TheHealthPlan

Agent Guide

Medicare Advantage Plans

SecureCare & SecureChoice Products

1110 Main St., Wheeling, WV 26003-2704 • 1.800.624.6961

healthplan.org

TheHealthPlan

Section 1

Introduction

Thank you for contracting with The Health Plan and becoming ready to sell our Medicare Advantage products. We're proud to offer high-quality, affordable Medicare Advantage plans.

As a health maintenance organization, our focus is on delivering a clinically-driven, customer-focused platform with products and services that manage and improve the health and well-being of our members. We achieve these results through a team of health care professionals and partners like you! Thank you for your support. Everything that we do is directed to ensuring quality and superior service to your clients, our members.

This guide gives important operational information on our requirements and CMS compliance. It is a valuable training resource for you to grow and retain business and win referrals.

Our consumer website for THP Medicare products is healthplan.org/medicare. It is easy to navigate and contains information that you need for your clients in one site.

Explore the guide, keep it handy, and call us if you need personal assistance at any time. The Health Plan's Broker Relations Team is here to support you to be successful and compliant.

We are committed to providing superior service using the highest set of standards for personal respect, courtesy and compassion for our members, providers and other health care systems. Service excellence and strong partnerships ensure our success and growth! Thank you for all that you do as a partner with The Health Plan.

Agent Communications

We primarily communicate with you through email. Through these emails, we update you on:

- Products and benefits
- Updated marketing materials
- Compliance information
- Training opportunities and more

We send communications to the email you provided when you first contracted with us. To update the email address or if you're not receiving our communications, please call 1.800.624.6961 and ask for Broker Relations. It's your responsibility to make sure we have a valid email address on file.

Section 1:
Introduction

Key Terms

Take a minute to review key terms and acronyms we'll use in this guide.

AEP – Annual Election Period

Agent – An appropriately licensed independent contractor, appointed by the company to transact insurance on its behalf.

Certified – A status achieved based on completing annual Medicare Rules and Regulations and Product certification training.

CMS – The Centers for Medicare & Medicaid Services, a federal agency within the U.S. Department of Health and Human Services (DHHS) that administers the Medicare program.

MA/MAPD – Medicare Advantage/Medicare Advantage and Prescription Drug

Medicare Advantage Open Enrollment Period (MA-OEP) – Allows beneficiaries who are already enrolled in Medicare Advantage plans to make one election change between January 1 and March 31.

Medicare Communications and Marketing Guidelines (MCMG) – MCMG contains CMS marketing requirements and related provisions for Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans, Medicare Prescription Drug Plans, Employer/Union-Sponsored Group Health Plans, Medicare-Medicaid Plans, and Section 1876 Cost Plans.

Payee – Someone who is assigned a commission by the writing agent.

PDP – Medicare Part D, a stand-alone prescription drug plan.

The Health Plan (THP) – THP refers to The Health Plan and all products and requirements under The Health Plan.

The Health Plan Brand, Mission and Values

The Health Plan is an established community health organization that delivers a clinically-driven, technology-enhanced, customer-focused platform by developing and implementing products and services that manage and improve the health and well-being of our members. We achieve these results through a team of health care professionals and partners across our community.

Core Values

We are committed to:

- Advancing the quality of care delivered by our providers and received by our members using the best available practices.
- Providing superior service using the highest set of standards for personal respect, courtesy and compassion for our members, providers and other health care systems.
- Growing through innovation, creativity and hard work.
- Offering the highest level of integrity and respect for our employees, members, providers and partners through a positive attitude of honesty, sincerity and determination.
- Supporting each of our communities with quality products and services.
- Creating a positive atmosphere for our employees, allowing them the opportunity for personal growth that meets the needs of our company, our clients and our members.

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Section 2

Product

Our Portfolio

Our Medicare managed care plans focus on service that is responsive and personal.

- We have Medicare Advantage plans available in various counties in Ohio and West Virginia.
- SecureCare (HMO) is a network-based Medicare Advantage plan, currently available with or without integrated prescription drug coverage.
- SecureChoice (PPO) is a Medicare Advantage plan, with prescription drug coverage. This is a traditional PPO plan with both in and out-of-network coverage for most services.

We offer an extensive list of contracted providers for both products.

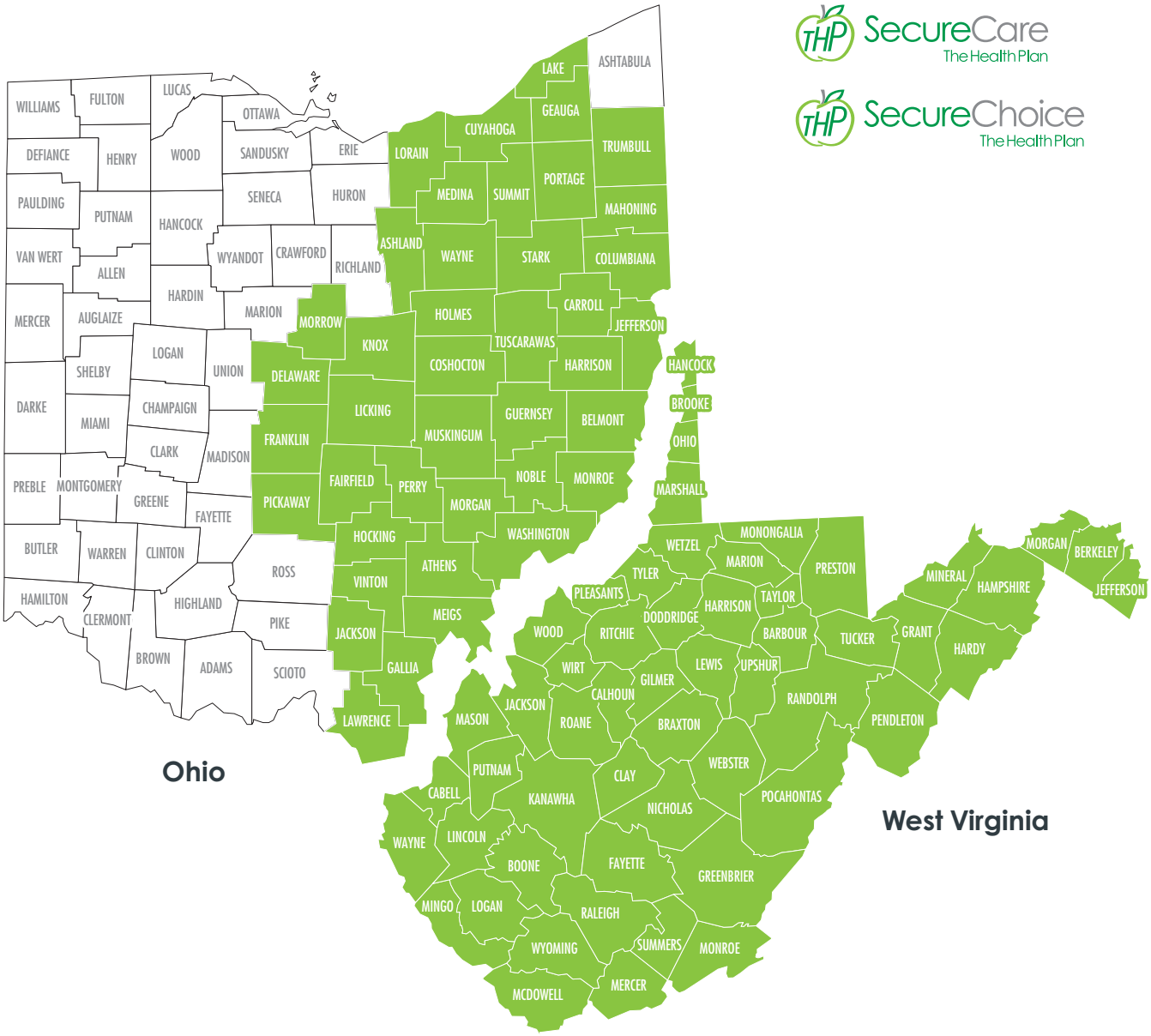
This guide only provides information related to our Medicare Advantage plans. For information about our Medicare Supplement plans, please contact our Medicare Sales team at 1.877.903.7506.

