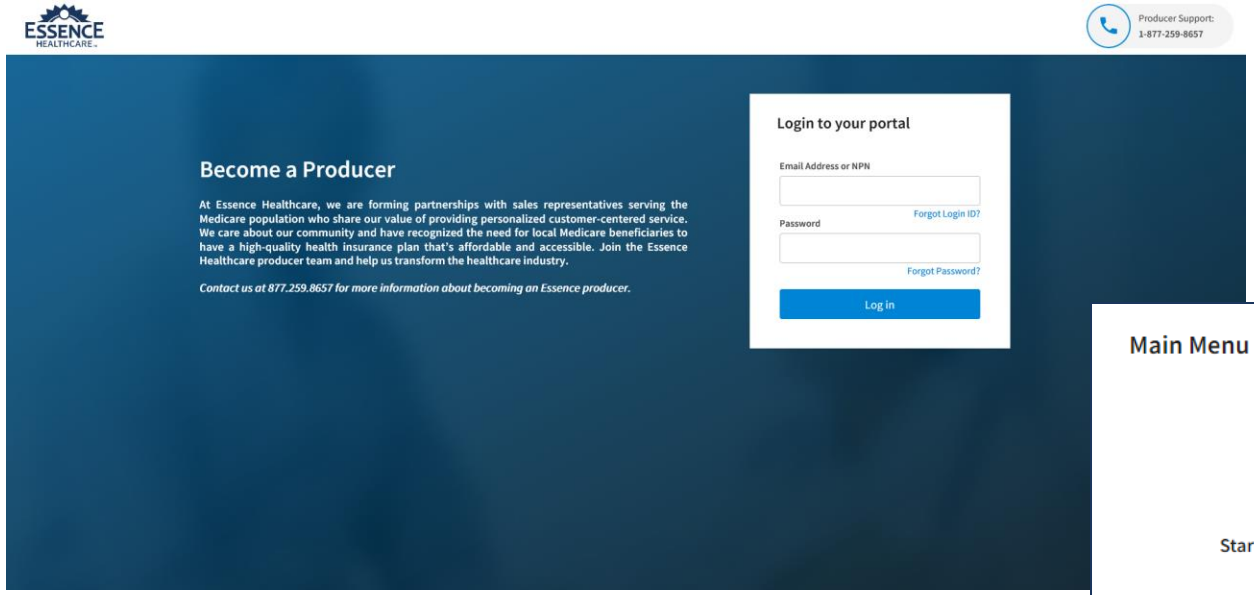
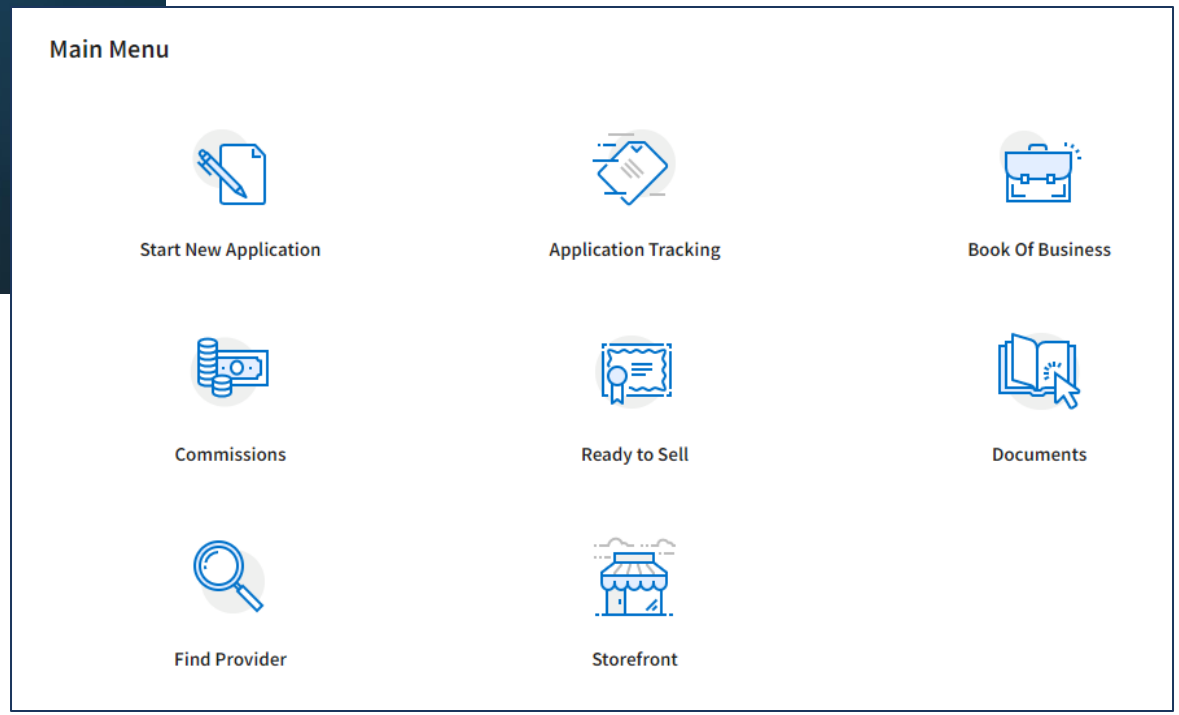
Producer Portal



Producer.EssenceHealthcare.com



Once you are RTS, you will have access to a variety of resources on the Producer Portal:

- **Storefront**
- **Training Videos**
- **Online Enrollment Application**
- **Application Tracking and Book of Business**
- **Commissions**

