NA [2024] CCP Wellcare Inbound/Outbound TeleSales Enrollment Script

Text Color Key
Blue Text = Representative to Customer
Blue Bold Underline Text = Recorded Statement
Red Bold Underline Text = Section Hyperlink
Black Bold Italics = Representative Conditional Statements ("If Statements")
Black Italics = Representative Actions
Red Text &/or [ ] = Variable Information

- **This script is used when an inbound caller wishes to complete an enrollment with a licensed Teleservices Representative through the Online Enrollment Portal. This will be used with CCP TelesalesTalking Points Inbound Calls.**
- **This script is used when an inbound caller wishes to complete an enrollment with a non-licensed Teleservices Representative through the Online Enrollment Portal after receiving a licensed agent sales presentation.**
- **This script is used during an outbound call when a beneficiary wishes to complete an enrollment with a Teleservices Representative through the Online Enrollment Portal. This will be used with the CCP Telesales Talking Points Outbound Calls when outreaching to current members who will be experiencing a loss of coverage or plan non-renewal.**
- **This script is used during an outbound call when a beneficiary wishes to complete an enrollment with a Teleservices Representative through the Online Enrollment Portal. This will be used with the CCP Telesales Talking Points Outbound Calls when outreaching our existing members to discuss our Medicare Advantage plan and Medicare Advantage Prescription Drug Plan options in compliance with MIPPA and 42 CFR Part 422 Subpart V -- Medicare Advantage Communication Requirements.**
- **Consent to monitor & record is captured in the IVR for inbound scripts NA [2024] CCP Telesales Talking Points Inbound Calls and NA CCP [2024] Inbound Prospect Non-Licensed Agent Lead Qualify Sales Script.**

0	**Setting up the application**

TSR Directive Licensed Agent: *Confirm you have the correct SFDC lead information by ensuring the name crossing over matches who you are speaking with before preceding with enrollment.*

TSR Directive Non-Licensed Agent: *When the warm transferring Licensed Agent comes on the line ask for the following information and once confirmed from SFDC*

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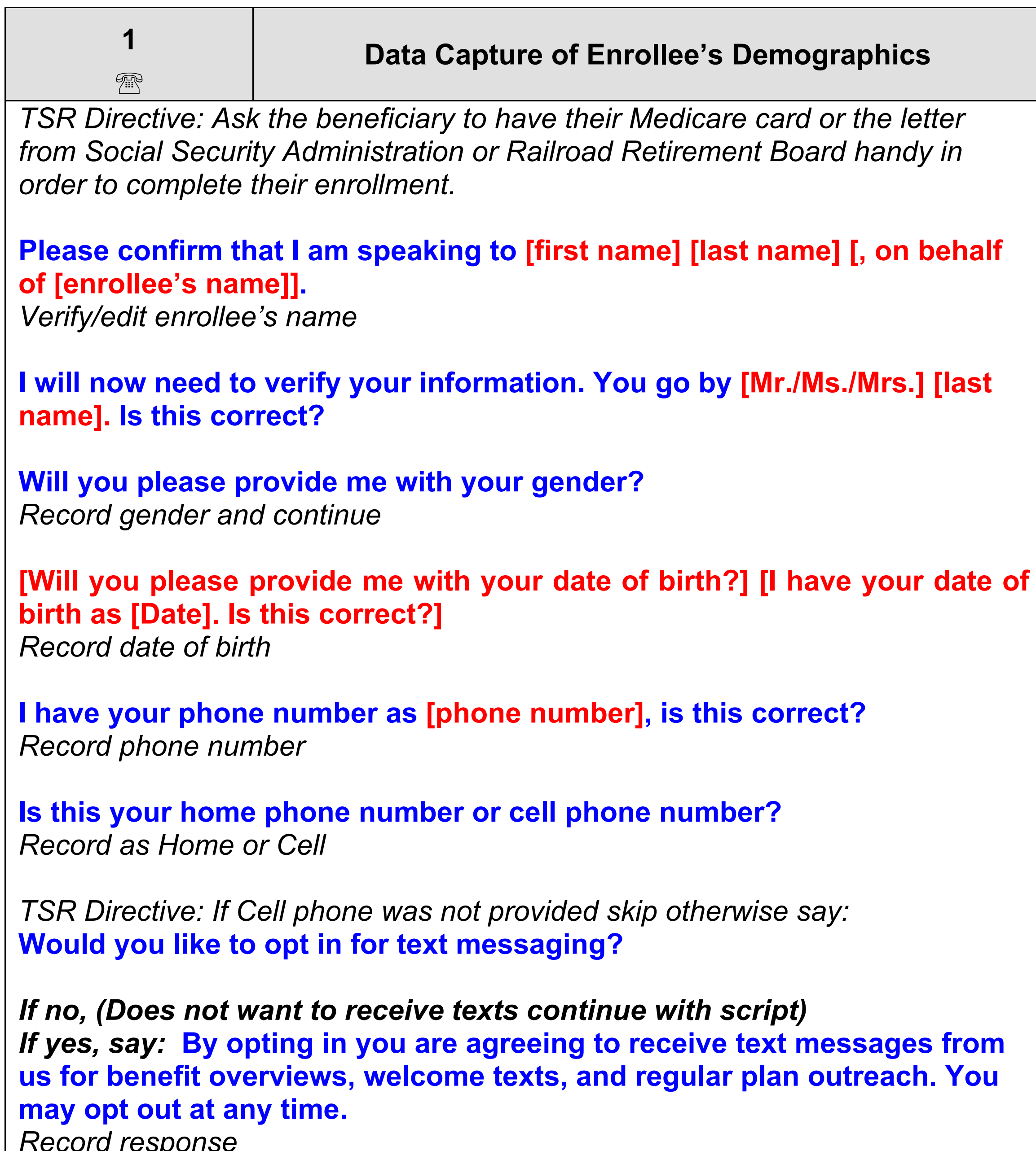
have them proceed with the transfer.
- *Licensed Agent Name*
- *Site Location Name*
- *Appointment ID#*
- *Plan Name (enrolling beneficiary into)*
- *Effective Date*
- Election Period (utilized)



1 ☏	**Data Capture of Enrollee's Demographics**

TSR Directive: Ask the beneficiary to have their Medicare card or the letter from Social Security Administration or Railroad Retirement Board handy in order to complete their enrollment.

