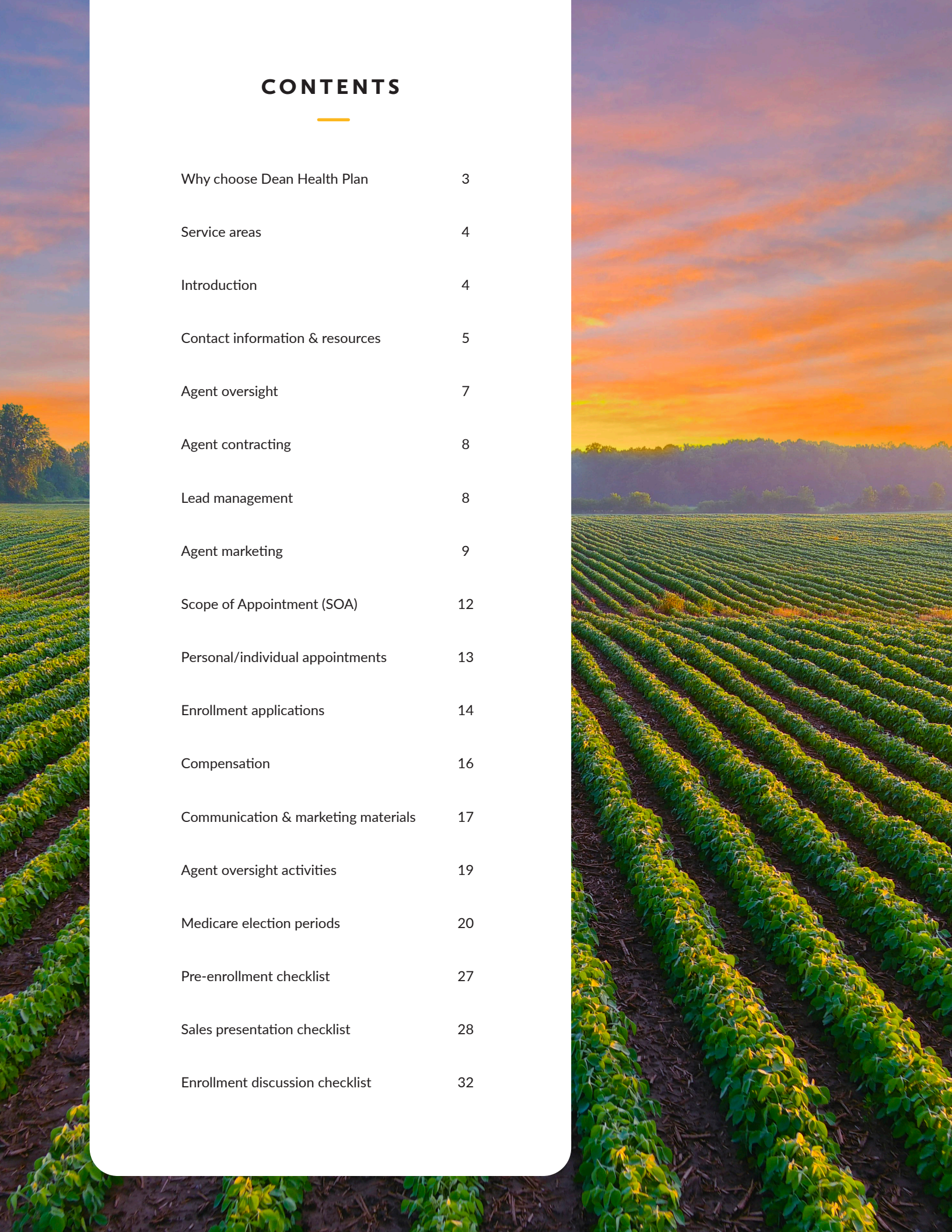
THE HEALTH PLAN FOR SOUTH-CENTRAL WISCONSIN

2024 Agent and Broker Guide

Dean Health Plan Medicare Advantage Products

Dean Health Plan by Medica

CONTENTS



THE HEALTH PLAN FOR SOUTH-CENTRAL WISCONSIN

Why choose Dean Health Plan

For more than 35 years, Dean Health Plan has been here helping southern Wisconsin residents make the most of their coverage. Together with local member support, doctors, clinics and hospitals, we offer our members complete care — it's insurance that works with your doctors to keep you healthy.

COORDINATED CARE NETWORK

Physicians + **Health Plan** + **Hospitals**

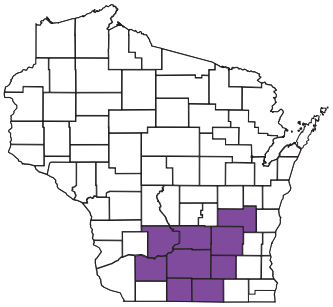
Our Coordinated Care Network is a true collaboration between health care experts, hospital partners, and Dean Health Plan, leading to a streamlined and simpler experience for you.

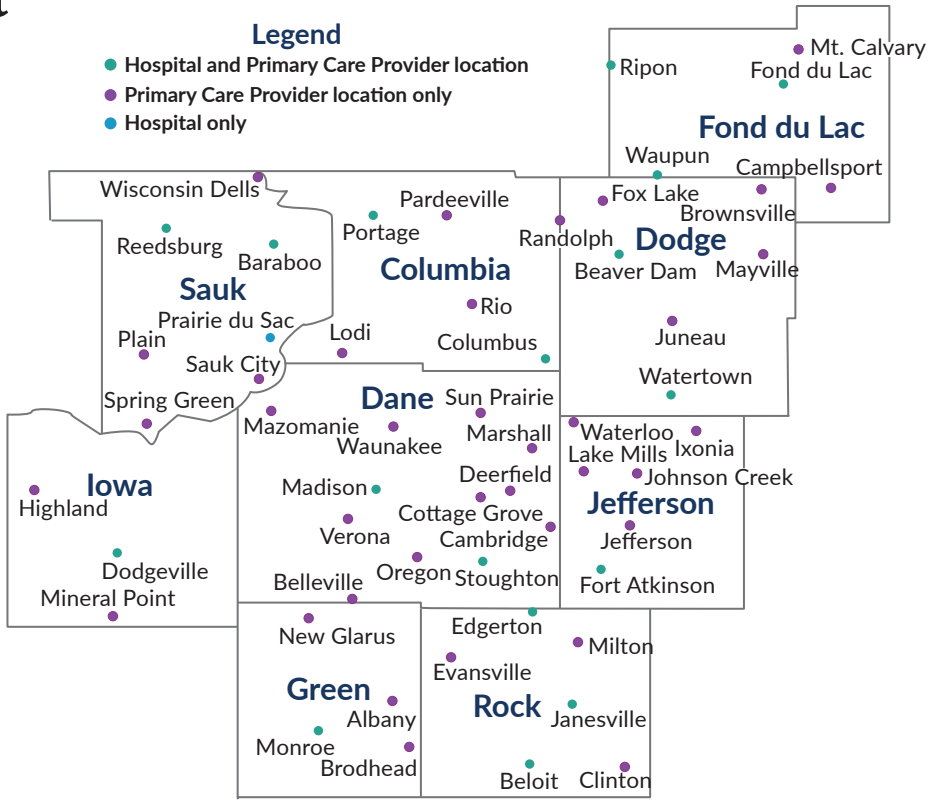
Local:
Our roots are local. Our employees are your friends and neighbors. And you'll find your primary care provider just down the road.