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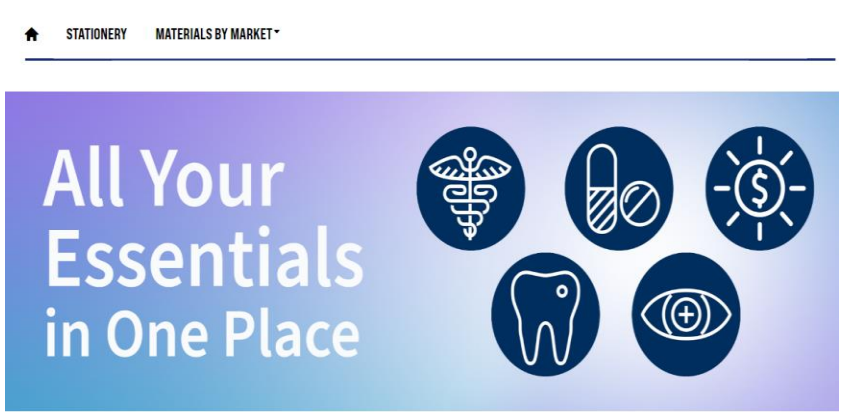
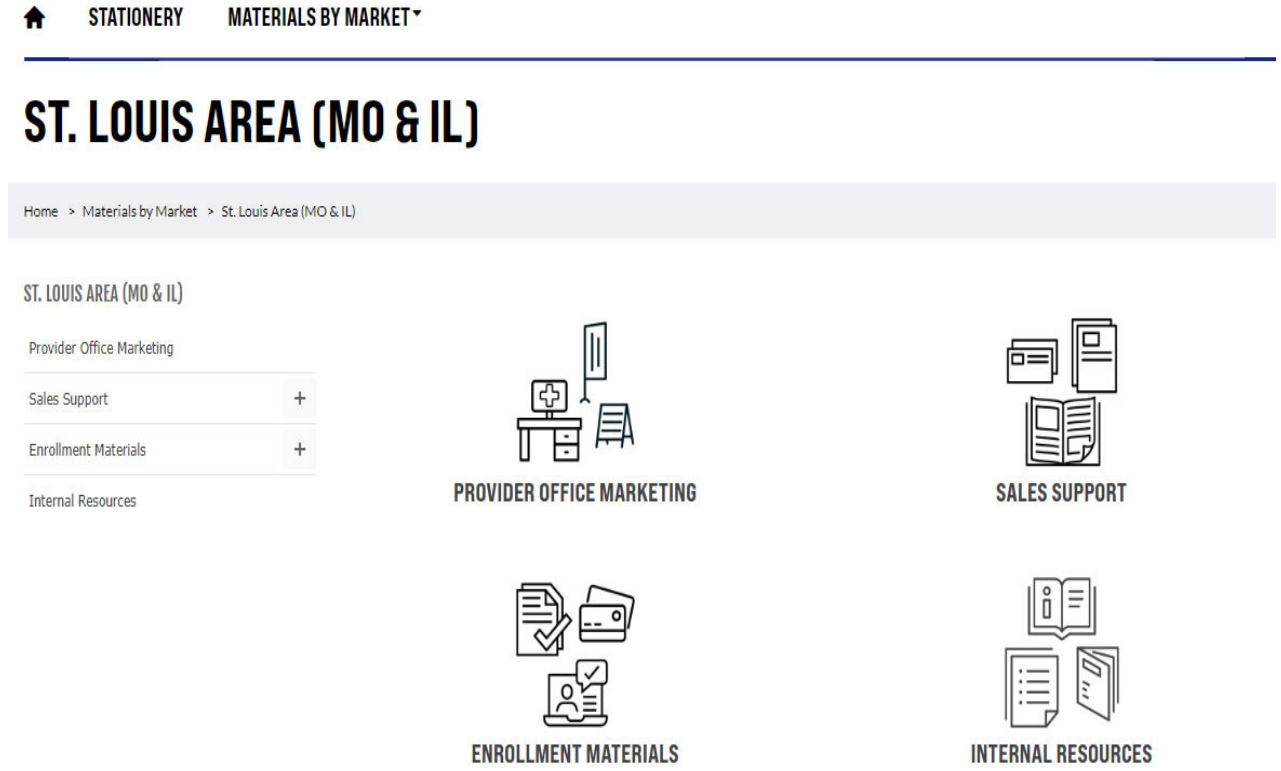
Use Storefront to access materials by Market



In the Producer Portal, click on the Storefront icon on the Main Menu to access plan materials and order/download enrollment kits.



Using Approved Materials to Sell

All producers have access to the approved Sales Presentation and Enrollment Kits to use with beneficiary interaction.

- Accessible on the Storefront via the Producer Portal
- Available in electronic format

Using approved materials helps you stay compliant:

- Covers all necessary plan components and CMS requirements
- Clarifies plan benefits
- Reduces confusion
- Builds credibility
- Avoids prohibited statements

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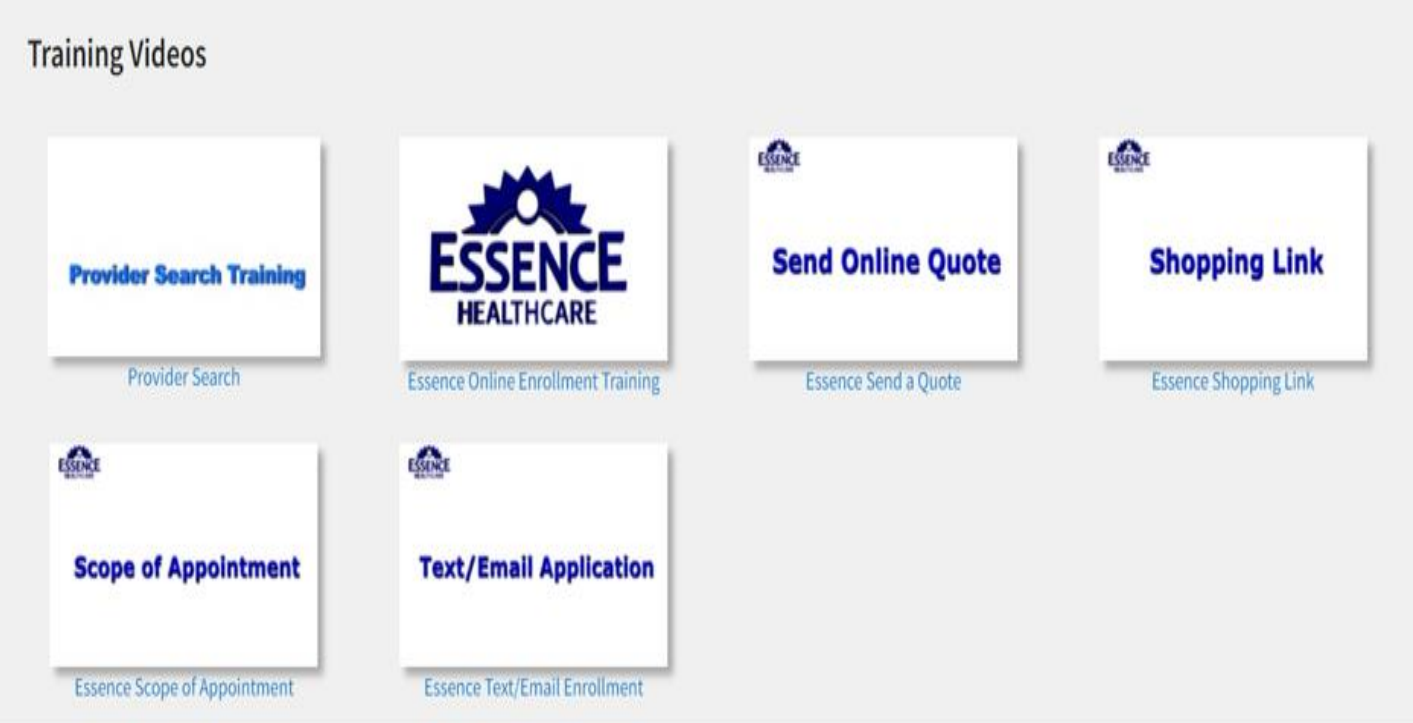
Producer Portal – Training Videos



