Diversified Call Center MA/MAPD/SNP Inbound/OB Inquiry Call Script

Purpose: For use when making outbound calls to existing clients, returning voicemails, or calling potential clients who have responded to a lead (either online or a BRC) or otherwise provided Consent to Contact, or when receiving inbound calls. This pre-enrollment script is for all product lines. If an enrollment is agreed upon the Enrollment Script in Sunfire/Carrier Portal is to be used.

NOTE TO AGENT: All red sections in must be read verbatim. Sections in gray boxes indicate agent notes. Sections in Yellow are to be reviewed carefully with member.

PAY ATTENTION TO SIGNS:

When you see this icon, slow down and review these sections carefully.

When you see this section, stop. These sections must be read Verbatim.

Introduction-Outbound

Good [Morning/Evening] may I please speak with [First Name]? Hello, this is [Broker Name], and I am a Licensed Sales Agent with [Agency Name/Carrier Name]. I am calling today because [Reason].

Introduction-Inbound

Hello, thank you for calling [Agency/Carrier Name], this is [Broker Name], a Licensed Sales Agent. How can I help you today?

Read: Before we continue, I have a short, required disclaimer: We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov or 1-800-Medicare , or your local State Health Insurance Program (SHIP to get information on all of your options.

<Agency Name> is not a government agency.

Basic Information

May I please have your First and Last Name?

Thank you, Can I get your Zip Code and the County you reside in?

Should our call get disconnected what is the best number to call you back on?

Mr./Mrs. [Member Last Name], I do want to inform you that this call is being recorded.

Do you give us permission to contact you to let you know about your Medicare plan and other product offerings may include mail, phone call, or text message to any phone number and or email address that you provide including mobile and landline. This also includes numbers that may be on the Federal or State Do Not Call list. You also understand that you are not required to agree to these terms as a condition to receive any property, goods or services that may be offered. And you may revoke your consent at any time by opting out.

Agent Note: You must obtain a verbal "yes" or "I agree" to the recording or the call must end.

Power of Attorney

Mr./Mrs./Ms. Before we continue to the enrollment process, we have a few CMS guidelines that we need to review. These are for your protection and will validate your full eligibility to enroll today.

Part 1

Are you enrolling for yourself or for someone else?

(If SELF, ask:) Do you make your own healthcare decisions?

If Yes, continue to Enrollment Period Verification)

(If No, continue to Part 1a)

(If SOMEONE ELSE, skip to *Part 2 – ENROLLING FOR SOMEONE ELSE*)

Part 1a

Would you like to have that person on this call to help discuss and enroll today?

(If NO, skip to *Part 1c*)

(If YES, proceed to Part 1b below:)

Part 1b

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

(If Yes) ask: Are you the legal representative or someone who is legally able to act on behalf of the beneficiary? For example, do you have a durable Power of Attorney or court appointed guardianship that allows you to make medical and insurance decisions for them? (If YES:) Ok, may I have your name, and your relationship to the beneficiary?

Are you the legal representative or someone who is legally authorized to act on behalf of the beneficiary under the applicable state law? And can you provide written document evidencing your authority if requested by CMS? For example, do you have a durable Power of Attorney, or a court appointed guardianship?

(If NO:) Okay, great. You can both stay on the line, and we can continue our conversation, but if

[BENEFICIARY NAME] decides to enroll in a plan today, they will need to remain on the call and complete the enrollment themself.

Part 1c

We will be enrolling in a Medicare health plan and this could change your health insurance coverage. If you usually have someone who helps you make healthcare decisions, are you sure you would not like them on the line to help you decide what is best for you?

(If NO, Enrollment Period Verification)

(If YES, they want to have person on the line, offer to set a call back or an appointment for a time in which the person will be able to be on the call.)

Part 2 – ENROLLING FOR SOMEONE ELSE

Ok, no problem.