Please confirm that I am speaking to [first name] [last name] [, on behalf of [enrollee's name]].
Verify/edit enrollee's name

I will now need to verify your information. You go by [Mr./Ms./Mrs.] [last name]. Is this correct?

Will you please provide me with your gender?
Record gender and continue

[Will you please provide me with your date of birth?] [I have your date of birth as [Date]. Is this correct?]
Record date of birth

I have your phone number as [phone number], is this correct?
Record phone number

Is this your home phone number or cell phone number?
Record as Home or Cell

TSR Directive: If Cell phone was not provided skip otherwise say:
Would you like to opt in for text messaging?

If no, (Does not want to receive texts continue with script)
If yes, say: **By opting in you are agreeing to receive text messages from us for benefit overviews, welcome texts, and regular plan outreach. You may opt out at any time.**
Record response

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Do you agree to receive non-telemarketing calls from the health plan using an automated phone dialing system that provides relevant, timely information regarding your health care and coverage? These calls may be prerecorded. You may opt out at any time by calling the number on the back of your ID card or by signing in to your [Company] account via the website. Giving your consent to get calls or texts is not a condition to get the plan's products or service.

If yes, (Agrees to Consent)
If no, (Does not Consent)
Capture response regarding consent.

TSR Directive: If email address was not provided skip otherwise say: **I have your email address as [email address], is this correct?**

Please know that by providing your email address, you are agreeing to receive emails from us. We will give you the opportunity to opt in and you may always opt out of future email communications.
Record email address

As a member many plan documents are available in digital format. To receive digital communications would you like to go paperless?
Record Yes or No response

What is your preferred method of contact phone, text, or email?
Record response
Please note that communications may be sent outside of chosen 'Preferred method of contact'

I have your permanent address as [street address, city, state, and county/parish]. Is this correct? ***Record address then say:***
Should you ever experience homelessness now or in the future and you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

I have your mailing address as [the same as your permanent address/[street address, city, state, and county/parish]]?

> ***If the address given is a P.O. BOX, say:*** **Per Medicare Guidance, we cannot accept a P.O. Box as a residential address. Your P.O. Box can be added as your Mailing Address. Can you please provide a**

physical address?

If YES, update the address.

If NO, add P.O. Box as the physical address and advise: **This application may be placed on HOLD through the enrollment process until the residential address is confirmed. You will receive a letter or call to obtain additional information in order to process the application.**
Record address

Go to Section 2.

2	Plan Selection

I am confirming that you are applying for yourself today?

If yes, *click here to continue with script.*

If no, say:
Please be advised that upon completion of this enrollment request, you will certify that you are authorized to complete this enrollment under state law and that documentation of this authority is available upon request by [Company] or by Medicare.

Please keep in mind that if you want additional information going forward regarding the enrollee's account or need to make updates such as member record changes, [Company] must have your documentation on file that authorizes you to review their account.

If being enrolled by the authorized representative, say:
May I have your name, phone number, address and relationship to the enrollee? Do you want all the enrollee's mail sent to this address?
Capture contact information. Capture response regarding mail request.

[Mr./Ms./Mrs.] [last name], you intend to enroll in the [plan name] [HMO/HMO-POS/HMO SNP/PPO/PFFS], which is a [MA/MAPD] plan offered by [Company] with an effective date of [effective date], is this correct?

If yes, **click here to continue with script**

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TSR directive: Confirm the proposed effective date with beneficiary and select in the drop-down. Confirm the Plan Name that the beneficiary would like to enroll in and select in the drop-down.

If no, say:

Which plan are you choosing to enroll in?

Record plan name, verify service area availability for selected plan.

If the plan selected is not in the [Company] service area, say:

I am sorry but the plan you have selected is not offered in your service area. Is there another plan you would like to select?

If yes, ***select appropriate plan and click here to continue with script.***

If no, ***go to section 13 Alternate Closing (Denial).***

Will you please confirm that your preferred language is [preferred language], is this correct?

TSR Directive: Confirm the preferred language the beneficiary needs when interacting with [Company] and select in the Drop-Down. Click "Continue Enrollment Application."

Go to Section 3.

3 	Emergency Contact Information

Would you like to provide us with Emergency Contact Information?

Record contact information if given

Capture and verify:

- *Contact name*
- *Contact Phone number*
- *Relationship to beneficiary*

Go to Section 4.

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4 ☏	Primary Care Physician

If enrolling beneficiary in a PPO plan, say: **[Please note if you are enrolling into a PPO Plan and your provider is not currently participating with [Company], the provider will need to agree to the payment terms of the plan in order to be seen.]** ***Continue below.***

If the beneficiary DID NOT SELECT a PCP/IPA, please say: **You will be automatically assigned a PCP and if you would like to change it, you may do so by calling Member Services after you have received your acknowledgement letter from [Company].** *Check off the check box where it states I do not wish to select a PCP. And* ***Click here to continue with script.***

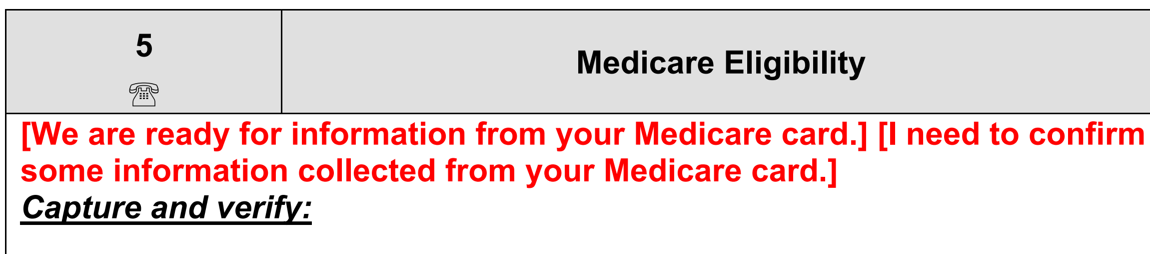
If the beneficiary SELECTED a PCP/IPA, please say: **You stated that you have [a] [[primary care physician (PCP)]/ [IPA][Clinic]/ [Health Center]]. Is this correct?**

If no, say: **You will be automatically assigned a PCP and if you would like to change it, you may do so by calling Member Services after you have received your acknowledgement letter from [Company].** ***Click here to continue with script.***