Caring:
Community is important to us. We participate in volunteer efforts throughout the year to make local life better for everyone.

Premier benefits:
We give members a plan that covers their health needs - including dental, over-the-counter (OTC) purchases, and more.

Service area





Introduction

Dean Health Plan requires all Sales Agents, Sales Entities, or any other downstream entities representing Dean Health Plan to comply with the Medicare Advantage Agent and Broker Guide, federal and state laws, CMS regulations and guidance, Dean Health Plan training requirements and all other regulatory requirements related to sales activities. Dean Health Plan expects that Agents will assist each Medicare beneficiary to obtain Medicare coverage that best meets the beneficiary's specific needs.

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

Note: This document is superseded by any new or updated federal and state laws, and other regulatory guidance, and Dean Health Plan policies.

Scope/limitations

Unless specifically stated, this policy applies to all Agents/Brokers associated with Dean Health Plan, whether employed or contracted (via an affiliated Sales Entity through an Agency Agreement). Hereafter, in this document, all selling individuals will be referred to as "Agents." The term "Sales Entity" refers to any Dean Health Plan contracted sales organization, including Agencies.

References

Medicare Managed Care Manual (MMCM) – Ch. 3 – Medicare Communication and Marketing Guidelines (MCMG)

Medicare Managed Care Manual (MMCM) – Ch. 2 – Medicare Advantage Enrollment and Disenrollment (42 CFR – Sections 422 (Part C) and 423 (Part D))

Contact information & resources

Agent Websites	
https://DHPuser.Litmos.com/	Litmos: DHP trainings and certifications
https://Arm.AscendProject.com	ARM: • Update/Reset your password • You can also download the Ascend Mobile App (AMA) • This site is the administrative site of Ascend
https://Dean.ISF.IO/2024/Agent	Ascend Agent Portal: Allows you to see all the applications that you have submitted via Ascend: • Use same credentials as Ascend • You can quote and submit apps in the Agent Portal but you can't track your leads or record meetings • *Some agents find the Portal more user friendly *Note: The NPN shown is our internal ID that we use to make sure that the application is tied to your name and that commissions are paid out appropriately*
DeanCare.com/AgentLibrary	DHP Co-Branded Agent Materials

Dean Advantage Websites	
DeanCare.com/Medicare/Shop-Medicare-Advantage-Plans	**Shopping/Sales Materials:** Access to materials in the Enrollment Kits
DeanCare.com/MedicareAdvantageMembers	**Member Information:** View ANOC's, EOC's, Locate a provider, view formulary, and find a pharmacy
DeanCare.com/ExtraBenefits	**Added Benefits:** Dental, Hearing, Living Healthy, Worldwide Emergency, OTC, Fitness, & Vision
https://www.deltadentalwi.com/s/find-a-provider?persona=member&network=medicareadvantage	Delta Dental Provider Directory Look-up
DeanCare.com/Find-a-Doctor	Find a Doctor Look-up
DeanCare.com/Location	Find a Location Look-up
https://app.deancare.com/Directories/MAPD-Directory.pdf	Provider Directory – PDF
DeanCare.com/Medicare/Medicare-Member-Center/Dean-Advantage-Member-Center/Pharmacy-Benefits	Printable Comprehensive Formulary Pharmacy Directory (Preferred Pharmacies are indicated with a "P" next to the Pharmacy)

Contact information & resources

Member Services	
Medicare Advantage Member Services Member questions: benefits, claims, providers etc.	**1 (877) 232-7566**
Other DHP/P360 Phone Numbers	
DeanCare Gold & Select Customer Service	**1 (888) 422-3326**
Dean Health Plan Commercial Customer Service	**1 (800) 279-1301**
Agent Services	
Medicare Agent Services	**1 (877) 316-7586**
Medicare Agent Sales and Service Manager Natasha Cook	**1 (608) 828-1948** **Natasha.cook@deancare.com**
Agent Inquiries (Certification requests, material requests, etc.)	**DHP.MAPDSales@deancare.com**
Medicare Sales Fax Number (Paper Applications and other documents)	**1 (608) 252-0801**

Medicare Numbers	
Medicare	**1 (800) 633-4227**
Social Security	**1 (800) 772-1213**
COB	**1 (855) 798-2627**
Mailing Addresses	
Dean Health Plan (Corporate Office)	1277 Deming Way Madison, WI 53717
Medicare Advantage Premiums	Dean Advantage 28452 Network Place Chicago, IL 60673-1284 Dean Advantage PO Box 56099 Madison, WI 53705

Agent oversight

Dean Health Plan has established Agent oversight policies in order to prevent detect and correct non-compliant sales activities, including any activities that mislead or confuse beneficiaries, or misrepresent the health plan. The policies have been designed to provide better visibility to the Medicare sales-related quality controls and monitoring activities which are embedded in the different departments and processes which support Dean Health Plan's Medicare Advantage line of business.

The Agent Oversight Policies provides oversight and monitoring of the following areas:

- Agent contracting
- Corrective action
- Enrollment applications
- Scope of appointment
- Lead management
- Broker compensation
- Sales allegations
- Personal appointments
- Event management
- Marketing materials (including websites)
- Rapid disenrollment
- Personal/individual marketing calls

As part of Agent oversight, Dean Health Plan has established a committee called the Agent Oversight Committee. The committee reviews oversight trends, provides direction on confirmed non-compliance issues and ensures implementation of appropriate corrective actions and process improvements.

Agents and Sales Entities are responsible for cooperating with Dean Health Plan's oversight and monitoring activities, including compliance with all corrective or disciplinary actions that are deemed appropriate by Dean Health Plan's Agent Oversight Committee and reporting non-compliance directly to CMS.

Agent contracting

Before an Agent may market or sell any of Dean Health Plan's Medicare Advantage products, all Dean Health Plan Medicare Advantage contracting requirements for Certification must be completed and kept current, including:

- Maintain an active State of Wisconsin health insurance Agent license
- Complete annual AHIP National Medicare Certification with Fraud, Waste and Abuse training, successfully pass the exam and provide the results to Dean Health Plan
- Complete annual Dean Health Plan Medicare and Product Training and pass the exam with an acceptable score. All training is provided online; if you need other arrangements, please email DHP.MAPDSales@DeanCare.com
- Complete contracting documentation and be appointed by Dean Health Plan pursuant to state law Agree to be enrolled in the Dean Health Plan monthly screening of the Office of the Inspector General (OIG) and Government Services Administration (GSA) exclusion lists. If an Agent is listed on an exclusion list, the Agent's Medicare Advantage Certification will be terminated. Agents affiliated with a Sales Entity who contracts with Dean Health Plan to sell Medicare Advantage products must meet all of the above requirements and also provide a signed Medicare Advantage Agent Marketing Authorization Agreement, which shows affiliation with a specific Sales Entity, and submit that to Dean Health Plan along with the other requirements listed above.

For more information about Dean Health Plan's contracting requirements, please refer to the Agent License page on DeanCare.com: DeanCare.com/Agents/Licensing.

Lead management

Agents must obtain permission from a beneficiary prior to contacting them to schedule a sales or marketing appointment. Permission given by a beneficiary may be obtained via a "Permission-to-Call" Card, also commonly referred to as a Lead Card or Business Reply Card (BRC).

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

- Only to the sales Agent or Sales 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 and is only valid for twelve months.