Are you the legal representative or someone who is legally able to act on behalf of [Enrollee Name]. For example, do you have a durable Power of Attorney or court appointed guardianship that allows you to make medical and insurance decisions for them? (If YES:) Ok, may I have your name, and your relationship to the beneficiary?

Are you the legal representative or someone who is legally authorized to act on behalf of the beneficiary under the applicable state law?

And can you provide written document evidencing your authority if requested by CMS? For example, do you have a durable Power of Attorney, or a court appointed guardianship?

If Yes Proceed to Enrollment Period Verification

If No Proceed Below:

> Mr./Mrs./Ms. We will not be able to complete the enrollment today without the members approval, are they available to come on the phone and complete the enrollment.

(If No) Set an appointment to contact another time and continue with the present person and Member.
Proceed to courtesy close

(If Yes) Confirm members intent to enroll and continue to Enrollment Period Verification

(*Proceed to Enrollment Period Verification)*

Scope of Appointment

Agent Note: Scope of Appointment should be read prior to sales presentation

Read: We have contracts with carriers who offer Medicare plans such as Medicare Advantage, Prescription Drug, and Medicare Supplement. There is no obligation to enroll, you will not be automatically enrolled, and your current or future Medicare enrollment status will not be impacted. Do you agree to review these plans?

Do I have permission to speak with you about these plans?

(If yes, Continue to Needs Analysis #1)

(In No, Proceed to Permission to Contact-Not Enrolled)

Needs Analysis #1

AGENT NOTE: Use this time to capture the members providers. This includes their Primary Care Provider and any Specialists they may see. It is also recommended to review the hospital and additional facilities.

The following questions will help us find the best plan to fit your needs:

Who is your current Primary Care Physician?

Do you have any specialists you see?

(Proceed to Medicare Eligibility)

MEDICARE ELIGIBILITY

Thank you, while I enter your information can you make your Red, White and Blue card available we will need your Medicare Part A and B effective dates along with your Medicare Number. While you grab that I will enter your information into our plan eligibility portal to determine your current information and pull up the available plans in your area.

Gather Medicare A/B Dates and Medicare Number and DOB

If member does not have card
Do you currently have or will soon have Medicare Part A and/or Part B?

AGENT NOTE: If member does not have card or know Medicare Number schedule a callback for a later time when they have that information. Or proceed without until enrollment.

AGENT NOTE: If member does not want to share health-related information: *I want to make you aware that you are not required to provide any health-related information; unless the information is needed to determine your eligibility to enroll in the [Plan/Program}. If you choose not to provide health information that is necessary to determine enrollment eligibility, then you may not be able to enroll in [Plan/Program].*

If information obtained, Proceed to *Needs Analysis #2*
If No A and B/Medicare, proceed to *Not Eligible for Medicare*
If Unsure proceed to *Unsure about Medicare*
If Part A only, proceed to *Part A only*
If Part B only, proceed to *Part B only*

Needs Analysis #2

AGENT NOTE: The following questions are optional but can help provide information to ensure proper plan selection. Use this time to find out if there is anything concerning the beneficiary that may help point you in the direction of a specific product, plan, or carrier.

Thank you, I am going to enter it in the system and pull up your current coverage and Medicare Eligibility information. While we do that do you mind telling me about current coverage? What do you like about it? What do you feel is missing in it?

- Are you interested in plan options that offer things such as dental, vision, hearing, or gym memberships?
- Do you receive any sort of state assistance such as Medicaid or Low-Income Subsidy that is helping pay for your prescription drug medications?
  (If UNSURE, proceed to MEDICAID COVERAGE on page 9)
- What would you add or alter to have coverage you'd like even more?"
- What are you hoping to gain by changing your coverage arrangement?
- Do you have any preference for plan types, like HMO or PPO?
- Is travel or living elsewhere at times part of your lifestyle?
- Is anything more important to you- like health vs prescription drug benefits?