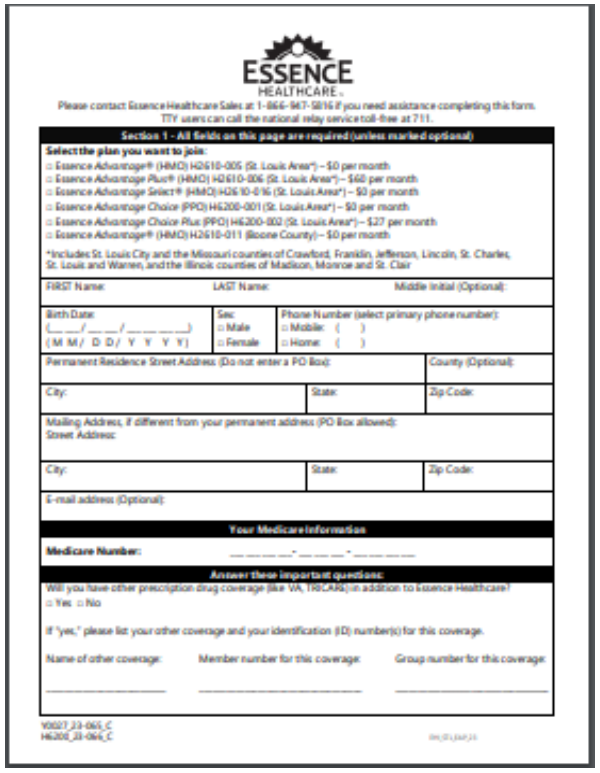
The Producer Portal houses training videos to visually assist you in the enrollment process.

You can access the videos by clicking on the Start New Application icon on the Main Menu.

Application Submission

Submission Requirements

Beginning September 30, 2023, we will require the **Application, Scope of Appointment (SOA), and Agent Checklist** with every submission.



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Please contact Essence Healthcare Sales at 1-866-967-5816 if you need assistance completing this form.
TTY users can call the national relay service toll-free at 711.

Section 1 - All fields on this page are required (unless marked optional)

Select the plan you want to join:

- Essence Advantage® (HMO) H2610-005 (St. Louis Area*) – $0 per month
- Essence Advantage Plus® (HMO) H2610-006 (St. Louis Area*) – $60 per month
- Essence Advantage Select® (HMO) H2610-016 (St. Louis Area*) – $0 per month
- Essence Advantage Choice (PPO) H6200-001 (St. Louis Area*) – $0 per month
- Essence Advantage Choice Plus (PPO) H6200-002 (St. Louis Area*) – $27 per month
- Essence Advantage® (HMO) H2610-011 (Boone County) – $0 per month

*Includes St. Louis City and the Missouri counties of Crawford, Franklin, Jefferson, Lincoln, St. Charles, St. Louis and Warren, and the Illinois counties of Madison, Monroe and St. Clair

FIRST Name: LAST Name: Middle Initial (Optional):

Birth Date: (____/____/____ ____) (M M/ D D/ Y Y Y Y) | Sex: ☐ Male ☐ Female | Phone Number (select primary phone number): ☐ Mobile: ( ) ☐ Home: ( )

Permanent Residence Street Address (Do not enter a PO Box): | County (Optional):

City: | State: | Zip Code:

Mailing Address, if different from your permanent address (PO Box allowed):
Street Address:

City: | State: | Zip Code:

E-mail address (Optional):

Your Medicare Information

Medicare Number: _____

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Essence Healthcare?
☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.

Name of other coverage: | Member number for this coverage: | Group number for this coverage:

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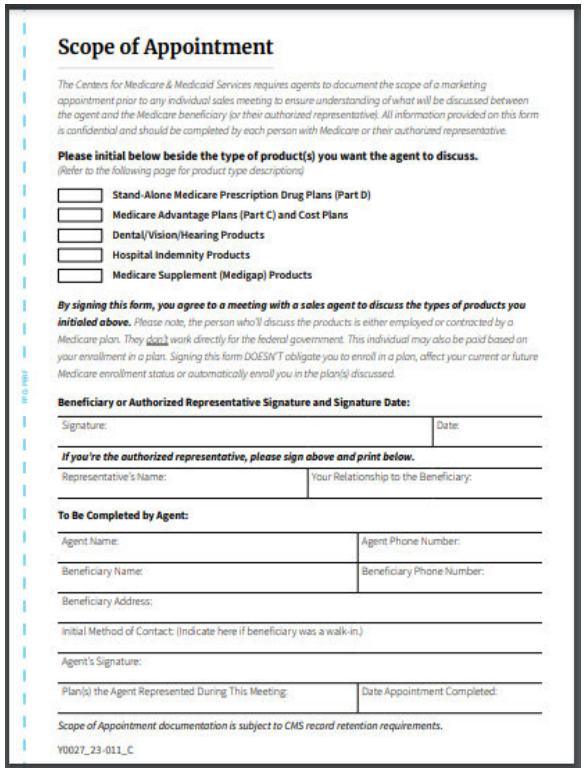