Agent marketing

Marketing through unsolicited contacts

You may make unsolicited direct contact with potential enrollees using the following methods:

- Conventional mail and other print media (e.g. advertisements, direct mail)
- Email provided all emails contain an opt-out function

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

- Door-to-door solicitation
- Telephonic or email solicitation, including voicemail messages or text messages
- Distribution of information at a residence or car
- Approach of potential enrollees in common areas
- Contact with an individual who comments, likes or follows a Plan Sponsor on social media

Prohibited telephonic activities include calls that:

- Are made to beneficiaries based on leads obtained from other sources
- Employ bait-and-switch strategies—making unsolicited calls about other business as a means of generating leads for Medicare plans
- Are made to a sales event attendee, unless the attendee gave express written permission at the event for a follow-up call
- Are based on referrals—If an individual would like to refer a friend or relative to an Agent or Plan/Part D Sponsor, the Agent or Plan/Part D Sponsor may provide contact information such as a business card that the individual may give to a friend or relative
- Are made to former enrollees who have disenrolled, or to current enrollees who are in the process of voluntarily disenrolling from market plans or products
- Are made to beneficiaries to confirm receipt of mailed information

Calls to beneficiaries who attended a sales event are prohibited, unless the beneficiary gave express permission at the event for a follow-up call and the Agent is able to provide documentation of permission to be contacted. The Medicare Advantage Agent Oversight Committee will investigate any reported instances of unsolicited or inappropriate beneficiary contact to determine if corrective action is necessary.

Marketing and sales event management

Marketing and Sales Events must be conducted in accordance with CMS' Medicare Communications and Marketing Guidelines which specify requirements related to sales and marketing activities, including event reporting, locations, materials, and gifts/promotional items. Please note that marketing events are prohibited from taking place within 12 hours of an educational event, in the same location. The same location is defined as the entire building or adjacent buildings.

Event reporting

Dean Health Plan requires Agents to notify Dean Health Plan at **DHP.MAPDSales@DeanCare.com** at least 14 days prior to any marketing/sales event or 7 days prior to the initial advertisement, whichever is earlier. Reporting of sales events should be submitted via Dean Health Plan's Agent Medicare Advantage Marketing Event Submission Form which can be obtained in the Medicare Advantage Broker Kit or from the Ascend Resources Folder (AMA).

Dean Health Plan will report event information to CMS upon request. CMS uses the Sales Event data reported by plans to determine "Secret Shopper" events to audit. Therefore, when an Agent reports a Sales Event to Dean Health Plan, a Dean Health Plan Medicare Advantage product must be presented at that specific event.

Cancellations and changes to sales events must be submitted to Dean Health Plan at least 48 hours prior to the event's scheduled date. Agents/Agencies may not submit their own events to CMS via HPMS. Agents are responsible for notifying beneficiaries of cancellations or changes by the same means used to advertise or promote the event.

Agent marketing (continued)

In the event that 48 hours advance notice cannot be provided, you must still 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 canceled due to inclement weather, a representative is not required to be present at the site. Agents must notify Dean Health Plan of the cancellation via email at DHP.MAPDSales@DeanCare.com, including an explanation of the cancellation reason.

Managing events

Dean Health Plan strongly recommends that Agents implement the following event management practices:

- Arrive at least 15 minutes early
- Use signage to direct attendees to the correct event location
- Inform the desk attendant about the specific event location so that attendees can be directed accordingly, if the event location has a lobby or general reception area,
- Announce your name, the company you represent and all plans to be discussed during your presentation
- Use Dean Health Plan's CMS approved sales presentation decks
- Make sure that the audience can hear you loud and clear
- Make sure that the audience can see a visual presentation

Dean Health Plan allows use of Permission-to-Call cards at sales events as a mechanism for a beneficiary to voluntarily provide contact information so that an Agent may follow-up with the beneficiary after the sales event. When distributing Permission-to-Call cards, the Agent must clearly inform beneficiaries that providing contact information is strictly optional. Agents must not pressure or coerce a beneficiary to provide contact information. The contact must be event-specific, and may not be treated as open-ended permission for future contacts. Please note that Permission-to-call, Business Reply Cards and Scope of Appointments, are only valid for twelve months.

In order to safeguard a beneficiary's privacy when he/she voluntarily provides contact information, Dean Health Plan does not allow Agents to use any kind of sign-in sheet at Dean Health Plan-specific sales events unless clearly labeled as optional.

Gifts and promotional items

Gifts and promotional items may be offered during the course of sales and marketing activities, provided that items have a nominal value of $15 per person or less. The total fair market value must not exceed the nominal per person value based on anticipated attendance. Anticipated attendance must be based on venue size, response rate, and/or advertisement circulation. Gifts and promotional items must be offered to all attendees, regardless of enrollment and without discrimination.

Gifts and Promotional items may not consist of:

- Cash, or other monetary rebates (including gift cards and gift certificates that can easily be converted to cash)
- Which includes big box stores like Amazon and Walmart and prohibition of Visa/Mastercard gift cards
- Items that could be considered a health benefit (e.g. a free checkup)
- Items directly or indirectly related to the provision of any other covered item or service
- Meals (refreshments or light snacks are acceptable)

Secret shopper/event surveillance

CMS' Medicare Communications and Marketing Guidelines specify sales and marketing event requirements and prohibit practices that are monitored by Secret Shoppers. Dean Health Plan and CMS regularly conduct Secret Shopper/ Event Surveillance activities in order to:

- Monitor Plan compliance with applicable Laws, Regulations and Policies
- Understand marketing, beneficiary education and enrollment practices better

- Respond to emerging problems/issues rapidly
- Strengthen knowledge for program administration and oversight

All deficiencies identified during Secret Shopper activities will be reviewed by Dean Health Plan's Medicare Advantage Agent Oversight Committee. Deficiencies are substantiated by reviewing supporting statements and/or documentation provided by the secret shopper. When a deficiency is substantiated, Dean Health Plan will contact the Agent who conducted the event to request a detailed response. Agents must provide the detailed response within five (5) calendar days of receiving Dean Health Plan's request.

The Agent Oversight Committee will evaluate the deficiencies, supporting statements, and the Agent response to determine if corrective actions are needed. The Agent Oversight Committee reviews secret shopper trends, provides direction on confirmed non-compliance issues and ensures implementation of appropriate corrective actions.

Marketing in health care settings

CMS regulations prohibit sales activities in any health care settings where patients primarily receive, or are waiting to receive, health care services. Providing plan information to beneficiaries on a frequently-scheduled basis at provider offices are not considered walk-in appointments. These marketing activities are informal events and are subject to CMS event reporting requirements.

Agents may not conduct any Sales/Marketing activities in health care settings except in common areas. Common areas are locations only accessible to the public. Conducting sales presentations, distributing and accepting enrollment applications and soliciting beneficiaries is prohibited in areas where individuals primarily receive, or are waiting to receive, health care services. Rooms that serve dual purpose as a treatment or waiting area and a "common" area should be considered a prohibited area and not used for sales or marketing purposes. The prohibition against conducting marketing activities in health care settings extends to activities planned in health care settings outside of normal business hours.