AGENT NOTE:

If VA benefits, discuss use of VA facility to determine type of plan that may or may not be needed.

If Tricare for Life or ChampVA, explain that benefits with Tricare for Life are generally more comprehensive than most other types of coverage available. Agent should explain to the beneficiary how enrolling in a plan will affect their Tricare/Champ VA (i.e. how the claims will pay differently and require coordination by the beneficiary and their provider ,Tricare/Champ VA will become the secondary insurance if an MAPD plan is selected the beneficiary will be limited to the network of providers on the MA/MAPD vs. Tricare where they can use any provider that accepts Original Medicare the MA/MAPD plan cannot only be utilized for additional benefits like dental or hearing. Therefore, while they can enroll in an MA/MAPD plan, it's not recommended." After explaining the issues, ask the beneficiary, "Do you still wish to proceed with this call to learn about MA/MAPD options?" If yes, proceed. If no, go to 'Closing the Call'.

Agent will provide summary of the Needs Analysis to the beneficiary*: I'll summarize my notes for you to make sure I did not miss anything (agent provides summary). Did I miss anything that is important to you?*

Needs Analysis #3

Mr./Mrs./Ms. [last name], thank you for that information, we are seeing plans available that will meet those needs. We will need one last piece of information to narrow down the plans. Do you currently take any prescription medications?

If Yes Proceed Below
If No Proceed to Plan Match

Great, it is important we enter those medications into the system, can you gather your current medications? We will need the medication name, dosage, and frequency of fill.

Enter in medications

[Mr./Mrs./Ms.] What pharmacy to you prefer to fill these at?

Once medications and pharmacy are entered proceed to Plan Match

Plan Match

AGENT NOTE: Use your tools to find the best plan/rate for the client.

You are required to review plan type, monthly premium, health plan deductible, PCP co-pay, specialist co-pay, prescriptions, for at least the plan in the caller's county that best fits the members needs based on the benefits most desired by the beneficiary.

At a minimum, you must review the Baseline Benefits for any plan the client wishes to learn more about. Review the plan(s) of interest by providing information on the plan (Agent can read from the Evidence of Coverage or Summary of Benefits, especially for those services for which you routinely see a doctor)

If there is no suitable option (i.e. area, current coverage exceeds coverage options available, etc.), state the following. If there are suitable plans, proceed to the baseline benefits in yellow below.

Based on the information you provided, it appears we may not have a plan that will work for you at this time.

AGENT NOTE: Explain to the caller why you believe there may not be suitable plan in their area. If the caller does not agree and wishes to continue discussing their Medicare plan options, proceed with the script below.

If the caller agrees that there is not a suitable plan for the caller, proceed to Consent to Contact –Not Enrolled

MEDICARE ADVANTAGE BASELINE BENEFITS

- Premium
- Medical Deductible
- Primary Care Co-Pay
- Specialist Co-Pay
- Primary Care Provider
- Offer to lookup any other providers to determine if they are in or out of the plan network.
- Emergency Care
- Urgent Care
- Hospital Coverage

Should you enroll into the plan, you will receive an Evidence of Coverage booklet that will explain all your benefits in detail. Would you like me to cover any additional benefits for you at this time or would you prefer to wait and review these in your Evidence of Coverage once received?

Agent Note: Review the full benefits of any the client wishes to hear as well as anything they mentioned during the needs assessment that may be covered such as Dental, Vision, Hearing, Transportation, OTC, Fitness, DME, Rehabilitation Services, MOOP, Preventative Care, In Patient Hospital Copay, etc. If these any additional benefits are discussed be sure to review costs and restrictions for each.

During this time confirm the PCP, Specialists, and hospital mentioned are reviewed for INN Status or explained for OON status.

If dental is reviewed, assure the member understands if the benefit is embedded, reimbursement, or a rider. You also must also mention any restrictions or limits.