Section 2:
Product

Product Availability Service Area

SecureCare The Health Plan

SecureChoice The Health Plan



Service Area
Ohio Only

SecureCare Option I, MA Only (HMO)
H3672, Plan 014
SecureCare Option II (HMO)
H3672, Plan 013

OHIO: Ashland, Athens, Carroll, Columbiana, Coshocton, Cuyahoga, Delaware, Fairfield, Franklin, Gallia, Geauga, Hocking, Holmes, Jackson, Knox, Lake, Lawrence, Licking, Lorain, Mahoning, Medina, Meigs, Morgan, Perry, Pickaway, Portage, Stark, Summit, Trumbull, Tuscarawas, Vinton and Wayne counties.

Service Area
West Virginia and Ohio

SecureCare Option I, MA Only (HMO)
H3672, Plan 021
SecureCare Option II (HMO)
H3672, Plan 020

OHIO: Belmont, Guernsey, Harrison, Jefferson, Monroe, Muskingum, Noble, and Washington counties.

WEST VIRGINIA: Barbour, Berkeley, Braxton, Brooke, Cabell, Calhoun, Doddridge, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Jefferson, Lewis, Lincoln, Logan, Marion, Marshall, Mason, McDowell, Mercer, Mineral, Mingo, Monongalia, Monroe, Morgan, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Raleigh, Randolph, Ritchie, Roane, Summers, Taylor, Tucker, Tyler, Upshur, Wayne, Webster, Wetzel, Wirt, Wood, and Wyoming counties.

Service Area
Capitol Plans

SecureCare – Capitol Plan (HMO)
H3672, Plan 023
SecureCare – Capitol Plan MA Only (HMO) H3672, Plan 024

WEST VIRGNIA: Boone, Clay, Fayette, Jackson, Kanawha, and Putnam counties.

Service Area
Ohio Only

SecureChoice Option II (PPO)
H8604, Plan 010

OHIO: Ashland, Athens, Carroll, Columbiana, Coshocton, Cuyahoga, Delaware, Fairfield, Franklin, Gallia, Geauga, Hocking, Holmes, Jackson, Knox, Lake, Lawrence, Licking, Lorain, Mahoning, Medina, Meigs, Morgan, Morrow, Perry, Pickaway, Portage, Stark, Summit, Trumbull, Tuscarawas, Vinton and Wayne counties.

Service Area
West Virginia and Ohio

SecureChoice Option II (PPO)
H8604, Plan 011

OHIO: Belmont, Guernsey, Harrison, Jefferson, Monroe, Muskingum, Noble, and Washington counties.

WEST VIRGINIA: Barbour, Berkeley, Braxton, Brooke, Cabell, Calhoun, Doddridge, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Jefferson, Lewis, Lincoln, Logan, Marion, Marshall, Mason, McDowell, Mercer, Mineral, Mingo, Monongalia, Monroe, Morgan, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Raleigh, Randolph, Ritchie, Roane, Summers, Taylor, Tucker, Tyler, Upshur, Wayne, Webster, Wetzel, Wirt, Wood, and Wyoming counties.

Section 2:
Product

Service Area Capitol Plan

SecureChoice – Capitol Plan (PPO)
H8604, Plan 013

WEST VIRGNIA: Boone, Clay, Fayette, Jackson, Kanawha, and Putnam counties.

Service Area West Virginia and Ohio

SecureCare SNP (HMO D-SNP)
H3672, Plan 019

OHIO: Ashland, Athens, Belmont, Carroll, Columbiana, Coshocton, Cuyahoga, Delaware, Fairfield, Franklin, Gallia, Geauga, Guernsey, Harrison, Hocking, Holmes, Jackson, Jefferson, Knox, Lake, Lawrence, Licking, Lorain, Mahoning, Medina, Meigs, Monroe, Morgan, Morrow, Muskingum, Noble, Perry, Picking, Portage, Stark, Summit, Trumbull, Tuscarawas, Vinton, Washington and Wayne counties.

WEST VIRGINIA: Barbour, Berkeley, Boone, Braxton, Brooke, Cabell, Calhoun, Clay, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Jackson, Jefferson, Kanawha, Lewis, Lincoln, Logan, Marion, Marshall, Mason, McDowell, Mercer, Mineral, Mingo, Monongalia, Monroe, Morgan, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Putnam, Raleigh, Randolph, Ritchie, Roane, Summers, Taylor, Tucker, Tyler, Upshur, Wayne, Webster, Wetzel, Wirt, Wood, and Wyoming counties.