Examples of acceptable and prohibited health care settings include:

Acceptable	Prohibited
Conference Rooms	Exam Rooms
Cafeterias	Treatment Areas
Recreation Rooms	Doctors' Private Offices
Community Rooms	Hospital Patient Rooms
Common Entryway	Pharmacy Counter Areas
Vestibule	Dialysis Center Treatment Areas
Waiting Rooms	

Scope of Appointment (SOA)

CMS' Medicare Communications and Marketing Guidelines require that a documented Scope of Appointment (SOA) be completed prior to any personal/individual marketing appointment. SOAs are required for all marketing appointments, regardless of whether or not the appointment results in an enrollment and regardless of venue (e.g. in-home, library, conference call or walk-ins to an Agent office).

Dean Health Plan requires a signed and completed SOA form with all Agent assisted enrollments (including agent-assisted online enrollments). Additionally, all SOA forms must be retained by the agent and available upon request for at least 10 years, regardless of the enrollment outcome.

Note: Telephonically recorded SOAs are not permitted by Dean Health Plan at this time. Unless obtained during the RATE telephonic enrollment through Ascend Mobile App (AMA)

SOAs must contain the following:

- Product type(s) that the beneficiary has agreed to discuss during the appointment. Must be signed by the beneficiary or his/her authorized representative
- Date of appointment
- Beneficiary contact information (e.g. name, address, telephone number)
- Signature (e.g. beneficiary or authorized representative)
- Method of contact (e.g. in home, walk-in, etc.)
- Agent information (e.g. name and contact information) and signature
- Statement that beneficiaries are not obligated to enroll in a plan; their current or future Medicare enrollment status will not be impacted, and the beneficiary is not automatically enrolled in the plan(s) discussed
- Explanation why the SOA was not completed prior to the appointment

An SOA is required at least 48 hours prior to the scheduled personal marketing, the MA plan (or agent or broker, as applicable) must agree upon and record the Scope of Appointment with the beneficiary(ies), except for: SOAs that are completed during the last four days of a valid election period for the beneficiary OR Unscheduled in person meetings (walk-ins) initiated by the beneficiary.

Plan lines of business that were not agreed to in advance by the beneficiary may not be discussed. Each beneficiary (or his/her appointed representative) must agree upon and document 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 the Agent must obtain a signed and completed SOA for each individual.

During an appointment, if a beneficiary would like to discuss additional plan products which the beneficiary did not agree to discuss in advance, the agent must document a second SOA prior to continuing the appointment.

An SOA is valid only for 12 months following signature.

Quarterly SOA audits are performed by Dean Health Plan to ensure adherence with CMS' Medicare Communications and Marketing Guidelines.

Agents and Agencies who successfully complete a quarterly audit with no deficiencies are removed from SOA audits for the remainder of the calendar year.

Personal/individual appointments

Agents conducting one-on-one appointments with beneficiaries, regardless of the venue (e.g., in home, telephonic, or library), must follow the scope of appointment guidance.

Agents may not:

- Discuss plan options that were NOT agreed to by the beneficiary.
- Market non-health care related products (such as annuities or life insurance).
- Ask a beneficiary for referrals.
- Solicit/accept an enrollment request (application) for a January 1 effective date prior to the start of the Annual Enrollment Period (AEP), unless the beneficiary is entitled to another enrollment period.
- Accept any funds from the potential enrollee for premiums or any other purposes.

Agents must:

Use the Dean Health Plan Medicare Advantage Agent/ Broker Enrollment Discussion Checklist Tool to make sure appropriate topics are covered. This document can be found in the Medicare Advantage Broker Kit or in the Resources Folder in AMA (Ascend Mobile App)

Example of items on the Agent/Broker Enrollment Discussion Checklist Tool include:

- Record all individual marketing/sales calls
- Discussion of required disclaimers: "We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or **1-800-MEDICARE** (TTY users should call **1-877-486-2048**) 24 hours a day/7 days a week to get information on all of your options.
- Provide a business card at the beginning of every appointment
- Announce their name, the company they represent and all plan types that will be discussed (as indicated on the SOA)
- Make sure the legal representative attends the appointment, if the beneficiary has a legal representative who assists with health care decisions (e.g. Power of Attorney, Conservator, or other state-appointed guardian)
- Ask about current health coverage
- Explain the benefits, copays, coinsurance, and Maximum Out-of-Pocket clearly
- Communicate clearly to the beneficiary what to expect when changing from his/her current coverage to a new plan
- Explain the limitations on coverage outside of the provider network thoroughly
- Explain prescription drug coverage clearly
- Ensure that the beneficiary receives a copy of the Pre-Enrollment Kit and all other necessary and required materials
- Remind the beneficiary that he/she will receive a welcome packet in the mail and an Outbound Enrollment Verification (OEV) letter that confirms their plan selection
- Encourage the beneficiary to contact you with any additional questions or concerns (at the end of the appointment)

Dean Health Plan's Agent Oversight team will investigate any reported instances of non-compliant or inappropriate conduct to determine if corrective actions are necessary.

Enrollment applications

Timely and accurate submission of enrollment applications is critical to ensuring that beneficiaries receive the benefits they expect and that Dean Health Plan is able to meet CMS requirements. Dean Health Plan requires Agents to submit enrollment applications to Dean Health Plan no later than one (1) calendar day after the Agent receives the enrollment application from the beneficiary. Failure to follow Dean Health Plan requirements for submitting applications may result in processing delays, which may impact beneficiaries' requested coverage date and/or commission payments.

Authorized Agents affiliated with a Dean Health Plan contracted Sales Entity may submit applications to their respective Sales Entities. In such cases, the Agent and Sales Entity are responsible for timely submission, ensuring Dean Health Plan receives the application no later than one (1) calendar day after receipt from the beneficiary. Note: Sharing beneficiary or application information with an individual or sales entity outside of a Dean Health Plan's contracting agreement is a violation of HIPAA privacy guidelines.

Electronic applications

To ensure all of this information is correctly managed, Agents are encouraged to use the Dean Health Plan Medicare Agent Sales Portal and submit applications electronically. This portal can be found: **https://dean.isf.io/2024/agent**

Paper applications

Paper Applications must be date stamped on the same day it was received and faxed (608-252-0801) or delivered in-person to Dean Health Plan (1277 Deming Way, Madison, WI 53717) within one (1) calendar day. Agents who do not comply with CMS and Dean Health Plan requirements for application delivery may be subject to termination.

Agents may assist beneficiaries with completing paper applications; however, only the beneficiary or his/her legal representative (as recognized by state law) may sign an enrollment request. Agents may also assist beneficiaries with entering information to submit online applications, but only through Dean Health Plan's website; beneficiaries are required to execute the signature portion of online enrollments.

Note: All corrections and amendments made on an application must be initialed and dated by the individual making the changes. This includes corrections made in the "Office Use Only" section.

Telephonic applications

Dean Health Plan only supports telephonic enrollments that are done through the RATE feature through Ascend Mobile App (AMA). Dean Health Plan doesn't allow other types of telephonic enrollments at this time. Agents must follow the approved CMS scripting provided by Dean Health Plan. If scripting is not followed, the agent will be placed on corrective action.

Best practices for enrollment applications

Use of the Ascend Mobile App (App) or the Agent Online Portal

- Confirmation of current contact information (address and phone number)
- Verification of basic eligibility—ask to see the beneficiary's red, white and blue Medicare card
- Verification that the beneficiary's permanent residence is within the county where the plan is offered
- Completion of the appropriate "Office Use Only" section with legible information
- Paper applications must include the agent's NPN number in the "Agent ID Number" field
- Inclusion of complete, legible information. Incorrect or illegible information may result in delays of commission payment and/or broker of record issues

Checking application status

You may check status of electronic applications by visiting the Agent Portal at **https://dean.isf.io/2024/agent**. You will be able to check enrollment and commissions for any applications that submitted through the Agent Portal or through the Ascend Mobile App (AMA).