If yes and the enrollee has a provider ID/IPA ID, say: **Your [[primary care physician (PCP)]/[IPA]] is [first name] [last name] and [his/her] ID number is [ID number] [IPA ID number]. Is this correct?**

If Yes or No, capture/verify Name and PCP/IPA#.Confirm accuracy of selection/valid PCP entered before continuing. ***Click here to Continue with script.***

Go to Section 5



5 ☏	Medicare Eligibility

[We are ready for information from your Medicare card.] [I need to confirm some information collected from your Medicare card.]
Capture and verify:

[What is your:] [May I please confirm your:]

- **Medicare Number?** *Capture without hyphens.*
- **Hospital (Part A) effective date?** *Capture (MM/DD/YYYY).*
- **Medical (Part B) effective date?** *Capture (MM/DD/YYYY).*

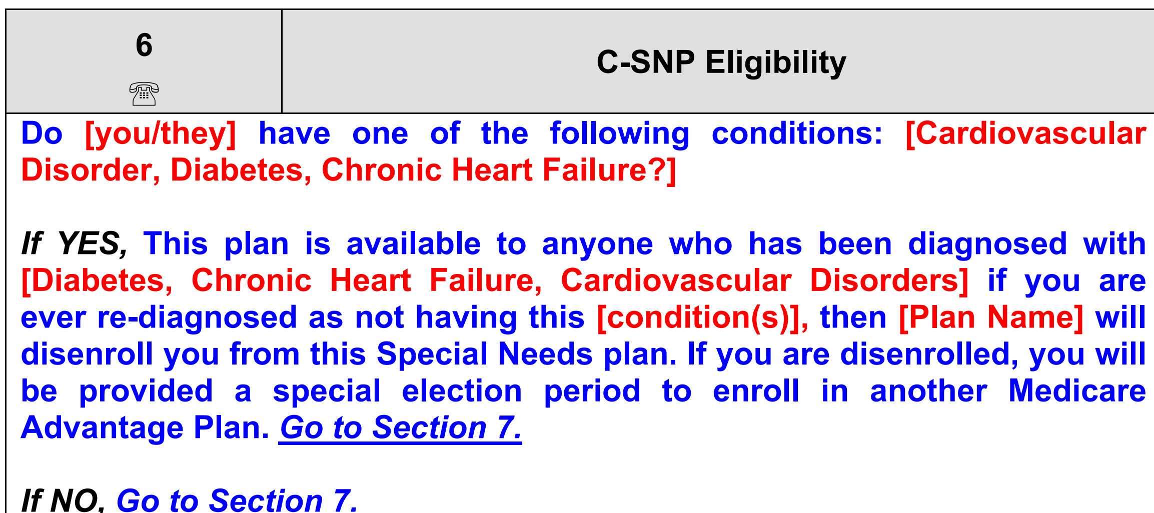
Thank you for providing me with this information.

If Medicare # given does not follow the standard format, say: **The Medicare ID number you provided does not match our records. Can you please provide me with the Medicare ID Number again?**

If YES, update the Medicare ID.

If NO, add the Medicare ID and advise: **This application may be placed on hold through the enrollment process until we receive a Medicare ID that is recognized by Medicare. You will receive a letter or call to obtain additional information in order to process the application.**

If Enrolling into C-SNP plan ***Go to Section 6.***
If Enrolling into All Other plans ***Go to Section 7.***



6 ☎	C-SNP Eligibility

Do [you/they] have one of the following conditions: [Cardiovascular Disorder, Diabetes, Chronic Heart Failure?]

If YES, **This plan is available to anyone who has been diagnosed with [Diabetes, Chronic Heart Failure, Cardiovascular Disorders] if you are ever re-diagnosed as not having this [condition(s)], then [Plan Name] will disenroll you from this Special Needs plan. If you are disenrolled, you will be provided a special election period to enroll in another Medicare Advantage Plan.** ***Go to Section 7.***

If NO, Go to Section 7.

7 ☎	Election Period Checklist

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*Note to TeleServices Representative: If it is during AEP (October 15 – December 7), **Go to Section 8**, or if it is December 8 to October 14, continue with the script below.*
Read the disclosure below and confirm the appropriate SEP that the beneficiary confirmed with you earlier in the call. If necessary, review the SEP list to determine the appropriate election period. Make sure to select all the boxes that apply.

[Mr./Ms./Mrs.] [last name], typically you may enroll in a Medicare Advantage Plan only during the Annual Enrollment Period from October 15 to December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage Plan outside the annual enrollment period. Based on our previous conversation,

TSR directive: Choose the appropriate SEP language below to complete the above statement.

1. **I am confirming that you are new to Medicare. Is this correct?**

   If yes, say: **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled. *Click here and continue with script.***

   If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

2. **I am confirming that you already have Hospital (Part A) and recently signed up for Medical (Part B). You want to join a Medicare Advantage Plan?**

   If yes, say: **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled. *Click here and continue with script.***

   If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

3. **I am confirming that you are new to Medicare and were notified about getting Medicare after your Part A and/or**

Part B coverage started?

If yes, say: **When did your coverage begin?** *Capture Date MM/DD/YYYY.* **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

4. **I am confirming that you recently moved outside of the service area for your current plan or you recently moved and this plan is a new option for you. Is that correct?**

   If yes, say: **When did you move?** *Capture Date MM/DD/YYYY.* **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

   If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

5. **I am confirming that you recently had a change in your Extra Help paying for your Medicare prescription drugs (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date). Is this correct?**

   If yes, say: **When did you stop receiving Extra Help?** *Capture Date MM/DD/YYYY.* **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

   If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

6. **I am confirming that you are moving into, currently live in**

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or have recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). Is this correct?