We Offer the Following Medicare Advantage Products:

SecureCare HMO

SecureCare HMO is a health maintenance organization (HMO) plan offering exceptional value by utilizing an extensive network of providers contracted with The Health Plan for covered services. Certain services are covered even if the member is out-of-network.

Members must use plan providers, except in emergency or urgent care situations, or for out-of-area renal dialysis or other services. If a member obtains routine care from out-of-network providers, neither Medicare nor The Health Plan will be responsible for the costs, without prior approval.

The Health Plan requires members to choose an in-network primary care physician (PCP) to assist with coordinating care however, we do not require a referral from the PCP to see in-network Specialists for covered services.

Some services require Prior-Authorization. Please contact Customer Service for additional details.

SecureChoice PPO

SecureChoice PPO is a preferred provider organization (PPO) plan that allows members to use network AND out-of-network providers for covered services. (With the exceptions of emergencies or urgent care, it may cost more to get care from out-of-network providers.) Choosing a primary care physician (PCP) is optional.

Reimbursement is provided for all covered benefits regardless of whether they are received in-network, as long as they are medically necessary.

Provider Overview

SecureCare HMO and SecureChoice PPO use the same provider network. The Health Plan has a longstanding relationship with local providers. You can view a complete list of our network providers, or use the provider search tool at: findadoc.healthplan.org.

Rx Overview

SecureCare HMO and SecureChoice PPO use the same pharmacy network, Express Scripts, (ESI). SecureCare HMO and SecureChoice PPO also use the same formulary list that can be found on our consumer portal, healthplan.org/medicare.

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Section 3

Certification "Ready-to-Sell" Requirements

What Does It Mean to Be Certified or "Ready-to-Sell"?

The term certified means that an agent is approved to sell applicable THP Medicare products for a specific plan year. The agent has completed all THP certification requirements, including licensing, training and testing and has received a written confirmation from THP of the approval to sell for a plan year. The approval contains the beginning date for the "ready-to-sell" status and to which state(s) and products it applies.

To become certified or "ready-to-sell" our Medicare Advantage products and receive commissions, you'll need to complete all of these requirements prior to marketing or selling:

1. Contracting: You must have an active contract at the time of sale, be properly licensed and appointed, and pass a background check:
   - New agents: If you've never contracted with The Health Plan to sell our Medicare Advantage products, please contact a Broker Relations Representative at 1.330.834.2289 or brokerrelations@healthplan.org.
   - Existing agents: Agents who are currently contracted and ready-to-sell The Health Plan Medicare Advantage plans do not need to re-contract unless they are changing hierarchy or contract level.

2. Certification: You'll need to successfully complete the annual THP Medicare certification process for the product(s) you intend to sell. This includes license and appointment verification, as well as applicable training and testing
   - LICENSING AND APPOINTMENT: You'll need to be properly licensed in states where you sell. You'll also need to be properly appointed by The Health Plan for all products you intend to sell.
   - BACKGROUND CHECK: New agents will also need to pass a background check. All agents may be subject to a background check at any time.
   - You cannot be listed on the EPLS/OIG exclusion lists (Excluded Parties List System/ Office of Inspector General)

3. You or your employer will receive a notice confirming your ready-to-sell status. It will list out the specific states and products that you're ready to sell and for which you can receive commissions. You are **not** permitted to market or sell products until receipt of this notification.

Compensation

The Health Plan follows all CMS guidelines regarding agent/broker compensation. Compensation will not be paid to agents who are no longer appointed to sell in the state (if required), agents who have not successfully completed annual training and certification or agents who have been terminated for cause.

The agent must be contracted, licensed, successfully certified and appointed at the time the application is taken to receive compensation for such sale. There will be 100 percent compensation charge-back if a Medicare policy is rescinded and premiums are returned. There will be charge-backs for Medicare Advantage products as set forth in CMS guidelines. All compensation payable is subject to adjustment due to limitations and or restrictions imposed by any applicable laws or regulations.

We will provide a monthly commission report to you. Please report any discrepancies to The Health Plan Finance Department.

Please see your agent/agency agreement for specific compensation amounts and rules/ regulations.

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Section 4

Compliance and Agent Oversight

Why Compliance Is So Important

As a partner with The Health Plan representing our Medicare Advantage plans, you must follow The Health Plan's and Centers for Medicare and Medicaid Services (CMS) regulations and guidelines in your daily Medicare sales activities. You are an extension of The Health Plan and are individually and solely responsible for knowing the rules and complying with them.

Potential consequences of engaging in inappropriate or prohibited marketing activities include disciplinary actions, termination and forfeiture of compensation. This is an overview of Medicare marketing guidelines and compliance program requirements from The Health Plan and CMS. It is not all-inclusive. Please review the Medicare Communications and Marketing Guidelines (MCMG) Chapter 3 each year, as regulations may change: **https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines**

Please note: Recent regulations regarding non-discrimination.

Agents for The Health Plan are required to comply to ACA Section 1557 regulations (posted July 18, 2016). Any agent that engages in prohibited discrimination in connection with the marketing of The Health Plan covered programs will be subject to disciplinary action including the termination with cause of his or her producer agreement.

On May 13, 2016 the U.S. Department of Health and Human Services (HHS)/Office of Civil Rights issued a Final Rule implementing Section 1557 of the Affordable Care Act (ACA). The new regulations prohibit discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. The law establishes new protections and applies to any health programs funded by HHS, including Medicare Advantage, Medicare Part D, and the Marketplace. The law strictly prohibits discrimination on the basis of sex, pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping and gender identity. Please review the HHS Sec. 1557 for guidance.

Sales Appointments and Marketing Events

Every time you meet with a beneficiary to discuss our products (this includes formal and individual one-on-one appointments), you must:

1. Use our CMS-approved sales presentations from beginning to end.
2. Use only approved marketing materials with the presentation.

3. Agents must obtain permission from a beneficiary prior to contacting them to schedule a sales or marketing appointment. Agents are never allowed to contact beneficiaries unsolicited.