Enrollment related oversight activities

The Agent Oversight Committee is responsible for reviewing and investigating:

- Agent-assisted AEP enrollment applications received prior to the start of AEP (October 15th)
- Enrollment applications submitted by unqualified and/or unlicensed uncertified Agents
- Late enrollment applications submitted by an Agent (i.e. an application submitted to Dean Health Plan more than one (1) calendar day after Agent receives from the beneficiary)

Enrollment will identify any Agent-assisted AEP enrollment applications received prior to the start of AEP (October 15th) and route those applications to the Agent Oversight Committee. Agents or Sales Entities that collect, offer to hold or submit AEP enrollment applications prior to the start of AEP will be subject to corrective action, as such activity is expressly prohibited by CMS.

If the results of the investigation confirm Agent or Sales Entity non-compliance, or patterns of failing to meet Dean Health Plan business requirements, then the Agent Oversight Committee will coordinate with Sales Management to determine appropriate corrective action.

Monitoring of applications submitted by unqualified Agents and untimely submission of applications is tracked by the Medicare Advantage Sales/Operations team. Results are provided to the Agent Oversight teams on a monthly basis.

Sales allegations

A "sales allegation" is a type of complaint which involves potential misconduct or misrepresentation by a Sales Agent. Sales Allegations are typically filed by a beneficiary (or an authorized representative) and may be received by Dean Health Plan as a complaint or grievance, as a complaint filed with CMS through the Complaint Tracking Module (CTM) or via other regulatory agencies.

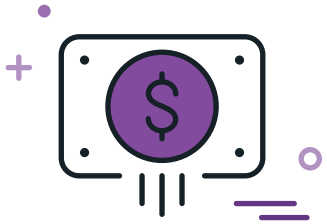
Sales allegations will be directed to Dean Health Plan's Agent Oversight Committee for full investigation. Sales Allegation details are tracked to ensure timely resolution and response.

Rapid disenrollment

A "rapid disenrollment" is defined as disenrollment from the plan during the first three (3) months of a beneficiary's enrollment. Rapid disenrollment also applies when a beneficiary moves from one Parent Organization to another Parent Organization or when a beneficiary moves from one plan to another plan within the same Parent Organization. Rapid disenrollments are subject to compensation recovery in accordance with CMS regulations and Dean Health Plan policies. Rapid disenrollment compensation recovery is not limited to when a beneficiary who enrolls effective October 1, November 1, or December 1 and subsequently uses the Annual Election Period to change plans for an effective date of January 1.

Dean Health Plan encourages all Agents to prevent rapid disenrollments by striving to enroll each beneficiary into a plan that best meets his or her particular needs and ensuring that all plan features, benefits, provider network restrictions, etc. are clearly explained.

Dean Health Plan's Agent Oversight Committee monitors rapid disenrollment rates for Agents and Sales Entities. Rapid disenrollment rates that exceed expected trends are flagged for investigation to determine why members have disenrolled. Agents with a book of business that exhibits a pattern of rapid disenrollment are subject to review. Additionally, Dean Health Plan follows CMS rules related to compensation recovery and will charge back any compensation paid to an Agent for an enrollment which results in a rapid disenrollment.



Compensation

In order to receive initial and renewal sales commissions, Agents must continue to be fully licensed and appointed, as required by CMS and state law and Certified to sell Medicare Advantage with Dean Health Plan. Additionally, both initial and renewal sales commissions are dependent on Agents completing annual Medicare training and certification, as well as all required Dean Health Plan product and compliance trainings. All Agent compensation is paid to the General Agency. This document outlines the general commission requirements and policies; however, commissions will be paid based on all CMS guidelines as outlined in the Medicare Communications and Marketing Guidelines. Dean Health Plan will investigate sales activity by unlicensed Agents and report instances to CMS or other state and federal regulatory agencies.

Dean Health Plan calculates and pays both initial and renewal compensation on a calendar year basis (i.e. January 1 – December 31), and pays commissions due in full before the end of the calendar year, based on the enrollment effective date. Initial Year compensation is defined as the period of January 1 – December 31 in the year of the effective date. Agent commissions may not be issued to Agents prior to the member's enrollment effective date as accepted by CMS.

Initial year commissions

Initial Year commissions are paid on an annual lump sum basis starting in the month of the enrollment effective date. In the event that a beneficiary disenrolls during the first three (3) months, and it qualifies as a "Rapid Disenrollment" as defined by CMS guidelines, Dean Health Plan will recover or "charge back" for the full commission amount paid. If a beneficiary disenrolls at any other time after the first three months during the initial year, Dean Health Plan will charge back a prorated amount equal to the total number of months a beneficiary is not enrolled during the Initial Year.

Initial Year compensation is paid in the following scenarios:

- A beneficiary's first year of enrollment in any plan (MA, PDP, MA-PD, Cost) where the MARx report has a prior plan type of "None";
- A beneficiary moves from an employer group plan to a non-employer group plan (either within the same Parent Organization or between Parent Organizations);
- A beneficiary changes plans during their initial enrollment year; or
- A beneficiary makes an "unlike plan change."

Renewal year commissions- new to Dean Health Plan

Members who are new to Dean Health Plan but made a like plan change, these renewal commissions are also paid on an annual lump sum basis starting in the month of the enrollment effective date and will follow the same rapid disenrollment and charge back rules as initial year commissions.

Renewal year commissions- not new to Dean Health Plan

Renewal Year commissions are paid on a monthly pro-rated basis starting in January of the year following the enrollment effective date. If a beneficiary disenrolls at any time during the Renewal period, Dean Health Plan will cease commissions payments for all following months and charge back for any months in which commissions were paid, but the member was not enrolled.

Renewal Year compensation is paid in the following scenarios:

- A beneficiary enrolls in the same plan following the initial year compensation;
- A beneficiary enrolls in a new "like plan" (MA to MA) within the same Parent Organization or between two different Parent Organizations; or
- A beneficiary enrolled in an MMP (Medicare-Medicaid Plans) switches to an MA plan or an MA-PD plan (and vice versa), if applicable per state MMP policy.

AOR (Agent of Record) change requests after enrollment initial commissions/ renewal year- new to DHP

The initial commission payment will remain with the current Agent of Record (AOR) until renewal. At renewal the new AOR will receive renewal commissions. Renewal Commissions (Not New to DHP): Renewal commissions will go into effect first of the month following the AOR change request to the new AOR.

Communication & marketing materials

Communications

Communication: means activities and use of materials created or administered by the plans or any downstream entity to provide information to current and prospective enrollees. All activities and materials aimed at prospective and current enrollees, including their caregivers, are "communications" within the scope of the regulations at 42 CFR Parts 417,422, and 423."

Marketing

Marketing: is a subset of communications and must, unless otherwise noted, adhere to all communication requirements. To be considered marketing, communications materials must meet both intent and content standards. In evaluating the intent of an activity or material, CMS will consider objective information including, but not limited to, the audience, timing, and other context of the activity or material, as well as other information communicated by the activity or material. The organization's stated intent will be reviewed but not solely relied upon.