If yes, say: **When [did you move/will you move] [into/out of] the facility?** *Capture Date MM/DD/YYYY.* **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

7. **I am confirming that you have recently left a PACE program. Is this correct?**

   If yes, say: **When did you leave?** *Capture Date MM/DD/YYYY.* **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

   If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

8. **I am confirming that you have recently involuntarily lost your prescription drug coverage that was as good as or better than the drug coverage provided by Medicare. Is this correct?**

   If yes, say: **When did you lose this coverage?** *Capture Date MM/DD/YYYY.* **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

   If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

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9. **I am confirming that you are leaving your employer or union coverage. Is this correct?**

   If yes, say: **When will you leave this coverage?** *Capture Date MM/DD/YYYY.* **By confirming you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

   If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

10. **I am confirming that you have both Medicare and Medicaid, (or the state helps pay for your Medicare premium) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change. Is this correct?**

    If yes, say: **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and Continue with script.***

    If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

11. **I am confirming that you belong to a pharmacy assistance program provided by the state. Is this correct?**

    If yes, say: **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

    If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

12. **I am confirming that you recently returned to the United States after living permanently outside of the country. Is this correct?**

    If yes, say: **When did you return to the U.S.?** *Capture Date MM/DD/YYYY.* **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

    If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

13. **I am confirming that you are enrolled in a Medicare Advantage Plan that is ending its contract with Medicare, or Medicare is ending its contract with your plan. Is this correct?**

    If yes, say: **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

    If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

14. **I am confirming that you were recently released from incarceration?**

    If yes, say: **On what date were you released?** *Capture Date MM/DD/YYYY.* **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

    If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

15. **I am confirming that you recently obtained lawful**

presence status in the United States?

If yes, say: **On what date was this status obtained?** *Capture Date MM/DD/YYYY.* **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

16. **I am confirming that you were enrolled in a Special Needs Plan, but you have lost the special needs qualifications required to be in that plan. Is this correct?**

    If yes, say: **When were you disenrolled from the SNP plan?** *Capture Date MM/DD/YYYY.* **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

17. **I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on** *Capture Date MM/DD/YYYY.*

    If yes, say: **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

    If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

18. **I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on** *Capture Date MM/DD/YYYY.*

    If yes, say: **By confirming, you are certifying to the best of your knowledge, you are eligible for an**

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Enrollment Period. If we later determine this information is incorrect, you may be disenrolled. ***Click here and continue with script.***

If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

19. **I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster. I missed the Enrollment for** *Capture Enrollment Period*

    If yes, say: **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

    If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

20. **I am confirming that in the last 12 months, you joined a Medicare Advantage plan with prescription drug coverage when you turned 65. Is this correct?**

    If yes, say: **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

    If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

21. **I am confirming that you are enrolling in a 5-Star Medicare Plan. Is this correct?**

    If yes, say: **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click***

here and continue with script.

If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

22. **I am confirming that you have had Medicare prior to now, but am now turning 65. Is this correct?**

    If yes, say: **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

    If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

23. **I am confirming that you are enrolled in a plan placed in receivership?**

    If yes, say: **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

    If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

24. **I am confirming that you are enrolled in a plan identified by CMS as a Consistent Poor Performer?**

    If yes, say: **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

    If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

25. **I am confirming that you want to join a Special Needs Plan that tailors its benefits to your chronic condition?**

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If yes, say: **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

If no, *continue to ask the rest of the SEP questions until you get a yes in order to continue with the enrollment.*

26. **I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).**

If yes, say: **By confirming, you are certifying to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine this information is incorrect, you may be disenrolled.** ***Click here and continue with script.***

If no, to all questions, and it is NOT during AEP (October 15 – December 7), say: **None of these election periods apply to you.** ***Go to section 13 Alternate Closing (Denial).***

Select 1 of the variables below:

- ***If the beneficiary confirms that the SEP that was given on the previous conversation is correct Go to Section 8.***
- ***If the SEP is different from the previous conversation, say:*** **Based on the information you have provided, you will have the following effective date of coverage [date(s)].** ***Go to Section 8.***

If multiple effective dates are available, say:
Which effective date would you prefer?
Edit/verify effective date and continue, ***Go to Section 8.***

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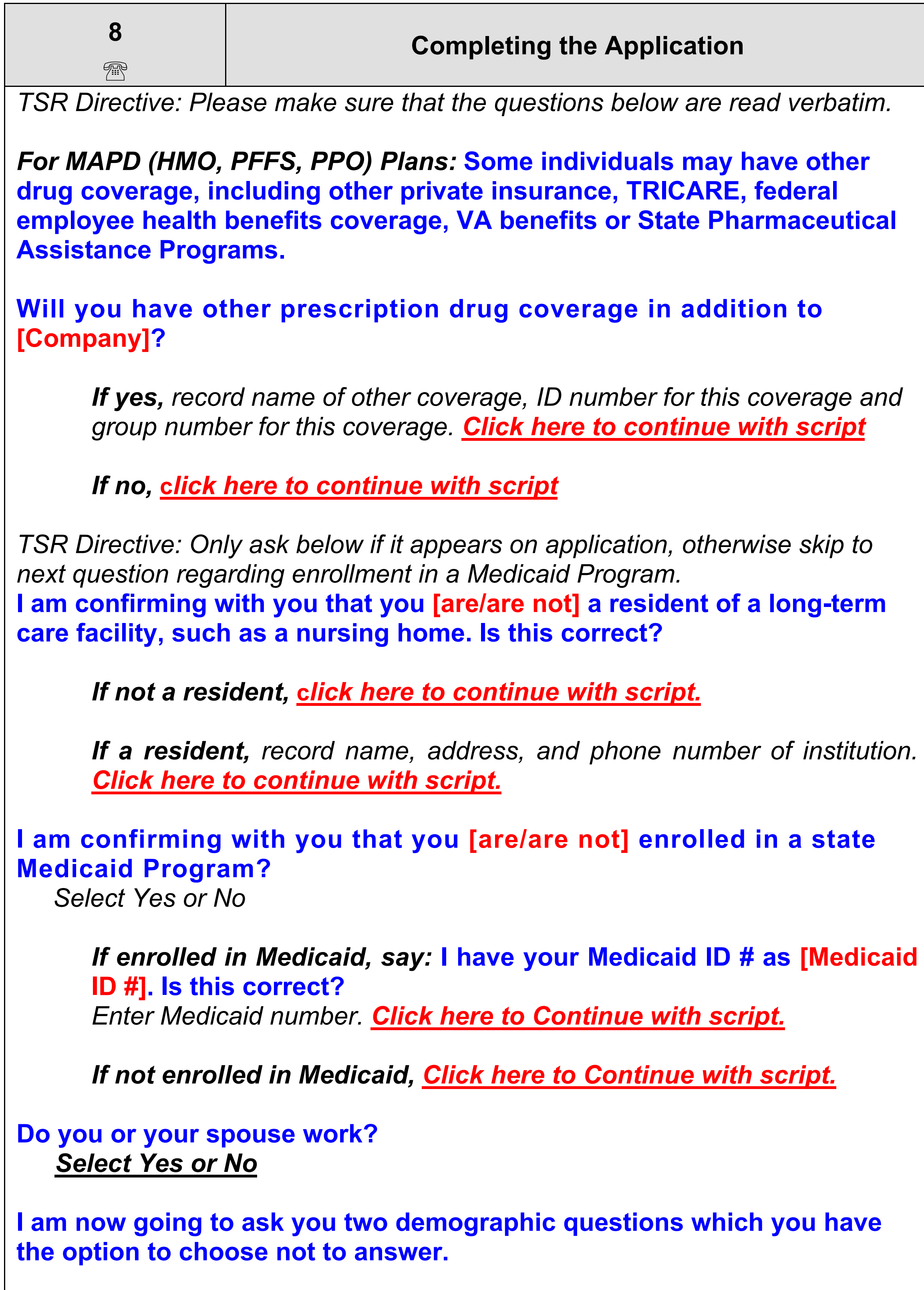