Scope of Appointment

The Centers for Medicare & Medicaid Services requires agents to document the scope of a marketing appointment prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or their authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.
(Refer to the following page for product type descriptions)

- ☐ **Stand-Alone Medicare Prescription Drug Plans (Part D)**
- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Dental/Vision/Hearing Products**
- ☐ **Hospital Indemnity Products**
- ☐ **Medicare Supplement (Medigap) Products**

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. *Please note, the person who'll discuss the products is either employed or contracted by a Medicare plan. They don't work directly for the federal government. This individual may also be paid based on your enrollment in a plan. Signing this form DOESN'T obligate you to enroll in a plan, affect your current or future Medicare enrollment status or automatically enroll you in the plan(s) discussed.*

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: | Date:

If you're the authorized representative, please sign above and print below.

Representative's Name: | Your Relationship to the Beneficiary:

To Be Completed by Agent:

Agent Name: | Agent Phone Number:

Beneficiary Name: | Beneficiary Phone Number:

Beneficiary Address:

Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)

Agent's Signature:

Plan(s) the Agent Represented During This Meeting: | Date Appointment Completed:

Scope of Appointment documentation is subject to CMS record retention requirements.

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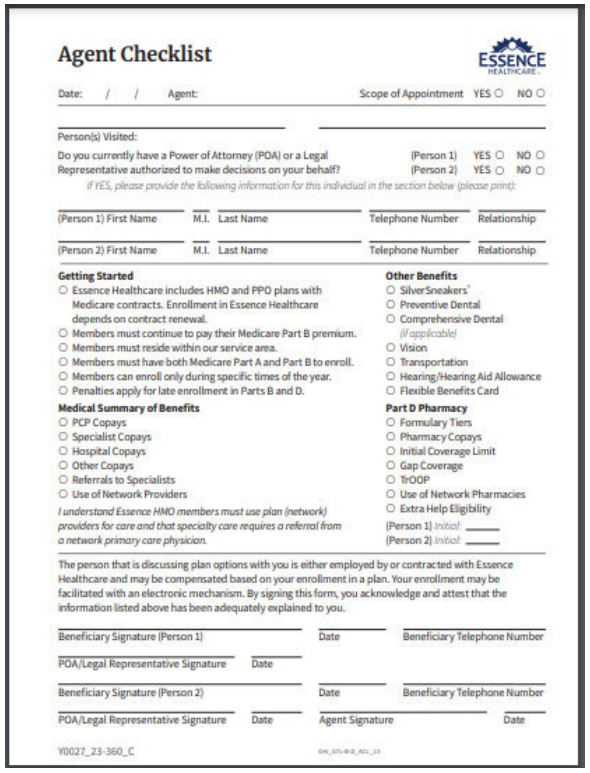

Agent Checklist

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Date: / / Agent: Scope of Appointment YES ☐ NO ☐

Person(s) Visited:

Do you currently have a Power of Attorney (POA) or a Legal Representative authorized to make decisions on your behalf? (Person 1) YES ☐ NO ☐ (Person 2) YES ☐ NO ☐

If YES, please provide the following information for this individual in the section below (please print):

(Person 1) First Name | M.I. | Last Name | Telephone Number | Relationship

(Person 2) First Name | M.I. | Last Name | Telephone Number | Relationship

Getting Started
- ☐ Essence Healthcare includes HMO and PPO plans with Medicare contracts. Enrollment in Essence Healthcare depends on contract renewal.
- ☐ Members must continue to pay their Medicare Part B premium.
- ☐ Members must reside within our service area.
- ☐ Members must have both Medicare Part A and Part B to enroll.
- ☐ Members can enroll only during specific times of the year.
- ☐ Penalties apply for late enrollment in Parts B and D.

Medical Summary of Benefits
- ☐ PCP Copays
- ☐ Specialist Copays
- ☐ Hospital Copays
- ☐ Other Copays
- ☐ Referrals to Specialists
- ☐ Use of Network Providers

I understand Essence HMO members must use plan (network) providers for care and that specialty care requires a referral from a network primary care physician.

Other Benefits
- ☐ SilverSneakers®
- ☐ Preventive Dental
- ☐ Comprehensive Dental *(if applicable)*
- ☐ Vision
- ☐ Transportation
- ☐ Hearing/Hearing Aid Allowance
- ☐ Flexible Benefits Card

Part D Pharmacy
- ☐ Formulary Tiers
- ☐ Pharmacy Copays
- ☐ Initial Coverage Limit
- ☐ Gap Coverage
- ☐ TrOOP
- ☐ Use of Network Pharmacies
- ☐ Extra Help Eligibility

(Person 1) *Initial:* ____
(Person 2) *Initial:* ____

The person that is discussing plan options with you is either employed by or contracted with Essence Healthcare and may be compensated based on your enrollment in a plan. Your enrollment may be facilitated with an electronic mechanism. By signing this form, you acknowledge and attest that the information listed above has been adequately explained to you.