Intent: Material or activities that CMS determines, as described above, are intended to:

- Draw a beneficiary's attention to a plan or plans,
- Influence a beneficiary's decision-making process when making a plan selection, or
- Influence a beneficiary's decision to stay enrolled in a plan (retention-based marketing).

Content: Materials or activities that include or address content regarding:

- The plan's benefits, benefits structure, premiums, or cost sharing,
- Measuring or ranking standards (for example, Star Ratings or plan comparisons), or
- Rewards and incentives as defined under 42 CFR § 422.134(a) (for MA and section 1876 cost plans only)"

All advertising, sales presentations, marketing and enrollment materials, including third party websites and social media, must be approved for use by Dean Health Plan and CMS prior to use by Agents.

Agents who seek approval of custom materials and/or websites should follow the following policies:

Agent/Agency Generated Materials

All Agent marketing materials that include the Dean Health Plan name, logo or specific plan information, including websites, multiple plan marketing materials and translated materials must be submitted to Dean Health Plan for approval prior to use by the Agent and/or sales entity. Translations of Marketing Materials must first have their material filed in English and CMS accepted. All marketing materials that support multiple plan sponsors must maintain documentation of approval by the plan sponsor that reviewed, submitted and received approval from CMS. CMS' Medicare Communications and Marketing Guidelines should always be followed when developing marketing or enrollment materials and are available for download on CMS's website:
https://www.cms.gov/files/document/medicare-communications-and-marketing-guidelines-3-16-2022.pdf

Marketing Material Submission

The Agent or sales entity submits marketing Material to Dean Health Plan via e-mail.

The following information must be completed:

- Description of Marketing Material
- Type of Marketing Material (new or revision)
- Medium that Marketing Material will be used (i.e., newspaper ad, flyer, poster, direct mail, website)
- Geographic areas where Marketing Material will be distributed (to determine Plan Benefit Package numbers)
- Proposed distribution date
- Target Audience

Communication & marketing materials (continued)

Agents should allow 10-14 days for Dean Health Plan's Compliance Dept to review Marketing Materials. If approved by our Compliance Dept the Marketing Material will be submitted to CMS for review. Depending on the type of Marketing Material, the CMS review timeframe could be from 10-45 days.

If you are unsure whether your marketing piece is considered "Communication" or "Marketing", please send the marketing piece to **DHP.MAPDSales@DeanCare.com** and we can determine whether the marketing piece needs to be filed with CMS.

Third-Party Websites

Third-party websites that market Dean Health Plan's products are expected to meet applicable CMS marketing requirements and must be submitted to Dean Health Plan for approval and submission to CMS. Agent and/or Sales Entity websites must be maintained with the most current Dean Health Plan- and CMS-approved materials and information.

Non-compliance can include, but is not limited to, the following:

- Inappropriate requests for health status information, such as pre-existing conditions, weight and tobacco use. Federal regulations prohibit discrimination on the basis of medical conditions or medical history and prohibit discriminatory marketing practices to Medicare beneficiaries.
- Misleading information, such as identifying a Medicare Supplement plan as a Medicare Advantage plan. (Links to separate Medicare Supplement pages are allowed.)
- Unauthorized use of prohibited terminology, including unsubstantiated absolute superlatives, such as "Dean Health Plan is the best plan we sell." Stating that a plan is "one of the best" is allowed because it is not an absolute superlative. Incorrect disclaimers or absence of required disclaimers per section 50 of the Medicare Communications and Marketing Guidance.
- Unsubstantiated claims that the Agent, Sales entity or plan are recommended or endorsed by CMS, Medicare or the Department of Health & Human Services (DHHS).
- Unsubstantiated claims that the third party will not disenroll individuals due to failure to pay premiums.
- Use of the term "free" to describe a zero dollar premium.
- Use of the term "free" in conjunction with any reduction in premiums, deductibles or cost share, including Part B premium buy-down, low-income subsidy or dual eligibility.

Agents or any downstream/delegated entity must prominently display one of four statements on the envelope or the mailing itself (if no envelope is being sent) regardless of the material inside of the envelope. All mailings should include one of these two statements.

- Plan information other than a mailing with the Annual Notice of Change: "Important plan information"
- Health and wellness information: "Health and wellness or prevention information"

Agent oversight activities

Auditing

Dean Health Plan may periodically request copies of Agent marketing materials that have been used to ensure only CMS-approved materials are being used and that the CMS-approved content was not modified by the Agent. Additionally, a random audit of Agent and Sales Entity websites may be conducted to ensure the most current Dean Health Plan materials are used.

Corrective Actions

Corrective action plans are developed to address Agent-specific non-compliance issues and are tracked to completion. The Agent Oversight Committee determines the appropriate corrective actions to be taken, which may include:

- Counseling
- Retraining
- Warnings
- Termination of Certification for marketing and selling Dean Health Plan Medicare Advantage products including reporting to CMS or other state and federal regulatory agencies

Agents are selected randomly for an initial audit by Dean Health Plan. If deficiencies are found from monthly audits in the contract year, the Agent remains in the monthly audit for the remainder of the contract year and the following actions occur:

- 1st Offense: A Deficiency Notice with details of the audit findings is provided to the Committee or delegate(s) who determine appropriate action(s) to take to prevent recurrence.
- 2nd Offense: A Corrective Action Plan is requested and sent to the Agent's Agency. The Medicare Advantage Sales Manager or delegate(s) shares offenses and coaching plan with the Agent and Agency. The Corrective Action Plan will include an explanation on how the Agency plans to counsel the Agent and any future offenses that will result in additional corrective actions up to and including termination of Medicare Advantage Certification. The duration of the Corrective Action Plan is 45 days from the date DHP receives the plan from the Agent or Agency. Any offenses occurring during the duration of the Corrective Action Plan will not be counted adversely towards the Agent or Agency total offenses.
- 3rd Offense: Agent is required to retake Certification Training
- 4th Offense: Upon decision of the Agent Oversight Committee it could result in the termination of Medicare Advantage Certification.

Agent becomes in good standing after one calendar year of their last offense.

Medicare election periods

#	Population	Qualifications	Reference	Time Frame	Effective Date
New to Medicare					
1	Newly Eligible (IEP/ICEP)	Has both Medicare Parts A and B for the first time. Either you are turning 65 or you are in month 24 of receiving Social Security or Rail Road Retirement Disability Benefits.	Copy of Medicare Card Medicare Entitlement Letter SSA Award Letter	Seven Month Election Frame Begins three months before month of entitlement. Includes birthday or month 24 of disability. Ends last day of the third month after the A/B start date.	Enrollment request made prior to month of eligibility, effective date is first day of the month of eligibility. Enrollment request made during or after first month of eligibility, effective date is first day of the month following the month of election. Generally, a beneficiary with a birth date of the first of the month will have an effective date that will be the first day of the previous month.
2	Enrolling into Part B after delayed enrollment	Entitled to Medicare Part A. Newly enrolled to Part B.	Copy of Medicare Card Medicare Entitlement Letter SSA Award Letter	Begins three months before Part B effective date. Ends last day of the month prior to effective date of Part B.	Equivalent to Part B effective date. Example: Part A has an effective date of 06-01-2020 Part B has an effective date of 08-01-2022. The plan effective date would be 08-01-2022.
3	Beneficiaries turning 65	Have Part A and B due to disability and are turning 65.	Individual's 65th Birthday	Begins month before month of birthday Includes birthday month. Ends last day of the third month after the A/B start date.	Enrollment request made prior to month of birthday, effective date is first day of the month of birthday. Enrollment request made during or after birth month, effective date is first day of the month following the month of election.
4	Enrolled into Part B during the Part B General Enrollment	Entitled to Medicare Part A. Enrolling into Part B for the first time during General Enrollment Period.	Copy of Medicare Card Medicare Entitlement Letter SSA Award Letter	General Enrollment Period Begins April 1 Ends June 30	July 1

SEP for Individuals Enrolled in a Plan Placed in Receivership

A SEP exists for individuals enrolled in a plan offered by an MA organization that has been placed into receivership by a state or territorial regulatory authority. The SEP begins the month the receivership is effective and continues until it is no longer in effect or until the enrollee makes an election, whichever occurs first. When instructed by CMS, the MA plan that has been placed under receivership must notify its enrollees, in the form and manner directed by CMS,of the enrollees' eligibility for this SEP and how to use the SEP.