PART D PRESCRIPTION DRUG BASELINE BENEFITS

Agent Note: If member provided medications, you should review the medication coverage in relation to the plans formulary. Along with the pharmacy network status, if not INN explain costs for OON and/or offer Pharmacy INN.

- Prescription Drug Plan Deducible
- 30-Day or 90-Day Supply (all tiers as needed) for Preferred Retail Pharmacy
- Coverage Gap
- Catastrophic Co-Pays/Coinsurance
- Prior Authorization
- Formulary Exceptions
- Step Therapy

**Confirm Extra Help eligibility for accurate quotes

*Only review coverage Gap and above phases if they apply

MEDICARE SUPPLEMENT AND ANCILLARY PLAN BASELINE BENEFITS (review if member asks for MediGap Plans)

Medicare Supplement Plans work with Original Medicare, Parts A and B, and may help pay for certain costs that Original Medicare doesn't cover. These plans don't provide stand-alone coverage; you need to remain enrolled in Part A and Part B for your hospital and medical coverage. If you need prescription drug coverage, you'd need to enroll in a stand-alone Medicare Prescription Drug Plan. In contrast, Medicare Advantage plans are an alternative to Original Medicare. Please note that the plans I am getting ready to review with you are not Medicare Advantage plans.

- Plan Premium
- Applicable Discounts
- Benefits (as applicable)

Enrollment Period Verification

Is this call taking place during the Annual Enrollment Period (October 15 through December 7)?

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

If this call is NOT during the Annual Enrollment Period, state: Since we are currently outside of the Medicare Annual Enrollment Period, which runs from October 15th to December 7th, and the Open Enrollment Period from January 1st to March 31st each year, you will need to have a Special Election Period (SEP) in order to qualify for a Medicare Advantage or Prescription Drug Plan. There are several election periods for which you may qualify based on your circumstances. I want to ask you a few questions to determine if you are eligible to enroll today, OK?

AGENT NOTE: Does the caller qualify for an election period now? Ask the following questions until you receive a "Yes" response. Once you receive a "yes', continue.

1. Are you new to Medicare?
2. Are you enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP)?
3. Have you recently moved outside of your plan's service area or have you moved and this plan is a new option? If yes, what was the date?
4. Have you recently been released from incarceration? If yes, what was the date?
5. Have you recently returned to the United States after living permanently outside of the United States? If yes, what was the date?
6. Have you recently obtained lawful presence status in the United States? If yes, what date did you obtain this status?
7. Have you recently had a change in your Medicaid (new to Medicaid, had a change in level of Medicaid assistance, or lost Medicaid)? If yes, what date was this change?
8. Have you recently had a change in your Extra Help paying for Medicare prescription drug coverage (newly received Extra Help, had a change in the level of Extra Help, or lost Extra Help)? If yes, what date was this change?
9. Do you have both Medicare and Medicaid or is your state helping to pay for Medicare premiums or do you get Extra Help paying for your Medicare prescription drug coverage, but you haven't had a change?
10. Are you moving into, live in, or recently moved out of a Long Term Care Facility (example, nursing home)? If yes, as of what date?
11. Have you recently left a Program of All-Inclusive Care for the Elderly (PACE)? If yes, when did you leave?
12. Have you recently involuntarily lost creditable prescription drug coverage (as good as Medicare's)?

    If yes, what was the date?
13. Are you losing or leaving coverage you had from an employer or union? If yes, what was the date?
14. Do you belong to a pharmacy assistance program provided by your state?
15. Were you enrolled in a plan by Medicare (or your state) and you want to choose a different plan? If yes, what date did your enrollment in that plan start on?
16. Is your plan ending its contract with Medicare or is Medicare ending its contract with your plan?

17. I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

18. I am in a plan that has had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher

19. I am in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan.

20. Were you enrolled in a Special Needs Plan but have lost the Special Needs qualification requirement to be in that plan? If yes, when?"