Beneficiary Signature (Person 1) | Date | Beneficiary Telephone Number

POA/Legal Representative Signature | Date

Beneficiary Signature (Person 2) | Date | Beneficiary Telephone Number

POA/Legal Representative Signature | Date | Agent Signature | Date

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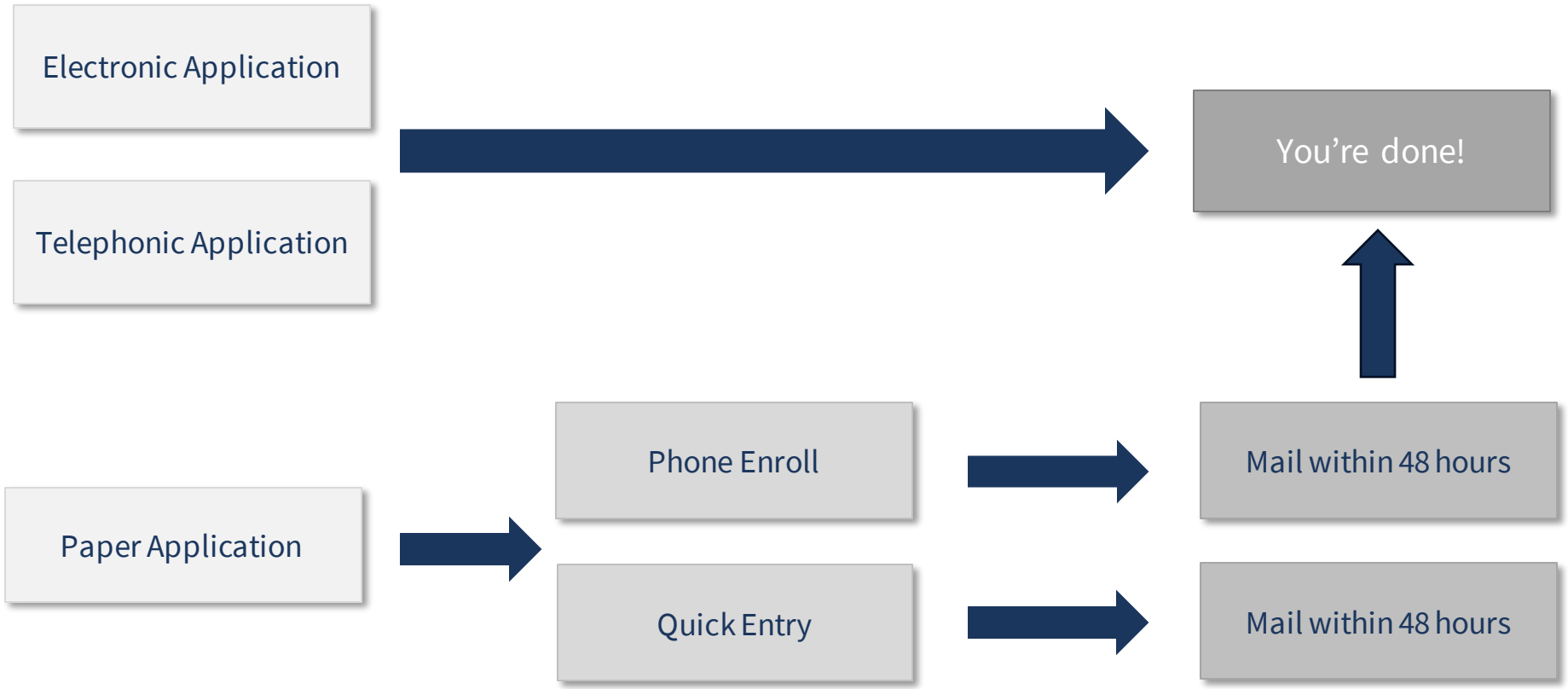
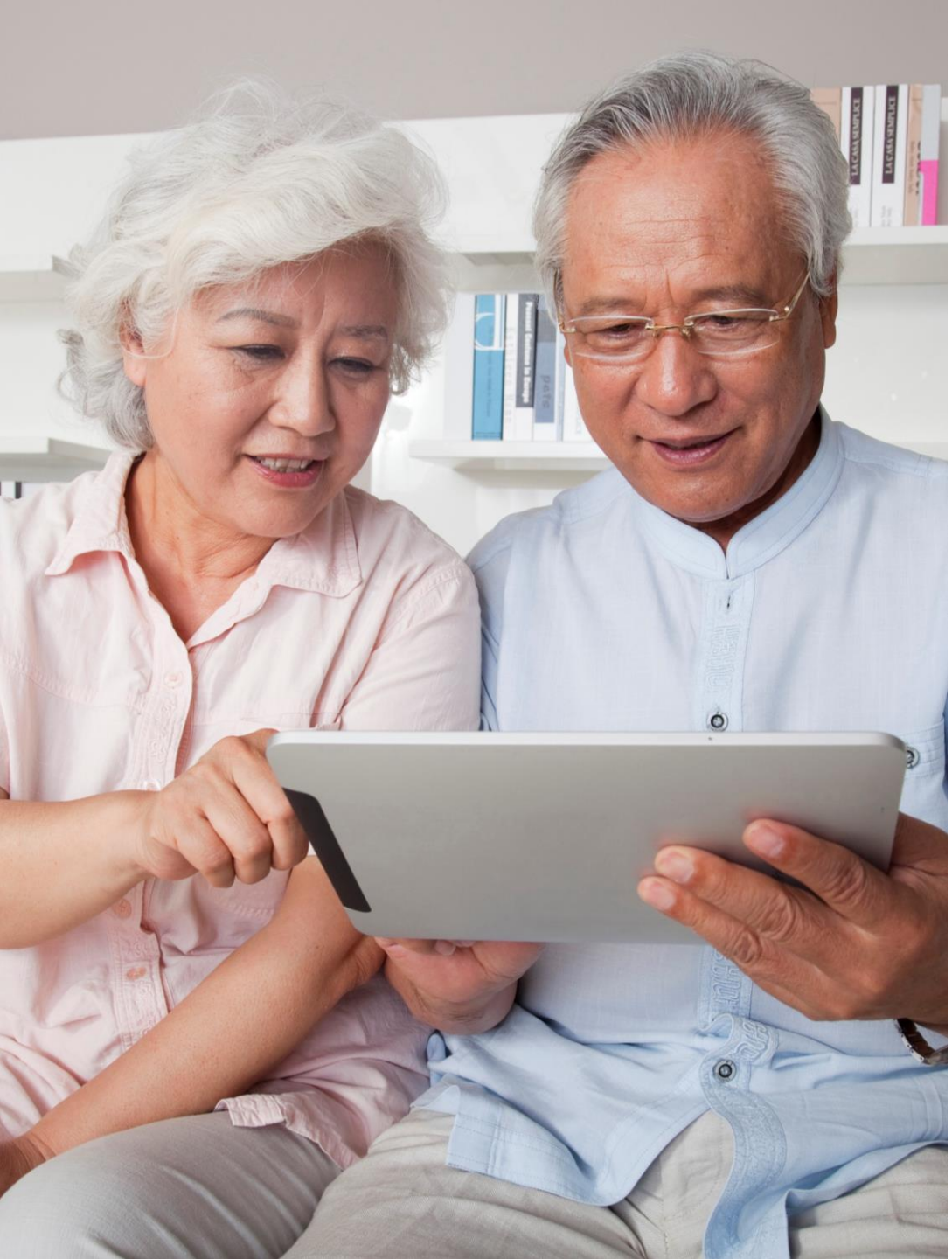
Application Submission Process



Electronic Application is the preferred method when you're with a beneficiary. Paper applications must be mailed within 48 hours of receipt.