   When permission to call is given by a beneficiary, such permission applies:

   - Only to the entity from which the individual requested contact
   - For the duration of that transaction
   - For the scope of products previously discussed or specified
   - Permission to contact may not be treated as open-ended permission for future contact

   Unsolicited, direct contact of beneficiaries is strictly prohibited, including, but not limited to:

   - Door-to-door solicitation
   - Cold call telemarketing or email solicitation
   - Approaching beneficiaries in common areas
   - Distribution of information at a residence or car
   - Making unsolicited calls about other business as a means to generate leads
   - Calls to a sales event attendee, unless written permission was given for a follow-up call
   - Calls based on referrals
   - Calls to former enrollees who have dis-enrolled and current enrollees who are in the process of voluntarily dis-enrolling

   Agents MUST follow CMS guidelines regarding beneficiary contact and sales solicitation in all cases.

4. Marketing and sales events must be conducted in accordance with CMS Medicare Communications and Marketing Guidelines (MCMG) which specify requirements related to sales and marketing activities, including event reporting, locations, materials and gifts/promotional items.

The Health Plan requires agents to notify THP at least 14 days prior to any marketing/sales event or seven days prior to the initial advertisement, whichever is earlier. Reporting of sales events should be submitted via the agent marketing event form provided by The Health Plan. There will be appropriate instructions on the form.

The Health Plan will report event information to CMS, as required and specified by CMS MCMG. Therefore, when an agent reports a sales event to The Health Plan, The Health Plan Medicare product must be presented at that specific event. The Health Plan reserves the right to make an unannounced visit to any agent event for auditing purposes.

Cancellations and changes to sales events must be submitted to The Health Plan for HPMS submission at least 48 hours prior to the event's scheduled date. Agents are responsible for notifying beneficiaries of cancellations or changes by the same means used to advertise or promote the event. The Health Plan has a strict policy that event cancellations be on an emergency basis only.

In the event that 48 hours advance notice cannot be provided, coordinate with your assigned THP representative to have a representative present at the event location at least 15 minutes prior to, through 15 minutes after the scheduled start time to inform beneficiaries of the cancellation or change. If the event was cancelled due to inclement weather, a representative is not required to be present at the site. However, the notification to Medicare Compliance must include a brief explanation of the cancellation reason.

Expectations for Medicare Marketing Events:

- Arrive at least 15 minutes – 30 minutes early.
- Hold events at appropriate venues with disability accessibility and plenty of parking.
- Use signage to direct attendees to the correct event location.
- If the event location has a lobby or general reception area, inform the desk attendant about the specific event location so that attendees can be directed accordingly.
- Announce your name, the company you represent, and all plans to be discussed during your presentation.
- Use approved THP sales presentation materials, and only display CMS approved marketing materials.
- Treat attendees with respect at all times - you are representing The Health Plan!
- Follow CMS guidelines regarding gifts, promotional items and meals.

Enrollment Process/Forms

Timely and accurate submission of enrollment applications is critical to ensuring that beneficiaries receive the benefits they expect and that The Health Plan is able to meet CMS requirements.

The Health Plan requires agents to submit enrollment applications and scope of appointment (SOA) forms to The Health Plan's Member Services Department no later than **48 hours** after the agent receives the enrollment application from the beneficiary.

Failure to follow The Health Plan's requirements for submitting applications may result in processing delays, which may impact enrollees' requested coverage date and/or the agents' sales privileges.

Please scan enrollment forms to **medicare_enrollment@healthplan.org**. You may also use the dedicated fax line 740.699.6164 for application submissions. Faxes sent to another number may delay processing and could create a compliance issue for uploading and acknowledging an application within the required CMS timeframes, especially during a busy annual enrollment period (AEP). We also accept enrollment forms through various electronic platforms. If you do not see The Health Plan products listed on the site that you use, please call our Sales Department at 1.877.903.7506.

Disposition Code Summaries

Contracted agents receive their client information in the form of an enrollment status report. Each enrollment will have a disposition status code. If you are a contracted agent who received this report, we ask that you examine it for accuracy and report any issues to The Health Plan within 24 hours. Please call Broker Relations if you are an agent who receives this report and you have questions.

The following is a list of status code definitions for your reference:

Received - Application has been entered but not yet ready to be released to the enrollment department.

Released - Available for the enrollment department to add to member files through the enrollment workbench.

Incomplete - Entered but not all the required information is available to allow the application to continue on. Awaiting the needed information and once received the application is "released". If the information is not received, the application is "denied."

Enrolled - Added into The Health Plan system through the enrollment workbench and now a The Health Plan member.

CMS Accepted - The MA enrollment confirmation from CMS has been received and the application has been accepted and member is now enrolled.

CMS Rejected - When notice is received from CMS that an enrollment is rejected.

CMS Cancelled - An enrollment has been processed and the member has been enrolled, however, a cancellation request is received before coverage has taken effect.

Disenrolled - A member has been disenrolled from the plan. These can be voluntary or involuntary.

Withdrawn - A member has contacted the provider and asked application to be withdrawn.

OEV Withdrawn - When a Medicare Advantage member has asked that the application for coverage be withdrawn. It is valid during the OEV time frame for agent-assisted applications only.

THP Enrolled - When a Medicare supplemental application is processed and the member has been enrolled.

THP Rejected - When an application is rejected by The Health Plan as not meeting enrollment requirements (no valid MA election period, does not have both Part A and B, a Medicare supplemental application was denied after underwriting review, etc.).

Removed - Typically used for applications received/entered twice, are for the same received date/effective date and are true exact duplicates. Applications can be entered manually or electronically.

Scope of Appointment

CMS Medicare Communications and Marketing Guidelines (MCMG) require that a documented Scope of Appointment (SOA) form be completed prior to any personal, face-to-face or telephonic sales/marketing appointment, regardless of whether or not the appointment results in an enrollment. Agent MUST use a CMS approved SOA form.

The Health Plan requires a signed and completed SOA form to be submitted with all agent-assisted enrollments. Additionally, all SOA forms must be retained for at least 10 years regardless of the enrollment outcome.

If the SOA form was not signed prior to the appointment, include an explanation why it was not completed.

Agents must document the scope of agreement for a marketing appointment before the appointment begins. Plan lines of business not agreed to in advance by the beneficiary may not be discussed. Each beneficiary (or his/her appointed representative) must initial the plan types to be discussed during the appointment and must sign and date a SOA form. If an agent conducts a personal appointment with more than one Medicare-eligible beneficiary, then that agent must obtain a signed and completed SOA form for each individual.