21. If none of these statements applies to you, is there another reason you believe you may be eligible to enroll?

(If SEP is determined, state the following and proceed) Based on the information you've provided, it appears you do qualify for an election period to enroll now.

(If SEP is not determined, read the following and proceed to PERMISSION TO CONTACT section)

I'm sorry but at this time it does not appear that you qualify for a special election period to enroll in a plan now. The Annual Enrollment Period is from October 15 through December 7 when you can change plans.

Enrollment Confirmation

[Member Name], based on everything we have discussed, it looks like the [Carrier, Plan Name, and Plan Number if applicable], which is a [Plan Type], will be the most beneficial plan for you and your needs.

Do you have any questions about this plan before we proceed?

(If YES, answer any questions the caller has. If they are ready to move forward, continue to the ENROLLMENT section. If they are not ready to enroll, proceed to the CLOSING - NOT INTERESTED)

(If NO, Proceed to Enrollment)

PRE-ENROLLMENT CHECKLIST

Prior to completing the PECL be sure to review the following:

- The right to cancel this enrollment as well as the specific date through which cancellation may occur
- Review coverage outside the United States
- Review how to file a complaint
- Explain that this is not a hearing/dental/vision "rider" but a full plan
- Go over premiums, including Part B premium, {insert dollar amount} per month/quarter/year. [This one only applies if there is a premium >$0.]

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at [insert customer service phone number].

Understanding the Benefits

The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [Plan Website] or call [CSO number] to view a copy of EOC.

Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Review the formulary to make sure your drugs are covered.

Effect on Current Coverage

If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

Understanding Important Rules

In addition to your monthly plan premium (may delete the monthly plan premium portion for $0 premium plans), you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

[Note: Fully integrated dual SNPs may elect to remove this section or modify it to convey that the Part B premium is already paid. Plans that have a Part B buy-down may alter the language to convey the amount the plan pays and the beneficiary owes.]

Benefits, premiums and/or copayments/co-insurance may change on January 1, [insert year].

[For plans that do not offer out of network coverage] Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

[For PPO, PFFS, and other plans that offer out of network coverage] Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services [HMO-POS may insert "certain covered services"], the provider must agree to treat you. Except in an emergency or urgent situation, non- contracted providers may deny care. [If applicable, plans must add the following language] In addition, you will pay a higher co-pay for services received by non- contracted providers.

[For C-SNP plans] This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

[For D-SNP plans] This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. [D-SNPs may provide additional information if they impose restrictions to specific Medicaid eligibility category(ies)]

[For I-SNP plans] This plan is an institutional special needs plan (I-SNP). Your ability to enroll will be based on verification that you, for 90 days or longer, have had or are expected to need the level of services provided in a skilled nursing facility, a nursing facility, an intermediate care facility for individuals with intellectual and developmental disabilities, a psychiatric hospital or unit, a rehabilitation hospital or unit, a long-term care hospital, a swing-bed hospital, or a facility approved by CMS that furnishes similar services.

[For MSAs] MSA Plans combine a high deductible Medicare Advantage Plan and a trust or custodial savings account (as defined and/or approved by the IRS). The plan deposits money from Medicare into the account. You can use this money to pay for your health care costs, but only Medicare-covered expenses count toward your deductible. The amount deposited is usually less than your deductible amount, so you generally have to pay money out of pocket before your coverage begins. Medicare MSA Plans do not cover prescription drugs. If you join a Medicare MSA Plan, you can also join any separate Medicare Prescription Drug Plan. There are additional restrictions to join an MSA plan, and enrollment is for a full calendar year unless you meet certain exceptions. Those who disenroll during the calendar year will owe a portion of the account deposit back to the plan. Contact the plan at [insert customer service and TTY] for additional information.