Electronic Application

Online Enrollment Options

- **Live with beneficiary**, complete application electronically with a live, secure internet connection. No paper required. Beneficiary signs electronically with mouse/finger.
- **Text-to-sign** – Application is sent electronically through Producer Portal to beneficiary's cell phone # or email address. Beneficiary signs completed app and hits submit. Agent is notified upon submission.
- **Send a Quote** – Send multiple options including Rx costs (optional) directly to beneficiary via email.
- **Personalized Shopping Link** – Beneficiary accesses application through a link on your email signature.

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Telephonic Application

Recorded Telephonic Enrollment

- Initiate inbound call to Producer Support with beneficiary on the line when ready to enroll. Producer **must** remain on the line for compliance purposes.
- Producer Support Representative reads the CMS-approved application script on a recorded line with a voice-recorded signature at the end.
- Producer Support can also facilitate a recorded Scope of Appointment (SOA) on a separate call with the producer remaining on the line. **Please note:** A telephonic SOA is only permissible for a telephonic appointment.

This is an excellent option when beneficiary has no ability to enroll online or through paper application.

Paper Application

Paper enrollment applications can be downloaded or found in the enrollment kit ordered through storefront.

Three ways to submit a paper application:

- **Electronic –** Enter the signed paper application through Quick Entry on the Producer Portal.
- **Broker Phone Enrollment –** Call Producer Support to supply the information from your signed paper application.
- **U.S. Mail –** Mail signed paper application using the Business Reply envelope enclosed in every kit.

IMPORTANT COMPLIANCE REQUIREMENT

All original paper applications **MUST BE** submitted to the plan within **48 hours**, along with the Scope of Appointment and Agent Checklist.

- Upload the documents in the Producer Portal **OR**
- Mail the documents in the pre-paid envelope found in the back of the enrollment kit

Beneficiary Payment Options

Payment Options

Option 1 – Payment Automatically Withheld (Preferred Method)

- Social Security Administration (SSA)
- Railroad Retirement Board (RRB)
- Electronic Funds Transfer (EFT)

Option 2 – Online Payment

- Credit card, debit card or online check

Option 3 – Payment Mailed Directly to the Plan

- Invoice – Can be paid by check or money order.

Payment Options – Enrollment Form Verbiage

If you do not select one of the payment options below, you will receive a monthly invoice. Please select a premium payment option:

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

I get monthly benefits from: ____ Social Security ____ RRB

It can take up to 90 days to receive SSA/RRB withhold acceptance. SSA/RRB will begin deducting on the date of acceptance. Members will receive an invoice for any months prior to the withhold acceptance date by SSA/RRB, which will be their responsibility to pay. In limited circumstances, Medicare may not allow for the SSA/RRB deduction option and may instruct the plan to directly bill the member. If this occurs, you will be notified in writing.

□ Electronic Funds Transfer (EFT) from your bank account each month.

If you choose to have the funds taken directly out of your checking account this is referred to as Electronic Funds Transfer (EFT). If you elect this method of payment, you will receive a letter from the plan requesting a Voided Check be returned with the letter for account setup. Do not submit a voided check at time of enrollment. Your request will be processed within 60 business days of receipt of returned voided check and letter. Premiums are deducted from your bank account on the 2nd day of the month for the current month's coverage.

□ Direct Pay

You will receive a monthly invoice containing payment instructions.

Compliance

Compliance

Compliance is a **top priority**.

Compliance isn’t just about regulations; it is about **protecting members**.

We want you to **understand** the policies and procedures.

Compliance Best Practices

Submit the Original Paper Application

- Original paper application **must be** submitted to the plan within 48 hours upon receipt. Applications may be mailed or uploaded through the electronic enrollment form. **Uploading is the preferred method**.

- If mailing, pre-paid envelopes may be found in the enrollment kit. Mail to:

  Essence Healthcare
  PO BOX 12487
  St. Louis, MO 63132-9922

Selection of the Correct Election Period and Effective Date

- Selecting the wrong enrollment period could impact the processing of the Member's enrollment. Please ensure the correct election period is selected. Please be cognizant of Members' time of the year and Members' eligibility with Medicare - the red, white, and blue card lets you know the effective date of Part A and Part B.

- When enrolling a beneficiary during the months of AEP for current year, ensure quoting the correct benefits for the correct plan year and ensure clearly identifying where benefits differ from current to next year.

Compliance Best Practices

Correctly handle/relay Member inquiries by routing to Customer Service

- While we understand the importance of maintaining Producer/Member relationships, it is crucial that all post-enrollment Member inquiries be routed through the Customer Service Department for Members to receive accurate information and to ensure compliance with CMS regulations for documenting and addressing Member concerns.
- Common post-enrollment Member topics are inquiries regarding coverage/reimbursement requests, network status of a provider, and complaints against the plan.
- Producers are welcome to remain on the call to ensure the Member receives efficient customer support.
- Please note: If a Producer calls into Customer Service for a Member inquiry without the Member on the line, Customer Service will only be able to provide limited support.

Common issues that have resulted from not transferring to Customer Service (CS)

- Members reached out to Producers regarding coverage issues but there was no communication by the Members to Customer Service; Therefore, the Plan never learned about the issues and no resolution steps were initiated.
- Members have received incorrect plan direction from Producers (saying something is covered when it is not).
- Members have been informed by Producers that a complaint would be initiated, but the complaint process did not commence because the Plan never became aware of the complaint as a result of the call not being routed to Customer Service.

Handling Common Member Questions

Is my Provider in the network?