During an appointment, if an agent would like to discuss additional plan products which the beneficiary did not agree to discuss in advance, he/she must:

- Document a second SOA form prior to continuing the appointment, and note the reason for the exception.
- Clearly explain plan features during the appointment, including but not limited to cost-sharing, provider networks and formularies.

The Health Plan does accept electronic SOA forms in many cases. Please call the Sales Department at 1.877.903.7506 with questions.

Section 4:

Compliance and Agent Oversight

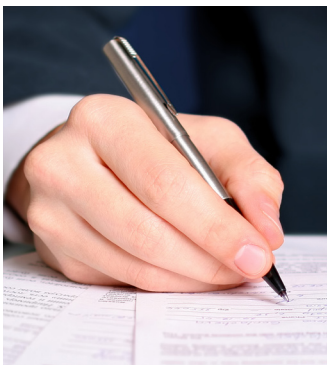
How to Report Compliance or Fraud, Waste and Abuse (FWA) Concerns

All contracted agents of The Health Plan will report suspicious activities and possible conflicts of interest of themselves and of others to The Health Plan compliance officer or the Fraud Hotline at 1.877.296.7283. You have the right to report anonymously.

The Health Plan believes it is the duty of every person who has knowledge of a potential compliance issue or suspected fraud, waste and abuse to promptly report the issue at the time of discovery. This obligation applies to all contracted agents of The Health Plan. You are required to report any known conflicts of interest or suspicious activities to The Health Plan's compliance officer or to the Fraud Hotline at 1.877.296.7283. You have the right to report anonymously and there will never be retaliation against anyone who reports in good faith suspected or actual misconduct. Failure to comply with this obligation could lead to disciplinary action, up to and including termination of your contract with The Health Plan.

Agent Guidelines

The Health Plan requires all sales agents, sales entities, or any other downstream entities representing The Health Plan to comply with The Health Plan's Corporate Code of Business Conduct and Ethics, federal and state laws, CMS regulations and guidance, and all other regulatory requirements related to sales activities. The Health Plan expects that agents will assist each Medicare beneficiary to obtain Medicare coverage that best meets the beneficiary's specific needs.



The Health Plan performs regular oversight and monitoring of agent activities to prevent, detect and correct compliance deficiencies with The Health Plan policies, federal and state laws, CMS regulations, and other regulatory requirements. When potential non-compliance is detected or reported, The Health Plan will investigate, correct, and monitor to ensure that appropriate corrective actions are undertaken and effective.

Expected Standards of Conduct

The successful business operation and reputation of The Health Plan is built upon principles of fair dealing and ethical conduct of our contracted agents. Our reputation for integrity and excellence requires careful observance of the spirit and letter of all applicable laws and regulations, as well as a scrupulous regard for the highest standards of conduct and personal integrity.

The continued success of The Health Plan is dependent upon our customers' trust and we are dedicated to preserving that trust. Contracted agents owe a duty to The Health Plan and its customers to act in a way that will merit the continued trust and confidence of the public.

The Health Plan will comply with all applicable laws and regulations and expects its directors, officers, and contracted agents to conduct business in accordance with the letter, often referred to as FDR's, spirit, and intent of all relevant laws and to refrain from any illegal, dishonest, or unethical conduct.

Agents will be asked to review and attest to the Code of Conduct annually, during the certification process.

Privacy and Requirements

All contracted agents must conform to all laws that apply to business of The Health Plan, wherever it is conducted.

All contracted agents must display good judgment and high ethical standards in business dealings. All The Health Plan business affairs must be conducted with honesty, fairness and integrity. These qualities are evidenced by truthfulness and the absence of deception or fraud. Special attention should be paid to dealing with providers where payment is involved and to all coding matters. It is important to understand the legal and ethical position of The Health Plan and its contracted agents to avoid concerns regarding fraud and abuse arrangements or practices.

The Health Plan representatives must not knowingly create, maintain or submit records, reports or statements that are inaccurate, false or misleading. No undisclosed or unrecorded funds or assets can be established. All items of income and expense and all assets and liabilities must be entered in the financial records and must be accurately and adequately described. All reports submitted to governmental authorities must be accurate and complete and all transactions shall be executed in accordance with management's authorization.

All confidential information will not be disclosed to unauthorized people. Contracted agents will not use confidential information in a way that is not related to The Health

Plan's business activities during or after their employment. Confidential information cannot be given to competitors, suppliers, and contractors or to other contracted agents who do not have a legitimate need to know.

Contracted agents must not participate in activities that could conflict or appear to conflict with their responsibilities to The Health Plan. Contracted agents may not realize any profit or gain as a result of their position with The Health Plan. A conflict of interest occurs if their activities or responsibilities are detrimental to the interest of The Health Plan or result in an improper or illegal gain for them.

No contracted agent of The Health Plan or any member of their family can receive gifts, loans or other special preferences from a person or organization that does or wants to do business with The Health Plan or is a competitor of The Health Plan. The only exception is gifts of limited value extended as a business courtesy.

Contracted agents must not provide gifts, loans or other benefits to a physician, potential member or client to obtain referrals or beneficial arrangements from clients or as an inducement to enroll in The Health Plan.

Gifts to physicians, clients, members or potential members are appropriate only if the monetary value is modest; the benefit is part of marketing, educational or other ordinary business activity; and the benefit does not violate any applicable law. Occasional business meals or entertainment events are acceptable provided they are of reasonable cost and the business purpose is clearly documented. In the case of Medicare and Medicaid beneficiaries it will not exceed the value set forth in regulations.

Contracted agents may not use The Health Plan funds for improper or illegal activities. There will be no payments to government officials to secure sales or obtain a favorable treatment. Gifts to or entertainment of government officials or contracted agents are prohibited because these actions could be construed as attempts to influence government decisions.

Agents who utilize faxes for submitting information should be reminded that paper documents are to be shredded when no longer required, and fax machines should have memories erased/wiped when machines are no longer in use by the contracted agent/broker.

Agents should not be using public fax machines to submit information on applicants, but if they do, they need to ensure the information is not being retained, or erased afterwards.

Agents should ensure they check the fax number prior to sending information, and ensure information has been received by the recipient.

No enrollee information should be left unattended or unsecured, and should not be kept in open view in a vehicle when the agent has to leave their vehicle, but rather in a lockable storage briefcase, etc. within the trunk, etc.