8 ☏	Completing the Application

TSR Directive: Please make sure that the questions below are read verbatim.

For MAPD (HMO, PFFS, PPO) Plans: **Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits or State Pharmaceutical Assistance Programs.**

Will you have other prescription drug coverage in addition to [Company]?

> ***If yes,*** *record name of other coverage, ID number for this coverage and group number for this coverage.* ***Click here to continue with script***
>
> ***If no, click here to continue with script***

TSR Directive: Only ask below if it appears on application, otherwise skip to next question regarding enrollment in a Medicaid Program.
I am confirming with you that you [are/are not] a resident of a long-term care facility, such as a nursing home. Is this correct?

> ***If not a resident, click here to continue with script.***
>
> ***If a resident,*** *record name, address, and phone number of institution.* ***Click here to continue with script.***

I am confirming with you that you [are/are not] enrolled in a state Medicaid Program?
Select Yes or No

> ***If enrolled in Medicaid, say:*** **I have your Medicaid ID # as [Medicaid ID #]. Is this correct?**
> *Enter Medicaid number.* ***Click here to Continue with script.***
>
> ***If not enrolled in Medicaid, Click here to Continue with script.***

Do you or your spouse work?
Select Yes or No

I am now going to ask you two demographic questions which you have the option to choose not to answer.

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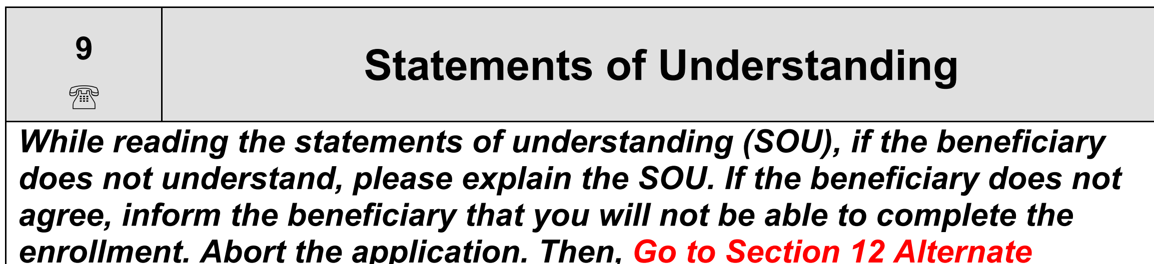
1. **Are you Hispanic, Latino/a, or Spanish origin?** *Capture response*
    - *Chooses Not to Answer*
    - *No, Not of Hispanic, Latino/a or Spanish origin*
    - *Yes, Provides Origin.*
    - *Yes, but did not provide origin say:* **May I know is that Mexican, Mexican American, Chicano, Puerto Rican, Cuban, or Another Hispanic/Latino/Spanish origin that I did not mention?** *Await response*

2. **What's your race?** *TSR Directive: If the race is not listed, select "Chooses Not to Answer"*
    - *Chooses Not to Answer*
    - *American Indian or Alaska Native*
    - *Asian Indian*
    - *Black or African American*
    - *Chinese*
    - *Filipino*
    - *Guamanian or Chamorro*
    - *Japanese*
    - *Korean*
    - *Native Hawaiian*
    - *Other Asian*
    - *Other Pacific Islander*
    - *Samoan*
    - *Vietnamese*
    - *White*

If you need information in a different language or format such as Braille or audio, please call us using the phone number on the back of your ID card to check the availability in your area.

Go to Section 9.



9	Statements of Understanding

While reading the statements of understanding (SOU), if the beneficiary does not understand, please explain the SOU. If the beneficiary does not agree, inform the beneficiary that you will not be able to complete the enrollment. Abort the application. Then, Go to Section 12 Alternate

Closing (Abort Application).

[Mr./Ms./Mrs.] [last name], I will now [read/play] several statements of understanding messages to ensure you understand the plan you wish to enroll in and to make sure you have the information needed to complete the enrollment process. After each statement, we will need for you to confirm if you understand. If you understand, please say "I agree" after each statement. If for some reason you don't understand what is being said to you, please say "stop" and I will explain any information you don't understand. Once you understand, we will read the same statement back to you and you will need to confirm you understand by saying "I agree." I will begin now:

1. ***If Plan has reimbursement (give back), say*****: The [[Company]] [plan name] Plan has a reimbursement of [$XX] for your Part B Coverage. It is important for you to know the reimbursement is set up by Medicare and administered by the Social Security Administration (SSA). If you pay your Part B premium through your Social Security benefit check, you will see an increase in your benefit check. If your premium is paid by Medicare, you will get a credit on your Medicare Part B Statement. Reimbursements typically take up to 90 days to be issued. However, if this is the case you will receive full credit once it is set up. If you have Medicaid, your Part B premium is paid for you by the state. Therefore, you will not receive a reimbursement for the premium.**

Continue with script.

Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

2. ***If MAPD Plan, say*****: If you currently have health coverage from**

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an employer or union, joining a [Company] plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join [Company]. Read the communications your employer or union sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.
Continue with script.

Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

3. ***3A. For MAPD plans, say:*** **[Plan Name] is a [Medicare Advantage] plan and has a contract with the Federal government. Our D-SNP plans have a contract with the state Medicaid program. Enrollment in our plans depends on contract renewal.** *Continue to 3B*

3B. **You must keep Hospital (Part A) and Medical (Part B) to stay in [Plan Name].**

When you enroll in one of our plans, [Company] pays for services covered by Medicare. However, you still need to pay for your Part B premium, unless it's paid on your behalf by someone else. You will be responsible for the amounts that [Company] does not cover such as co-pays or coinsurances, if applicable.

You understand that you can be enrolled in only one MA plan at a time - and that enrollment in this plan will automatically end your enrollment in anotherMA Plan (exceptions apply for MA

PFFS, MA MSA Plans).

Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

4. ***If MA-only Plan, say:*** **The plan you had selected does not have prescription drug coverage. Do you understand that if you don't have or get other Medicare Prescription Drug Coverage or creditable prescription drug coverage (as good as Medicare's) for a continuous period of 63 days or more, you may have to pay a late enrollment penalty if you enroll in Medicare Prescription Drug coverage in the future?**
   Continue with script.

Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

5. **Enrollment in this plan is generally for the entire year. Once you enroll, you may leave this plan or make changes only at certain times of the year when an enrollment period is available, generally during the Annual Enrollment Period**

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(October 15–December 7 of every year), unless you qualify for certain special circumstances.

Continue with script.

Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

6. ***If HMO w/POS Plan, say:*** **You may get health care services from any provider who is in [Company] [plan name] Plan's network. You may also receive certain health care services from providers out of [Company] [plan name] Plan's network with a referral from your primary care physician (PCP). With the exception of emergencies or urgent care, it may cost more to get care from out-of-network providers.**

   Continue with script.

Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

7. **[Company] serves a specific service area. If you move out of the area that [Company] serves, you need to notify the plan so you can disenroll and find a new plan in your new area.**

Once you are a member of [Company], you have the right to appeal plan decisions about payment or services if you disagree. You will read the Evidence of Coverage document from [Company] when you get it so you know which rules you must follow to get coverage with this Medicare Advantage plan. You understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

8. **For MAPD Plans**

8A. [MAPD Plans say] you understand that when your [Company] coverage begins, you must get all of your medical [and prescription drug benefits] from [Company]. *Continue to 8B.*

8B. Benfits and services provided by [Company] and contained in your [Company] "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. NEITHER MEDICARE NOR [Company] WILL PAY FOR THE SERVICES THAT ARE NOT COVERED.

You understand that if you are getting assistance from a licensed sales agent, broker or other individual employed by or contracted with [Company], he/she may be paid based on your enrollment in [Company].

Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

9. **By joining this Medicare Advantage plan, you acknowledge that [Company] will share your information with Medicare, who may use it to track your enrollment, to make payments, for other plans and providers, and purposes allowed by Federal law that authorize the collection of this information.**
Your response to this enrollment is voluntary. However, failure to respond may affect enrollment in the plan. The information on this enrollment application is correct to the best of your knowledge. You understand that if you intentionally provide false information on this application, you will be disenrolled from the plan.

Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

10. **On this date, you understand that by completing this enrollment request, you understand the enrollment application process as described to you on this call.**

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If you are not the enrollee, only authorized individuals can enroll on behalf of an enrollee. Your agreement means you certify that: 1) you are authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request by [Company] or by Medicare.

Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

Go to Section 10. To Continue for MAPD Plans

For PFFS Plans

11. **Wellcare PFFS, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare Supplement plan as well as other Medicare Advantage plans. We have network providers (that is, providers who have signed contracts with our plan) for all services covered under Original Medicare. These providers have already agreed to see members of our plan. If your provider is not one of our network providers, then the provider is not required to agree to accept to the plan's terms and conditions of payment, they may choose not to provide healthcare services to you, except in emergencies. If this happens, you will need to find another provider that will accept our terms and conditions of payment. You should verify that your provider(s) will accept Wellcare PFFS before each visit. Providers can find the plan's terms and conditions of payment on our website at: www.Wellcare.com/medicare. Once Wellcare PFFS has your enrollment application, you will get a call from a plan representative. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intent to enroll in Wellcare PFFS. If Wellcare PFFS is not able to reach you by telephone, then you will get a letter by mail that contains similar**

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information.

Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

12A. For PFFS MA Only plans say: **You understand that if you choose a Wellcare PFFS plan without prescription drug coverage, you may get coverage from another Medicare prescription drug plan. If you have not selected a plan that includes prescription drug coverage, and if you do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.**

12B. For PFFS MAPD plans say: **If you currently have health coverage from an employer or union, joining Wellcare PFFS could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Wellcare PFFS may change how your current coverage works. You or your dependents could lose your other health or drug coverage completely and not get it back if you join Wellcare PFFS. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.**

Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,

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Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

13. **You must keep both Hospital (Part A) and Medical (Part B) to stay in Wellcare PFFS. You understand that this plan is a Medicare Advantage Private Fee-for-Service plan and you can be in only one Medicare health plan at a time. You understand that your enrollment in this plan will automatically end your enrollment in another Medicare health plan or Medicare prescription drug plan. It is your responsibility to inform us of any prescription drug coverage that you have or may get in the future.**

Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

14. **Enrollment in this plan is generally for the entire year. Once you enroll, you may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7 of every year), or under certain special circumstances.**

Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee

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understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

***15.* <u>As a Medicare Private Fee-for-Service plan, Wellcare PFFS works differently than a Medicare supplement plan as well as other Medicare Advantage plans. Wellcare PFFS pays instead of Medicare, and you will be responsible for the amounts that Wellcare PFFS does not cover, such as copayments and co-insurances. Original Medicare will not pay for your healthcare while you are enrolled in Wellcare PFFS. Before seeing a provider, you should verify that the provider will accept Wellcare PFFS. You understand that your healthcare providers have the right to choose whether to accept Wellcare PFFS payment terms and conditions every time you see them. You understand that if your provider does not accept Wellcare PFFS, You will need to find another provider who will.</u>**

Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

***16.* <u>You understand that when your Wellcare PFFS coverage begins, you must get all of your medical and prescription drug benefits from Wellcare PFFS. Wellcare PFFS serves a specific service area. If you move out of the area that Wellcare PFFS serves, you need to notify Wellcare PFFS so you can disenroll and find a new plan in your new area. Once you are a member of Wellcare PFFS, You have the right to appeal plan decisions about payment or services if you disagree. You will read the Evidence of Coverage</u>**

from Wellcare PFFS when you get it to know which rules you must follow to get coverage with this Private Fee-for-Service plan. You understand that people with Medicare are not usually covered under Medicare while out of the country except for limited coverage near the U.S. border. You understand that if you are getting assistance from a sales agent, broker, or other individual employed by or contracted with Wellcare PFFS he or she may be paid based on my enrollment in Wellcare PFFS. Benefits and services provided by Wellcare PFFS and contained in my Wellcare PFFS "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Wellcare PFFS will pay for benefits or services that are not covered. You understand that if you are getting assistance from a sales agent, broker, or other individual employed by or contracted with Wellcare PFFS he or she may be paid based on your enrollment in Wellcare PFFS.

Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

17. **By joining this Medicare Advantage plan, you acknowledge that Wellcare will share your information with Medicare, who may use it to track your enrollment, to make payments, and for other plans, providers and purposes allowed by Federal law that authorize the collection of this information. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan. The information on this enrollment form is correct to the best of your knowledge. You understand that if you intentionally provide false information on this enrollment application, You will be disenrolled from the plan.**

Do you understand?

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If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

18. **On this date, you understand that by completing this enrollment request, you understand the enrollment application process as described to you on this call.**

If you are not the enrollee, only authorized individuals can enroll on behalf of an enrollee. Your agreement means you certify that: 1) you are authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request by [Company] or by Medicare.

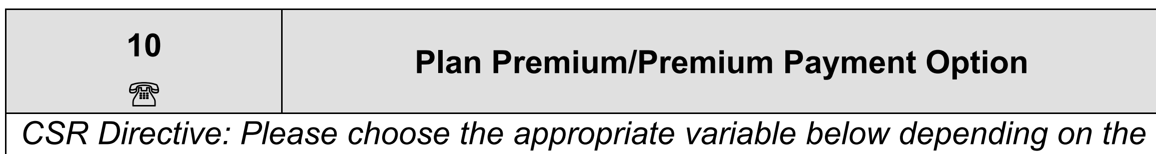
Do you understand?

If enrollee agrees, ________
Continue with script.

If no ________ because enrollee doesn't understand,
Provide clarification on any of the enrollee's questions. Once enrollee understands, proceed with script.

If no ________ and enrollee doesn't want to proceed,
Abort the application and select the appropriate action code (Enrollee did not agree with the Statements of Understanding). Go to Section 12 Alternative Closing (Abort Application).

Go to Section 10. To Continue for PFFS Plans



10 ☎	Plan Premium/Premium Payment Option
CSR Directive: Please choose the appropriate variable below depending on the	

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plan the beneficiary is enrolling into.

If enrolling in a MAPD (HMO, PFFS ,PPO) plan with a $0 monthly premium:

[Mr./Ms./Mrs.] [last name], if we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, credit card, [pay by phone,] or through Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month, if eligible.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay [Company] the Part D-IRMAA.

If we determine that you owe a late enrollment penalty or a Part D-Income Related Income Adjustment, how would you prefer to pay? *Go to Capture Payment Method*

If enrolling in a plan with a monthly premium:

[Mr./Ms./Mrs.] [last name], you can pay your monthly plan premium *[For MAPD (HMO, PFFS, PPO) plans, say:* (including any late enrollment penalty that you currently have or may owe)] by mail, credit card, [pay by phone,] through Electronic Funds Transfer (EFT), or by having it automatically deducted from your bank (checking/savings) account each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month, if eligible. *Continue with script below.*

***For MAPD (HMO, PFFS, PPO) plans, say:* If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social**

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Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay [Company] the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and do not even know it. For more information about Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at https://www.ssa.gov/medicare/part-d-extra-help.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. Even if you have Extra Help now, you may need to reapply for it later. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. ***Continue with script below.***

If you don't select a payment option, you will get a coupon book to pay your monthly premiums.

How would you like to pay your monthly premium? ***Go to Capture payment method.***

Capture payment method

If enrollee selects coupon book, say:

You will receive monthly premium coupons each month as your preferred payment method. You may also pay your plan premiums by credit card or by deduction from your bank account (checking/savings) instead of using the monthly coupons. To set up your payment visit our website at [URL] or call member services on the back of your membership card.

Go to Section 11.

If enrollee selects Electronic Funds Transfer (EFT), say:

If you would like to have your monthly plan premiums deducted from your bank (checking/savings) account instead of using the monthly premium coupons each month we will need to collect the necessary information onto this application. Benefits of having an Electronic Funds Transfer (EFT) withdrawal include:

- **You won't need to remember to send in a check each month.**
- **The money is automatically drafted from your account between the 15th through the 20th of each month.**

Please provide the following information for EFT withdraw setup:

Account Holder Name, _________
Bank Name, _________
Routing Number, _________
Account Number, _________
Account Type: select Checking or Savings

By agreeing to have EFT as your preferred payment method this authorization will remain in effect until you provide us written notification terminating this service.