- Essence offers a variety of plan options, depending on the area. Check the rules of the plan for network requirements.
- At the time of enrollment, when a Member is inquiring about whether a Primary Care Physician (PCP), specialist or hospital is participating with the plan, Producers should resource the online Provider directory, as it is most-up-to-date.
    - Please note: Producers should not call a Provider's office or resource the Provider's website to inquire whether the Provider is in network. Producers should resource the online Provider directory.
- To ensure that the appropriate PCP is assigned to a Member, please confirm that the PCP ID number, which can be found on the Provider directory, is provided on the application and that the spelling of the PCP's name is correct.
    - Failure to do so may result in the Member's PCP being auto-assigned.

How do I change my Provider?

- The member should call customer service to change their Primary Care Physician (PCP). A change to PCP will be effective starting on the first of the following month.
- PPO Plans do not require a Primary Care Physician choice.

Handling Common Member Questions

Is my medication covered?

- When discussing a Member's medication, please read the formulary thoroughly when responding to a Member's question and reference the Plan's online formulary for the most up-to-date information.
- For example, on the formulary Producers should pay close attention to the dosage, the form (capsule, tablet, injectable, etc.), the release mechanism (extended release, standard, etc.), special requirements, and the B vs Part D determination.
- At the time of enrollment, if a Member has a question about the coverage of a non-covered drug or service, Producers should educate the member on proper procedures for submitting a coverage request. The Member can contact Customer Service, once their coverage is effective, to request an exception for the non-covered drug or service.

Is this plan a Medicare supplement?

- It's important for Members to understand a Medicare Advantage (MA) plan is a replacement plan, not a Medicare supplement. Please make sure that Members are aware that this is not a traditional Medicare plan.

Handling Common Member Questions

Why isn't my name correct on my ID card?

- To ensure that a Member's name is generated correctly on ID cards, please confirm that the Member's name on the application matches the Member's name on their red, white, and blue Medicare card.

Why am I receiving letters from the plan?

- The Member may receive correspondence requesting additional information regarding a late enrollment penalty (LEP), other health insurance (OHI), or requesting completion of the Health Risk Assessment. The Member should promptly respond to all correspondence sent by the plan to ensure their record is up-to-date.

How do I find plan related information?

- Members can set up an account online at **www.everythingessence.com** to view benefit information, documents, and other helpful information.

Formulary Exceptions and Restrictions

Always use the plan's online formulary to determine how your member's medication is covered and for any details on restrictions. It is important to note that Medicare.gov may not list all restrictions like those below:

- **Step Therapy (ST):** requires you to first try certain drugs before the plan will cover the requested drug.
- **Quantity Limit (QL):** limits the amount of a prescription drug you can get at each prescription fill.
- **Prior Authorization (PA):** requires approval from the plan before the plan will cover the prescription drug.
- **Exceptions:** If a drug is not covered in the way you would like it to be covered (e.g., subject to a restriction or other requirement), you can request an exception by contacting the plan.
- **Pay close attention to capsules vs. tablets and B vs. D drugs. Certain pain medications may have limited refill requirements.**

IMPORTANT UPDATE – INFLATION REDUCTION ACT

For Part B insulin (insulin administered through a durable medical equipment pump) beneficiaries won't pay more than $35 for a one-month supply beginning July 1, 2023. All beneficiaries who take Part D formulary insulins will continue to receive a one-month supply for no more than $35.

Complaints

Types of complaints

- CTM (Medicare)
- CS (Customer Service)
- Compliance Hotline

Complaints can be

- Founded
- Inconclusive
- Unfounded

Founded complaints are either **major** or **minor**.

Complaint Procedure

1. Agents are notified via email, U.S. mail or overnight delivery of any complaints against them.
   - Agency uplines are cc'd on all complaints.
   - Agent response, including supporting documentation, required within 5 business days of receipt
   - All calls including virtual platforms (Zoom) should be recorded and are expected to be provided to the Plan in response of the complaint. This includes but is not limited to calls scheduling appointments and discussing general plan benefits.
   - Agent must NOT contact the member who filed the complaint under any circumstance. If they call you, do answer the call and facilitate a transfer to Customer Service.
2. Essence investigator contacts the beneficiary to research the complaint.
3. All information gathered is presented to the Sales Complaint Review Committee.
   - The committee is comprised of representatives from Sales, Compliance, Legal, Appeals and Grievance and other departments as necessary.
4. In addition to the required agent response, agents have the right to appear in person or telephonically.
5. The complaint is determined by the Sales Complaint Review Committee to be either "founded," "unfounded" or "inconclusive." All complaints may require additional education.
6. Producer is contacted by sales manager with resolution and course of action. Complete process documented in broker's file and held for 10 years.

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TPMO – Third Party Marketing Organizations Call Recordings

Definition

- Third Party Marketing Organization (TPMO) is defined as organizations and **individuals**, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA plan or plans to making an enrollment decision). TPMOs may be a first tier, downstream or related entity (FDRs), but may also be entities that are not FDRs but provide services to an MA plan or an MA plan's FDR.

Disclaimer

- Required standardized disclaimer for TPMOs that sell plans on behalf of more than one MA or Part D plan
- Disclaimer is required to be prominently displayed on TPMO website and marketing materials developed, used, or distributed by TPMO.
- Must be conveyed verbally within first minute of a sales call and electronically when TPMO is communicating with beneficiary through an electronic mechanism.

Call Recording

- TPMOs must record ALL sales, marketing calls, and enrollment calls in their entirety including virtual platforms like Zoom.

Best Practice

- Record it ALL (if in doubt, record!)
- File/Save it to a beneficiary record immediately
- Recordings must be retained for 10 years!

TPMO – Recording Oversight

Random Producer Selection

- Producers may be randomly selected during a monthly audit to supply call or audio meeting recordings of sales activities including but not limited to scheduling appointments and questions about general benefits.
- Producer Support will notify the Producers that they have been selected along with how to submit any call recordings both telephonic and virtual in nature for the request.
- If Producers do not respond to the request, the matter will be turned over to the SIU of the Compliance team for follow up.

Call or Virtual Platform Recordings

- Required standardized disclaimer for TPMOs that sell plans on behalf of more than one MA or Part D plan
- This includes inbound and outbound calls
- CMS is holding all Producers to the same standard.

TPMO – Third Party Marketing Organizations Disclaimers

Disclaimer: Plan does not contract
Disclaimer: We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options.