Medicare Agent of Record Change Policy

An Agent of Record (AOR) change is sometimes needed to ensure that our members receive continuous quality service. It is The Health Plan's (THP) policy to accept AOR requests if the request adheres to approved policy. Therefore, please make note of the following THP policy requirement when submitting an AOR request for Medicare members:

An individual agent of record change must be member initiated. The member has two options for requesting this change:

- **Medicare AOR request by written communication:** The member must submit a handwritten letter to Broker Relations via fax, email or mail. The member letter should not be written on agency letterhead, nor should it look like a form letter that is written or typed by the agent. The letter must include the member's:

  First and last name
  Address
  Phone
  THP Member ID #
  Date of birth

  The letter should also contain the following information regarding the request:

  - The reason why the member is requesting the change
  - Requested effective date of the change
  - Requested agent's name and agent writing number (AWN)

  The letter should be sent via email to **brokerrelations@healthplan.org.** The letter can also be faxed to Broker Relations at 1.330.830.4384. Broker Relations will follow up with the member by phone to confirm the request and notify the member of the effective date.

- **Medicare AOR request by phone:** The member can contact The Health Plan by phone at the Customer Service phone number indicated on the back of their ID card. The agent must not be present during the time of the phone call. Member Services will obtain all necessary information and notify Broker Relations of the request.

Broker Relations will review all requests for approval.

Please note: The requested agent must have a ready-to-sell status for the request to be approved.

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Section 5

Marketing Materials

Marketing Policy Overview

Before marketing or selling The Health Plan (THP) Medicare Advantage products, you must be appropriately licensed in the state where you intend to sell, properly contracted, appointed, and certified under The Health Plan Medicare Advantage annual certification process.

- You're required to follow all THP and CMS marketing requirements. You can find and review the CMS Medicare Communications and Marketing Guidelines (MCMG) at cms.gov.
- You may only use CMS and The Health Plan approved marketing materials when discussing The Health Plan Medicare Advantage Plans, SecureCare or SecureChoice. You may only use materials that have been created by our marketing team, approved by us, and, as necessary, filed with CMS by us. This includes multi-plan marketing materials (as described in the MCMG).
- You may not alter CMS-approved materials in any way, other than to add personal information like agent name, phone number, email or event date where permitted.
- Materials must be used as intended. You cannot copy a newspaper ad and mail it to beneficiaries. Newspaper ads are filed with CMS specifically for that purpose and are not for use as a direct mail piece.
- Under CMS guidelines, the official marketing period for AEP for the upcoming benefit year begins October 1. You cannot market or advertise The Health Plan products for the upcoming benefit year before October 1, even if you have marketing/sales events scheduled in early October. Once you begin marketing current year products, you must cease marketing prior year products. Prior year materials may be provided upon request and enrollment applications may be processed.
- You may not solicit or accept an enrollment application for a January 1 effective date prior to the start of AEP on October 15, unless the beneficiary is entitled to another enrollment period.
- You must follow all CMS guidelines related to marketing during the MA-OEP. Marketing to Medicare Advantage enrollees is prohibited during the MA-OEP except in limited circumstances.
- See the Compliance and Agent Oversight section for marketing rules and requirements for the Scope of Appointment form, sales presentations and other specific marketing materials. Please direct any questions to your THP representative.
- Third-party websites that market MA/MAPD and PDP must meet all applicable CMS marketing guidance, including that found in the CMS Medicare Communications and Marketing Guidelines (MCMG) (Refer to third-party marketing and enrollment websites in the information that follows).

Section 5:
Marketing Materials

Remember to always refer to, and follow, the complete and current CMS Medicare Communications and Marketing Guidelines (MCMG).

Using Our Logos

You can request to show The Health Plan logo on your website to reflect that you sell The Health Plan Medicare Advantage products. You just need to request permission and get approval first.

It's a simple process. Email marketing at marketing@healthplan.org to request our logo. Please submit a sample layout showing how you want to use the logo. Approval takes about 1–3 business days. We'll provide comments or approval via email.

Note: We only approve requests that appropriately reflect that The Health Plan are among the brands you sell. We are unable to approve requests that imply exclusivity or special status to sell our products.

Co-branding

Co-branding requires pre-approval.* Co-branding refers to the use of The Health Plan logo or other trademarked information in a marketing piece, or the joint development of marketing material(s) to promote The Health Plan Medicare Advantage products. Marketing materials (print or other media) include advertising and marketing campaigns, events, and activities.

*At all times, you must obtain The Health Plan's advance written approval for co-branding.

Upon approval to co-brand, all of the following requirements apply:

- You must coordinate directly with the appropriate THP Medicare and marketing management staff members.
- The co-branded material is subject to The Health Plan and the applicable CMS filing and/or approval processes.
- Approved co-branded advertising and marketing may include permissible promotion of co-marketed educational and wellness programs for prospective or existing members of The Health Plan.
- All promotional and outreach activities undertaken based on approved co-branding must comply with applicable law (including, but not limited to the CMS Medicare Communications and Marketing Guidelines and HIPAA).

Third-Party Marketing and Enrollment Websites

Third-party websites are those used by contracted agent/brokers and entities to reference or promote Medicare plans, or to obtain beneficiary information for the purposes of marketing or enrollment into an Medicare Advantage plan. This also includes websites designed to provide agents with beneficiary leads.

- We require you to notify us if they receive leads concerning Medicare products from another entity
- If the leads are from a third party website or entity operating a website which markets Medicare products, those website URLs must be identified
- CMS rules regarding third party websites and unsolicited telephone calls apply to any sales or lead generating service

What Are the Rules?

Third-party websites that market Medicare Advantage must meet The Health Plan and all applicable CMS marketing guidance, including the CMS Medicare Communications and Marketing Guidelines (MCMG). For example:

- They cannot request health status information such as pre-existing conditions, weight, and whether the beneficiary smokes. See 42 C.F.R.
- §422.110(a), which prohibits discrimination on the basis of medical conditions or medical history. See also 42 C.F.R. §422.2268(c) and 423.2268(c), which prohibit discriminatory marketing practices
- They cannot provide misleading information, such as identifying a Medicare Supplement plan as a Medicare Advantage plan. See 42 C.F.R. §§422.2268(e) and 423.2268(e).
- They cannot use prohibited terminology, including unsubstantiated absolute superlatives. They must include required disclaimers.