ENROLLMENT

AGENT NOTE: For Medicare Advantage and Part D: If this is an outbound call, you must have the client call back in to enroll. Please read the statement below before disconnecting, then proceed to the Enrollment Script. Proceed below at the conclusion of the enrollment process. For Medicare Supplement and ancillary product enrollments: Proceed to the enrollment portal then continue below.

If Outbound Call: In order to enroll, I will need you to call me back directly since all enrollments must be done on an inbound call. Do you have a pen and paper handy so that I can provide you with the number to call me back? Great, my number is [XXX-XXX-XXXX]. I will be waiting for your call back to get started. I look forward to talking to you in a few minutes.

[Partner/Agency] is a licensed and certified representative of Medicare Advantage [HMO, HMO SNP, PPO, PPO SNP and PFFS] organizations [and stand-alone PDP prescription drug plans] that have a Medicare contract. Enrollment in any plan depends on contract renewal."

(If member agrees, proceed to PRODUCT SPECIFIC ENROLLMENT SCRIPT IN SUNFIRE then proceed below to POST-ENROLLMENT)

(If NO, proceed to DOES NOT WISH TO ENROLL)

(If YES, proceed to PRODUCT SPECIFIC ENROLLMENT SCRIPT IN SUNFIRE then proceed below to POST-ENROLLMENT)

(If NO, proceed to DOES NOT WISH TO ENROLL)

CLOSING

Alright [Client Name], you are all set. Once CMS, the Center for Medicare & Medicaid Services has approved your application, you should receive your member ID card and important plan documents in the mail shortly thereafter. Make sure you are on the lookout for those. You have made a great decision today with your [Carrier] plan.

Let me provide you with our contact information – do you have something to write with? Provide the agent with your name and the toll-free number [Phone Number], TTY 711. Our hours of operation are [Hours of Operation]. Make sure you keep my information on hand so you can give me a call if you have any questions or issues that pop up.

Thank you for letting us assist you with your healthcare needs today. Please keep us in mind if you have any other insurance questions or needs in the future. We also work with dental, vision, hearing, and hospital indemnity plans, to name a few.

Also, if you have any friends or family who may need assistance, please send them our way. Thank you and have a great day!

-----THIS IS THE END OF THE SCRIPT----

Alternate Scenarios

Unsure About Medicare

There are a few ways you can assist someone if they are not sure if they have Parts A and B of Medicare. Walk them through the following:

1. [Client Name] - do you have your Medicare red, white, and blue card handy? If so, can you grab that and let me know if you see a date beside both Part A and Part B?

2. Do you know if you have anything in withdrawn from your Social Security check each month? (If YES, ask how much. If they say approximately $134, that should be their Part B premium.
(If NO, proceed below)

(If YES, provide them with the number to call Medicare (1-800-MEDICARE) and proceed below).
(If NO, advise them that, without that, you cannot assist them with specific plan information at this time but you can provide non-specific plan information according to their zip code. Set up a callback for when they have that information.)

AGENT NOTE: If member does not want to share health-related information: *I want to make you aware that you are not required to provide any health-related information to me other than what is required should you decide to enroll into a plan, and that the information you do provide will only be used to determine enrollment eligibility and available plans in your area.*

NOT ELIGIBLE FOR MEDICARE

Unfortunately, without have Parts A and/or B of Medicare, we cannot get you enrolled into a healthcare plan at this time. Try and determine when they will be eligible for Medicare.

AGENT NOTE: You can use this opportunity to cross-sell DVH, Hospital Indemnity, etc. Also, if someone is eligible for Part A (but not enrolled) but enrolled in Part B, you can still enroll them into a Part D Standalone Plan.

(If NOT INTERESTED proceed to CONSENT TO CONTACT – NOT ENROLLED)
(If INTERESTED in an ancillary product, proceed to ANCILLARY PRODUCTS)

Would it be alright if we give you a call back when you are eligible for Medicare?