Disclaimer: Plan does contract
Disclaimer: Currently we represent (insert # of organizations) organizations which offer (insert # of plans) products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program to get information on all your options.

Centers for Medicare and Medicaid Services (CMS) Contract Year (CY) 2024 Final Rule

CMS CY 2024 Final Rule

- On April 12, 2023, CMS released their CY 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (Final Rule).

- The marketing and communications provisions go into effect September 30, 2023, and are applicable for contract year 2024 and beyond marketing and communications.

- The following slides outline the impact of the CMS CY 2024 Final Rule on your role as contracted brokers, agents and Third-Party Marketing Organizations (TPMOs) during the upcoming Annual Enrollment Period and beyond.

- Compliance is everyone's responsibility. Please reach out to the Plan with questions about the following provisions. We're here to support you.

CMS CY 2024 Final Rule

Prohibited Practices:

- Misleading use of the Medicare name and/or associated Federal Government Logos
  - Use of the Medicare card image is permitted only with prior authorization from CMS (applicable to both marketing and communication materials or activities).
- The use of superlatives not supported by cited data.
  - Cited data must be about, from or based on the current year or prior contract year.
- Advertising benefits not available to all beneficiaries in a service area.
  - "Unavoidable Marketing" exception to this rule exists only for advertising in local media where reaching beneficiaries who reside in a service area where the benefits are not available is unavoidable. This exception does not apply to national marketing.
- Promoting unrealistic savings opportunities to potential enrollees
  - Promoting savings that are based on a comparison of expenses paid by uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a Medicare beneficiary is prohibited.

CMS CY 2024 Final Rule

Prohibited Practices:

Marketing of any products, plans, benefits, or costs, unless the Plan's name or marketing name is identified in the marketing material.

The Plan's name or marketing name must be displayed in the marketing material in accordance with the following requirements:

- **Print** must be in 12-point font and may not solely be in the disclaimer or fine print (fine print means printed matter in small type or inconspicuous manner).

- **TV, online, and social media** must be either read at the same pace as the phone number or must be displayed throughout the entire advertisement in a font size equivalent to the advertised phone number, contact information, or benefits.

- **Radio** and other only voice-based materials must be read at the same pace as the advertised phone numbers or other contact information.

CMS CY 2024 Final Rule

TPMO Marketing Requirements:

- TPMOs are required to submit relevant marketing materials to Plans for review **prior** to CMS submission.
  - This will give Plans the opportunity to address concerns with the TPMO and incorporate updates appropriately prior to CMS submission; reducing the potential need for a material to be pulled or for a material not to be used for a Plan having opted-out in HPMS.

- TPMOs must identify all MA organizations or Part D sponsors that a marketing material is applicable to that markets any products, plans, benefits, or costs.
  - By requiring MA organization and Part D sponsor names in marketing materials, both CMS and the organization can ensure that only those MA organizations and Part D sponsors who opted into the TPMOs marketing piece are being advertised in that material.

- Updates to current TPMO disclaimer and new TPMO disclaimer:
  - New TPMO Disclaimer for TPMOs that **do** contract with every MA organization or Part D sponsor in a service area.
  - Add State Health Insurance Programs (SHIPs) as an option for beneficiaries to obtain additional help
  - Disclaimer must state the number of organizations represented by the TPMO as well as the number of plans offered by the TPMO in the beneficiary's service area.

CMS CY 2024 Final Rule

Sales and Marketing Guidelines:

- 12-hour waiting period required for holding marketing events in the same location within an educational event.
  - The same location means the entire building and/or adjacent buildings
- Distributing and collecting SOAs and setting up future marketing appointments at educational events is prohibited.
  - However, the collection of beneficiary contact information, including the dissemination and collection of Business Reply Cards at educational events is permitted.
- After the completion of a SOA, there is a 48-hour waiting period for holding a personal marketing appointment.
  - The two exceptions are for (1) SOAs completed during the last 4 days of a valid election period and (2) unscheduled in-person visits (walk-ins) initiated by the beneficiary.

CMS CY 2024 Final Rule

Sales and Marketing Guidelines:

- SOAs and requests for more information from beneficiaries are valid for 12 months.

- Door to door solicitation is prohibited unless an appointment at the beneficiary's home at the applicable date and time was previously scheduled.
  - Request for Information (RFI), such as permission to contact, a business reply card, or other type of document where the beneficiary requests additional information does not permit door-to-door solicitation.
  - RFIs are intended to permit the agent to reach out via phone, email, or direct mail.

CMS CY 2024 Final Rule

Sales and Marketing Guidelines:

- All marketing, sales, and enrollment calls must be recorded in their entirety (including the audio portion of calls occurring via web-based technology).
- Agents and brokers are required to review specific topics (a checklist) with beneficiaries prior to an enrollment.
    - The checklist must cover topics such as network, prescription and healthcare costs, and beneficiary need in a healthcare plan.
    - CMS will provide detailed questions and subjects that must be covered on the checklist; We will provide the checklist to you once the guidance is finalized.
- In addition to the standardized Pre-Enrollment Checklist (PECL) being required to accompany an enrollment form, the PECL must also be reviewed prior to the completion of a telephonic enrollment.
- We will monitor agent and broker adherence to the CMS checklist requirement.

Reminders

Important Dates – Don't Forget!

October 1 – Annual Election Period (AEP) marketing begins

October 15 – AEP selling begins

- AEP applications can be received beginning this day.

December 7 – AEP ends

- Any AEP application submitted after this day must have an attestation that it was received on 12/7.

January 1 to March 31 – Medicare Open Enrollment Period (OEP)

- Beneficiaries can make a one-time enrollment into another MA plan (with or without drug coverage) if they are currently in a MA plan (with or without drug coverage) or they may return to Original Medicare and enroll in a Prescription Drug Plan (PDP).
- Be aware of CMS marketing guidance regarding sales activity during OEP.

Who to Call, When to Call

Producer Support

Technical issues regarding the producer portal

Assistance submitting an enrollment

Help using provider search tool

Onboarding support

877-259-8657

producersupport @lumeris.com

Customer Service

Benefit questions

Request for documents or ID cards

Questions regarding billing

Member complaints or grievances

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