Any website that markets Medicare products, including any sites that may provide upline leads concerning Medicare products, is subject to a formal review and approval process. We will take appropriate action if we find a non-compliant website marketing our products.

Referencing The Health Plan

Every time we speak or write the name of our company, it reflects upon us and The Health Plan as a whole. That is why it is critical that our corporate name and identity is used correctly and consistently. When addressing The Health Plan in general communications or marketing assets, please remember:

- Start with "The"
- Capitalize the "T"

You may reference The Health Plan in public electronic communications as long as your THP representative first reviews the reference for accuracy. However, you may not show our company logos (without additional approval; see the next section), The Health Plan branding elements, or any product-specific information. For additional

questions or to request a logo, please contact Wendy Hodorowski, Marketing Director, at 1.800.624.6961, ext. 6140.

The following are permitted:

- Electronic communications to downline agents
- Recruitment and training documents (e.g., emails, fliers)
- Materials that only indicate the product types you or your company sell (e.g., HMO, PPO or PDP)

Ownership of Marks

The Health Plan name, trade names, trademarks, graphics, trade devices, service marks, insignias, symbols, codes, logotypes, logos, and other brand elements (collectively, the "marks") and any advertising materials are the property of The Health Plan.

You may not use any of these items without the prior written consent of The Health Plan.

Use on Websites

No agent or any affiliate thereof may use The Health Plan's names or marks (including logos) on any website or other online digital assets without obtaining The Health Plan's prior written approval.

If any THP Medicare Advantage plans are marketed or mentioned on any website of an agent or any affiliate thereof, the contracted agent as applicable must obtain The Health Plan's prior written consent through the process.

Submitting Member/Prospect Materials to Us for CMS Approval

We recommend you take advantage of CMS-compliant marketing materials available to you.

If you create a Medicare marketing piece on your own that mentions The Health Plan, or product/plan benefits, we must review and approve it before it's used. This includes direct mailers, flyers, newspaper ads, radio scripts and other marketing materials.

To get materials approved:

- Send a Word file to your THP sales manager for review.
- Your piece must comply with CMS Medicare Communications and Marketing Guidelines and include all required information and disclaimers. If it doesn't, we'll return it as unapproved.
- Once approved, we'll return your piece with a CMS material ID tag, which must appear on the final version.

As a last step, you must send us (by way of your THP sales manager) a copy of the final version for our records. For newspaper ads, you must send us a copy each time the ad appears in the newspaper.

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Section 6

Enrollment Kits

Enrollment Kits Ordering Process

You can order The Health Plan Medicare Advantage enrollment kits online at thehealthplan.mp-b.com or by contacting Broker Relations at **brokerrelations@healthplan.org**.

Online Requirements

To initially access the Medicare Online Agent Order website, you must be ready to sell. Once you receive the email with login instructions for ordering kits online, you may order online. To learn about how to order online, please refer to the **Agent QuickStart Guide**.

Kit Limits

There is a limit of 100 kits you can order at a time. If your order exceeds those parameters, the order will be routed to Broker Relations for approval. Once approved, you will receive notification of the order's status.

Bookmark the website for easy access in tracking your order. You can login to the website to review your order and check the order status.

Delivery

Once processed, you should get your kits within 7 -14 business days depending on size of order and shipping location. Overnight shipping and P.O. Box delivery are not available.

Kits are shrink-wrapped with everything needed to enroll in one package.

- Enrollment application w/business return envelope
- Enrollment guide
- Summary of benefits
- Star ratings
- Directory flyer
- Formulary
- Silver Sneakers information
- Liberty Dental Information

In addition, scope of appointment forms, formularies, pharmacy and provider directories are also available to order on demand through the kit ordering site.

Enrollment Kit Essentials

Be sure to provide a complete enrollment kit (application, summary of benefits, plan ratings and other required items) to every beneficiary. Our kits are built to help beneficiaries understand the plan, and enroll. Kits include an enrollment application, enrollment guide, a summary of benefits, plan ratings and other related information.

The plan ratings sheet is a required component in all enrollment kits. When CMS announces Star Ratings, we'll update this page and notify you. It should happen in October. You'll then need to remove the current plan year ratings page from your existing kits and insert the new year plan rating page to ensure beneficiaries receive the correct information. All plan materials are also available as PDFs for download on our website at healthplan.org/medicare. If you do not see what you need, please call Broker Relations at 330.834.2289 or the Sales Help Line at 877.903.7506.

Agent QuickStart Guide

Order your marketing materials via a shopping cart process!

Through our Medicare Online Agent Order website, access and order kits, directories, formularies and agent presentations by adding them to your shopping cart and checking out.

Supplies will be printed, packed and on their way free of charge (maximum allowed quantity of 100). Please call THP to make arrangements for additional quantities.

Login with your email address and password. Your password should have been emailed to you. If you did not receive the email, please contact Broker Relations at brokerrelations@healthplan.org.

- Log in at **thehealthplan.mp-b.com**
- Click on "Store" to see items available to you.
- Filter your specific product by selecting the correct group from the "Group" dropdown.
- Click on a "Kit" to see the description of the contents or an individual item to see more information.
- Place the "Quantity" amount in the box provided and click "Add" to place in the shopping basket.
- Click the shopping cart icon to view the items added to your basket. Click "Checkout" when you are ready to place your order.
- Select "+ Add address" from the dropdown for delivery details and place your company name, the address of where you want your supplies delivered and your name.
- Select a "Required by" date of at least two weeks.
- Place your first initial and last name and date (MM/DD/YYYY) of order as the "Order-no." (EXAMPLE: TDOE04122017)

You can login in at any time to review your order and tracking information. Simply select "Orders" to see status. Clicking on the actual order will bring up "Order Details." The "Deliveries" tab allows you to select the order and view the Delivery Note PDF with tracking information.

For questions, problems, or to request additional materials, please contact Broker Relations at brokerrelations@healthplan.org. You can also call Minerva Salewsky, Broker Relations Representative, at 1.330.834.2289 or Tracie Soptelean, Broker Relations Manager, at 1.330.834.2294 for additional questions.

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Section 7

Enrollment Process

Election Periods Overview

Annual Enrollment Period (AEP)

AEP runs from October 15 through December 7. Beneficiaries can change or add a Prescription Drug Plan, change Medicare Advantage (MA) plans, return to Original Medicare, or enroll in an MA plan for the first time even if they did not enroll during their Initial Election Period.