(If YES, proceed to CONSENT TO CONTACT – NOT ENROLLED)
(If NO, proceed to CLOSING – NOT INTERESTED)

PART A ONLY

To enroll into a Medicare health plan, you must have Parts A and B of Medicare. You will need to enroll into Part B before we can assist you with this.

Advise the caller they can enroll into Part B in one of the following ways:

1. Visiting their local Social Security office
2. Calling 1-800-MEDICARE
3. Enrolling online at www.medicare.gov

[Client Name], once you have taken care of your Part B enrollment and have been given your Medicare ID number and Part B effective date, we can help find a plan to fit your needs. Give us a call back at [Phone Number] when you are ready, and we can get you all taken care of.

AGENT NOTE: Try and secure Consent to Contact in case you do not hear back from them by asking **Do we have permission to reach back out to you in the future to see if you need any assistance with your healthcare options?**

PART B ONLY

[Client Name], since you only have Part B of Medicare, the only plan I can assist you with today is a Part D Prescription Drug plan. Would you like me to review those with you now?

(If YES, proceed below)
(If NO, proceed to ANCILLARY PRODUCTS)

(If YES, proceed to PLAN SELECTION) (If NO, proceed below)

ANCILLARY PRODUCTS

We also represent quite a few ancillary product lines including dental, vision, and hearing plans, hospital indemnity options, and plans covering critical illnesses such as cancer and chronic heart or lung disease. Would you like to learn more about any of these options?

(If YES, proceed below)

(If NO, proceed to CLOSING – NOT INTERESTED)

Discuss with the caller any of the ancillary products and benefits that may be of interested to them.

Are you ready to enroll into the [Carrier and Plan Name] today?

(If YES, proceed to ENROLLMENT PORTAL then to POST-ENROLLMENT)

(If NOT AT THIS TIME, try to overcome objections before proceed with the enrollment below or proceeding to CLOSING – NOT INTERESTED)

MEDICAID COVERAGE

Use this time to help the caller if they are unsure of their Medicaid or LIS status. You can follow the steps below.

1.Do you have a Medicaid card?

(If YES, proceed to PLAN SELECTION)
(If NO, proceed below)

2.Would you be willing to complete a three-way call with me to [Carrier Name] so that we can verify your eligibility? They will ask you to confirm some information on the call.

AGENT NOTE: Make sure that you confirm LIS eligibility and, if eligible, also confirm if the client has used their quarterly SEP or when they will be eligible for their next SEP.

3.Would you be willing to call Social Security and confirm your status and give me a call back?

(If YES, proceed below)

(If NO, let the client know that you can only provide non-specific information regarding plans available in their zip code then proceed to CLOSING – NOT INTERESTED)

[Client Name], once you confirmed your Medicaid or Low-Income status, we can help find a plan to fit your needs. Give us a call back at [Phone Number] when you are ready and we can get you all taken care of.

CONSENT TO CONTACT – NOT ENROLLED

Great – when we call you, we will be able to talk to you about products and plans offered by various companies which may include Medicare Advantage plans, Medicare Supplement Insurance plans, Part D Prescription Drug plans, and other ancillary products. We will only call you on the number provided which may be a cell phone or a land line. What number would you like to receive a call back on?

Set a “Schedule Call Back” or “AEP Only” disposition (based on the situation) and let the caller know when you will be calling them.

[Client Name], I will give you a call back [Time Frame]. If you need anything or have any questions before then, feel free to give us a call at [Phone Number]. Have a great day, and I look forward to speaking with you soon.

DOES NOT WISH TO ENROLL

Unfortunately, without your consent, we cannot continue at this time. May I ask what your concerns are? (Attempt to overcome objections. Assist the prospect with additional concerns)

(Address concerns. If they wish to proceed, return to section of the script you were at previously. If they do not wish to proceed, move to the CLOSING – NOT INTERESTED)

CLOSING – NOT INTERESTED

I understand. Thank you for your time. Please keep us in mind if you need anything down the road. Have a wonderful day.