SEP for Individuals Enrolled in a Plan That Has Been Identified by CMS as a Consistent Poor Performer

A SEP exists for individuals enrolled in a plan that has been identified with the low performing icon in accordance with 42 CFR 422.166(h)(1)(ii). This SEP exists while the individual is enrolled in the low performing MA plan

A plan that is Auto facilitated.

The SEP permits a onetime election within three months of the effective date of the assignment, or notification of the assignment, whichever is later. It allows the individual to make an election before the enrollment is effective in the receiving plan or after the coverage in the receiving plan starts. This SEP must be used within three months of the start of coverage in the receiving plan. In the case where the notice is sent after the coverage in the receiving plan starts, the SEP ends three months after the date of the notice."

This SEP can be used to enroll or disenrollment from a Medicare Advantage plan.

SEP for Other Exceptional Circumstances

CMS will establish a SEP, on a case by case basis, for individuals whom CMS determines have experienced exceptional circumstances related to enrollments into or disenrollments from an MA plan that are not otherwise captured in regulation. Consistent with current practice, CMS will consider granting an enrollment or disenrollment opportunity in situations such as the following:

- Circumstances beyond the beneficiary's control that prevented him or her from submitting a timely request to enroll or disenroll from a plan during a valid election period. This is inclusive of, but not limited to, a serious medical emergency of the beneficiary or his or her authorized representative during an entire election period, a change in hospice status, or mailed enrollment or disenrollment requests returned as undeliverable on or after the last day of an enrollment period.

- Situations in which a beneficiary provides a verbal or written allegation that his or her enrollment in a MA or Part D plan was based upon misleading or incorrect information provided by a plan representative or State Health Insurance Assistance Program (SHIP) counselor, including situations where a beneficiary states that he or she was enrolled into a plan without his or her knowledge or consent, and requests cancellation of the enrollment or disenrollment from the plan.

- A SEP may be warranted to ensure beneficiary access to services and where without the approval of an enrollment exception, there could be adverse health consequences for the beneficiary. This is inclusive of, but not limited to, maintaining continuity of care for a chronic condition and preventing an interruption in treatment.

Medicare election periods (continued)

#	Population	Qualifications	Reference	Time Frame	Effective Date
Annual Election Period (AEP)					
5	All Beneficiaries	Annual Election Period (AEP)		**Begins** October 15 **Ends** December 7	January 1
6	All Beneficiaries	Open Enrollment Period (OEP)		**Begins** January 1; **Ends** March 31 Also available during the initial election period (IEP) for new beneficiaries.	First day of the month following the enrollment request Starts the month Part A and B are effective. Last day is the third day of the month of entitlement.
Beneficiaries Who Move					
7	Change in Primary Residence	Permanently moved inside plan's service area with new plan options available. Permanently moved outside plan's service area.	Beneficiary's Attestation	**Before Move Begins** the month before month of permanent move. **Ends** two months after the move. **After the Move Begins** month beneficiary notified plan of the move. **Ends** two months after notification of the move.	First day of the month following the notification of the move, but not earlier then the move.
8	Change in Residence	Returning to the U.S. after permanently living outside the U.S.	Beneficiary's Attestation	**Before Move Begins** the month before month of permanent move. **Ends** two months after the move. **After Move Begins** month beneficiary notified plan of the move. **Ends** two months after notification of the move.	First day of the month following the notification of the move, but not earlier then the move.

#	Population	Qualifications	Reference	Time Frame	Effective Date
Institutionalized Beneficiaries					
9	Institutionalized Beneficiaries	Resides in skilled nursing facility, intermediate care facility, psychiatric, rehab, long-term care, or swing-bed hospital.	Beneficiary's Attestation Members address located in the facility	**Begins** first day Institutionalized. **Ends** two months after discharge. This election is continuous for those that reside in these facilities.	First of the month following receipt of the enrollment request.
Low Income Beneficiaries					
10	LIS (Non-Medicaid)	Have Part D subsidy.	Beneficiary's Attestation SSA	Once per quarter as long as beneficiary has a subsidy.	First of the month following receipt of the enrollment request.
11	LIS (Loss of Status)	Have lost the Part D subsidy.	Beneficiary's Attestation SSA	**Begins** month of lost eligibility. **Ends** two months after loss of eligibility.	First of the month following receipt of the enrollment request.
12	Dual Eligible	Have Medicaid.	Medicaid validated using the ForwardHealth Portal	Once per quarter as long as they have Medicaid.	First of the month following receipt of the enrollment request.
13	Dual Eligible (Loss of Status) *Consider Member Most Likely Has LIS	Have lost Medicaid benefits.	Medicaid validated using the Forward Health Portal	**Begins** month of lost eligibility. **Ends** two months after loss of eligibility.	First of the month following receipt of the enrollment request.
14	Loss of Employer Group Coverage	Voluntary or involuntary termination of group coverage.	Beneficiaries' Attestation	**Begins** month group allows or disenrollment or date COBRA ends. **Ends** two months after group coverage ends.	Can choose an effective date up to three months in advance after receipt of election but not earlier than the first of the month following month in which the request is made.
15	Involuntary Loss of Creditable Prescription Drug Coverage	Involuntary loss of coverage. Coverage is no longer creditable. This does not include loss of coverage due to nonpayment of premium. *Enrollment into MAPD.	Beneficiaries' Attestation Letter stating loss of creditable coverage	**Begins** either month of notice or month the loss or reduction of coverage occurs, whichever is later. **Ends** two months later.	First of the month following receipt of the enrollment request.

Medicare election periods (continued)

#	Population	Qualifications	Reference	Time Frame	Effective Date
Termination of Plan Contract					
16	Termination of plan contract with Medicare with mutual consent	Contract with Medicare is ending with mutual consent.	Beneficiaries' Attestation Termination Letter	**Begins** two months before termination. **Ends** one month after effective termination.	First day of the month after notice received or up to two months after the effective date of termination but not earlier than receipt of election.
17	Termination of plan contract with Medicare without mutual consent	Contract with Medicare is ending without mutual consent.	Member Attestation Termination Letter	**Begins** one month before termination. **Ends** two month after effective termination.	First day of the month after notice received up to three months after month of termination but not earlier than receipt of election.
State Pharmaceutical Assistance Programs					
18	Some beneficiaries belonging to a State Pharmaceutical Assistance Program (SPAP) like Wisconsin Senior Care	Wisconsin Senior Care at any level. Senior Care ending. (Loss of Senior Care due to failure to pay premium is not considered involuntary.)	Wisconsin Senior Care award letter State of Wisconsin ForwardHealth Portal Member Attestation	**Begins** Immediately. **Ends** date of disenrollment. This election can only be used once per year.	First of the month following receipt of the enrollment request. This SEP is only to enroll into an MAPD or to switch from MA to MAPD.
5-Star Plan					
19	Enroll into 5- Star Plan	Beneficiary may enroll into a plan with a 5-Star Rating during the year the plan has an overall 5-Star.	Plan Performance Star Rating	Continuous when the plan holds the 5-Star Rating.	First of the month following receipt of the enrollment request.