You can begin marketing for the upcoming benefit year on October 1. You must not market or advertise The Health Plan products for the upcoming benefit year prior to October 1. You must not advertise marketing/sales events to discuss subsequent-year benefits prior to October 1, even if your events are scheduled for anytime in October.

You may not accept or solicit paper enrollment forms or accept telephone or online enrollment requests prior to the start of AEP on October 15. Any AEP applications received before October 15 will be denied, and agent commissions on these sales won't be paid.

Annual Medicare Advantage Open Enrollment Period (MA OEP)

The MA OEP occurs from January 1 to March 31. Effective 2019, for the first three months of the calendar year, there will be a continuous open enrollment and disenrollment period for beneficiaries enrolled in Medicare Advantage Plans. This enrollment period will allow for one election change only.

Note: MA OEP members are automatically disenrolled from their current plan when the new Medicare Advantage or PDP application is processed and do not need to submit a disenrollment request to their plan.

Initial Coverage Election Period (ICEP) and Initial Election Period (IEP)

ICEP and IEP occur when consumers first become eligible for Medicare. These periods are for all consumers becoming eligible for Medicare, whether it's due to turning 65 or a qualifying disability. Eligible consumers can enroll in an MA plan of their choosing, including a Medicare Advantage Prescription Drug Plan (MAPD). Those already enrolled in Medicare due to disability have a second IEP when they turn 65. Based on eligibility criteria and election choices, ICEP and IEP may occur together or separately.

Section 7:
Enrollment Process

Special Election Period (SEP)

A Special Election Period lets beneficiaries change their election in accordance with requirements anytime during the year, even the period outside AEP. SEPs vary in qualifications to use them and in the types of elections allowed. Situations such as dual-eligible status and institutionalization let beneficiaries switch plans at any time during the year. SEPs are determined and announced by CMS

Enrollment Process

Before completing an enrollment application with a beneficiary, individuals must:

- Be entitled to Medicare Part A and enrolled in Medicare Part B to enroll. Person must continue to pay their Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.
- Must reside in one of the counties in our approved service area.
- For SecureCare SNP (HMO D-SNP), must also be eligible for Medicaid benefits. If the member no longer meets eligibility requirements due to a change in their Medicaid, membership in SecureCare SNP (HMO D-SNP) will end within six months of loss of eligibility. They will receive notice informing them of the loss of eligibility and the end date of their membership. This notice will outline their ability to switch plans. During this time, their cost share amounts may vary based on their level of Medicaid and Extra Help with Part D drug cost assistance.

Member Services

For existing members, please call Member Services at 1.877.847.7907.

For potential member inquiries, please call 1.877.903.7506.

Online Tools

Our website, healthplan.org/medicare allows you and your clients to learn about Medicare, compare our plan options, access plan documents like the provider directory and plan formulary and enroll in one of our Medicare Advantage plans.

Find a Pharmacy

To search for an in-network pharmacy, The Health Plan members can access healthplan.org/medicare and click on Find a Pharmacy.

Find a Provider

We offer online tools to help find in-network doctors, hospitals and specialists. To access our provider search, go to:

findadoc.healthplan.org.

Member Engagement Programs

Members who enroll in one of our Medicare Advantage plans may receive letters or phone calls from us, or from contracted health care service providers we work with, for valuable services that are part of their plan benefits and available free of charge.

We offer programs for health risk assessments, transition of care, and healthy home visits.

Again, these programs are part of members' plan. They're voluntary and confidential. If your clients have any questions about any of them, they should call member services at the number on their member ID card.

Health Risk Assessments

In order to be clinically successful with the Medicare Advantage population, we identify and intervene with high-risk Medicare beneficiaries with the goals of providing quality care that is responsive to their health needs and to managing their health care costs. CMS also recognizes the importance of this activity and requires assessments of all new enrollees within 90 days of enrollment.

Transition of Care

Transition of care is an outreach program with each Medicare Advantage member who needs to utilize benefits on day one of their effective date. This allows us to ensure Medicare Advantage member needs are met related to selection and documentation of the primary care physician, durable medical equipment, home health care, mental health, upcoming surgeries, diabetes and prescribed medications.

We remind Medicare Advantage members who need maintenance medications that a 90-day supply may be accessed through mail order upon their effective date.

With regard to flu shots and the annual wellness exam, we review what's covered, including colon cancer screening, yearly mammograms and glaucoma testing as part of preventive health measures.

Tools to Assist You with The Health Plan Medicare Advantage Plans

Enrollment kits - Contact Broker Relations for a supply order form to request kit materials if you have issues ordering through the online portal

Marketing materials - Contact Broker Relations

Section 7:
Enrollment Process

Find in-network doctors, hospitals and specialists - findadoc.healthplan.org/

Find in-network pharmacies - healthplan.org/medicare

Member website - healthplan.org/medicare

Product and sales questions: 1.877.903.7506

THP Contact Information

Contracting, Supplies, Training and Testing Set-up

Minerva Salewsky, Broker Relations Representative: 1.330.834.2289

Tracie Soptelean, Manager, Broker Relations: 1.330.834.2294

Compensation Payments and Reports

Tanner Stephens, Staff Accountant: 1.740.699.6135
tstephens@healthplan.org

Certification (Training and Testing) System Issues

The Health Plan Help Desk: 1.877.903.7501

Enrollment Applications

Fax: 740.699.6164

Scan: Medicare_enrollment@healthplan.org

Please call Broker Relations or your assigned sales representative for other options if you cannot fax or scan applications as referenced above.

General Issues/Sales

Sales Help Line: 1.877.903.7506

Chuck Cheton, Medicare Broker Sales Manager: 1.330.834.2328

Cindy Christian, Assistant Vice President, Medicare: 1.330.834.2303

Miscellaneous

If not sent with enrollment forms, bank withdrawal forms (ACH) and required attachments can be emailed to accountspayable@healthplan.org or faxed to 740.699.6161

Agents must be contracted, licensed in the applicable state, appointed by The Health Plan and certified before engaging in the marketing or sale of The Health Plan products.

This communication is intended for use by agents only and is not intended for distribution to Medicare beneficiaries. Any publication or distribution of this communication to unauthorized recipients without The Health Plan's approval is prohibited.