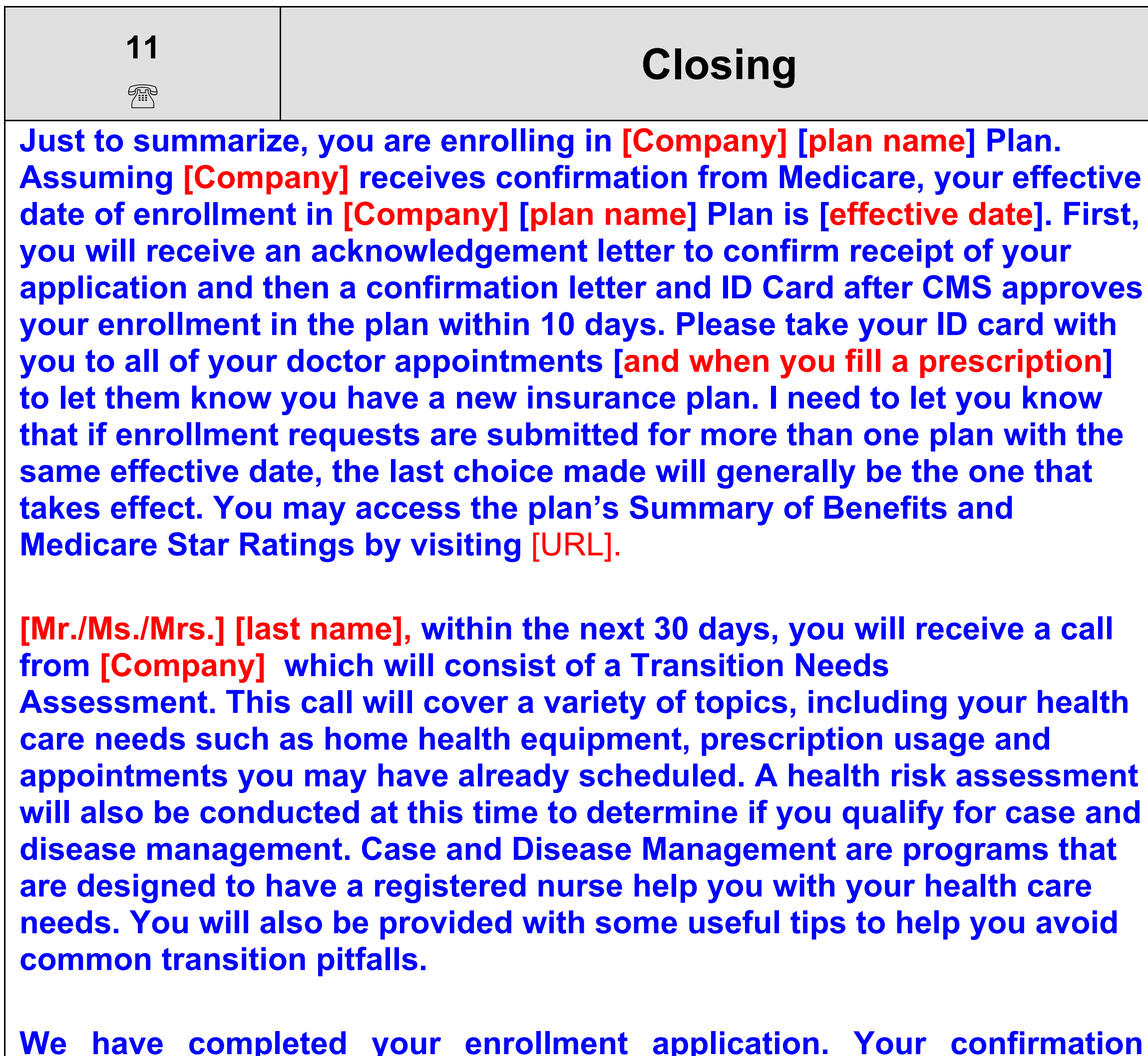
Go to Section 11.

If enrollee selects [SSA/RRB] deduction, say:

Your premiums will be automatically deducted from your monthly [Social Security/RRB] benefit check, if eligible. Your [Social Security/RRB] deduction may take two or more months to begin after [Social Security/RRB] approves the deduction. In most cases, if [Social Security/RRB] accepts your request for automatic deduction, the first deduction from your [Social security/RRB] benefit check will include all premiums due from

	your enrollment effective date up to the point withholding begins. If [Social Security/RRB] does not approve your request for automatic deduction, or approves deductions to begin after the enrollment effective date, we will send you a paper bill for your monthly premiums. **As a reminder to you that your [SS/RRB] deduction may take two or more months to begin after [SS/RRB] approves deduction.** ***Go to Section 11.***

11 ☎	Closing



Just to summarize, you are enrolling in [Company] [plan name] Plan. Assuming [Company] receives confirmation from Medicare, your effective date of enrollment in [Company] [plan name] Plan is [effective date]. First, you will receive an acknowledgement letter to confirm receipt of your application and then a confirmation letter and ID Card after CMS approves your enrollment in the plan within 10 days. Please take your ID card with you to all of your doctor appointments [and when you fill a prescription] to let them know you have a new insurance plan. I need to let you know that if enrollment requests are submitted for more than one plan with the same effective date, the last choice made will generally be the one that takes effect. You may access the plan's Summary of Benefits and Medicare Star Ratings by visiting [URL].

[Mr./Ms./Mrs.] [last name], within the next 30 days, you will receive a call from [Company] which will consist of a Transition Needs Assessment. This call will cover a variety of topics, including your health care needs such as home health equipment, prescription usage and appointments you may have already scheduled. A health risk assessment will also be conducted at this time to determine if you qualify for case and disease management. Case and Disease Management are programs that are designed to have a registered nurse help you with your health care needs. You will also be provided with some useful tips to help you avoid common transition pitfalls.

We have completed your enrollment application. Your confirmation

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number is [XXXXX]. You can use this number to check on the status of your application. **Thank you for enrolling with [Company] we look forward to serving your healthcare coverage needs.** **[Company], is committed to providing you with reliable support and service you can trust. If you need any information or have any questions prior to becoming effective or if you have questions about obtaining services, please call [Company] at [***Member Services number based on State beneficiary is calling from*** [1-xxx-xxx-xxxx]], [day–day], [8 a.m. to 9 p.m.] [Time Zone] or visit us on the web at [URL]. TTY users should call [711]. Thank you for calling [Company].** *Submit the application.*

12	Alternate Closing (Abort Application)
I am sorry that I was unable to assist in completing your application at this time. If you change your mind, please call us at [1-866-907-9594] [Monday–Sunday], [8 a.m. to 8 p.m.] [Time Zone]. TTY users should call [711]. Thank you for calling [Company].	

13	Alternate Closing (Denial)
Thank you for applying with [Company]. We can not accept your request for enrollment in [Company] [plan name] Plan because: **[you attempted to enroll outside of an enrollment period.]** **[your permanent residence is outside our service area.]** **If anything should change, please call us at [1-866-907-9594] [Monday–Sunday], [8 a.m. to 8 p.m.] [Time Zone]. TTY users may call [711]. Thank you for calling [Company].**	

Wellcare is the Medicare brand for Centene Corporation, an HMO, PPO, PFFS, PDP plan with a Medicare contract and is an approved Part D Sponsor. Our D-SNP plans have a contract with the state Medicaid program. Enrollment in our plans depends on contract renewal.

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