#	Population	Qualifications	Reference	Time Frame	Effective Date
Disenrollment Elections					
20	Gain or maintain other creditable coverage	Gain or enroll in coverage such as Tri-Care, Wisconsin Senior Care or Veterans Affairs (VA).	Validation of Wisconsin Senior Care Letter indicating gain of creditable coverage	**Begins** immediately. **Ends** date elect disenrollment.	First of the month following receipt of the **written disenrollment request**. This is election is for disenrollment from a MAPD plan It can also be used to change from MAPD to MA.
21	Trial Period	Individuals who are within their first 12 months of trying a Medicare Advantage Plan and wish to go back to go to a supplement with a guaranteed issue.	Plan must receive written request to disenroll to go back to Original Medicare or Supplement sighting they are in their first 12 months of an MA plan. *With MSA members who were previously enrolled in a supplement and who are enrolling for the first time into a Medicare Advantage plan and have a valid SEP to disenroll during their first 12 months of being on the MSA. They may go back to original Medicare and have a guaranteed issue of a Medicare Supplement. *With members of an MSA who have used their Initial Election Period (IEP) to enroll in the plan and do not have a valid disenrollment period. They may not use the SEP trial to disenroll from the plan.	**Begins** first time they are enrolled in MA. **Ends** 12 months after effective date.	First of the month following receipt of the **written disenrollment request**. This is election is for disenrollment from a MAPD plan It can also be used to change from MAPD to MA.

Medicare election periods (continued)

#	Population	Qualifications	Reference	Time Frame	Effective Date
Disenrollment Elections					
22	Beneficiaries turning 65	Have Parts A and B due to disability and are turning 65.	Individual's 65th Birthday	**Begins** three months before month of birthday. Includes birthday month. **Ends** last day of the third month after the 65th birthday.	**Written disenrollment request** made prior to month of birthday, termination date is first day of the month of birthday. **Written** disenrollment request made during or after birth month, termination date is first day of the month following the month of written notice.
Cancelling Applications					
23	First time MSA enrollees (during AEP)	First time MSA application.	Return to original Medicare	After December 7 and up to December 15.	Verbal or written request.
24	New applications to Network Health	Prior to plan effective date.	Return to prior plan or original Medicare	Prior to application date.	Verbal or written request.

Dean Advantage (HMO-POS and HMO) Pre-Enrollment Checklist

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 toll-free at **1 (877) 234-0126 (TTY: 711).**

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 **Deancare.com/MedicareAdvantageMembers** or call toll-free at **1 (877) 234-0126 (TTY: 711)** to view a copy of the 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. (Applies to plans with Part D coverage).

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on Jan. 1, 2025.
- ☐ 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).
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher co-pay for services received by non-contracted providers. When selecting an HMO product, remember that 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).
- ☐ 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

DeanHealthPlan by Medica

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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Sales presentation checklist

The items on this checklist are reminders of points Agents want to be sure to cover during Dean Health Plan Medicare Advantage sales presentations. Use ONLY Marketing Materials, Sales Presentations, and Documents that have been approved by Dean Health Plan and the Centers for Medicare & Medicaid Services (CMS). Agents are responsible for presenting the information to the consumer in an understandable format. This is a tool for the Agents reference only and is not approved for public distribution or for a use as a presentation script.

Housekeeping

- Ensure all sales events are reported to Dean Health Plan by the 10th of the month prior to the event date
- Ensure all sales event venues are ADA accessible
- Arrive at least 15 minutes to the event's start time and remain at least 15 minutes after the start time (in the event of no-shows)) to allow for late comers
- Use only currently marketing materials that contain CMS material

Introduction

- Presenter name, company represented, and contact information (Business Card)
- Presenter is a state licensed insurance agent and may receive compensation as a result of enrollment
- Presenter does not represent any branch of the federal or state government
- Identify the plan(s) and type of product(s) to be presented (include all plans filed with event in HPMS)
- Permission-to-Call cards may be offered, but it must be clearly stated that completion is options. Sign-in sheet are prohibited at Dean Health Plan specific events
- Introduce Pre-Enrollment Packet- Explain where the Benefit Overview, Plan Guide, Summary of Benefits, Enrollment Form, Multi-Language Insert, and Plan Star Ratings can be found

Medicare Overview

- Review the four Parts of Medicare (A, B, C, & D)
- Provide an overview of Medicare Advantage
- Explain how a Medicare Advantage plan differs from Original Medicare and Medicare Supplements

Eligibility Requirements

- MA/MAPD Plans- Medicare A & B
- Beneficiary must continue to pay Medicare Part B
- Permanent residency in service area (at least 6 months per year)

Enrollment Periods

- Provide overview of election periods and timeframes beneficiaries may enroll in or disenroll from Medicare Advantage plans (Examples: IEP (Initial Enrollment Period), AEP (Annual Enrollment Period, OEP (Medicare Advantage Open Enrollment Period), and SEP (Special Enrollment Period)
- Member may not change MA plans after December 7th unless they qualify for an SEP

Example of items on the Agent Appointment Checklist include:

- If you do not sell for all MA organizations in the service area use the below 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, 1–800–MEDICARE, or your local State Health Insurance Program to get information on all of your options."
- If you sell all MA organizations in the service area use the below the disclaimer: "Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1–800–MEDICARE, or your local State Health Insurance Program for help with plan choices."
- Provide a business card at the beginning of every appointment
- Announce their name, the company they represent and all plan types that will be discussed (as indicated on the SOA)
- Make sure the legal representative attends the appointment, if the beneficiary has a legal representative who assists with health care decisions (e.g. Power of Attorney, Conservator, or other state-appointed guardian)
- Ask about current health coverage
- Explain the benefits, copays, coinsurance, and Maximum Out-of-Pocket clearly
- Communicate clearly to the beneficiary what to expect when changing from his/her current coverage to a new plan
- Explain the limitations on coverage outside of the provider network thoroughly
- Explain prescription drug coverage clearly
- Ensure that the beneficiary receives a copy of the Pre-Enrollment Kit and all other necessary and required materials
- Remind the beneficiary that he/she will receive a welcome packet in the mail and an Outbound Enrollment Verification (OEV) letter that confirms their plan selection
- Encourage the beneficiary to contact you with any additional questions or concerns (at the end of the appointment)

Dean Health Plan's Agent Oversight team will investigate any reported instances of non-compliant or inappropriate conduct to determine if corrective actions are necessary.

Dean Health Plan Types

- **HMO:**
  - Coverage only in-network- except emergency, urgent or authorized
  - Non-authorized/referred, non-emergency and/or out-of-network, member pays full costs. The Plan will not pay
  - In-network Primary Care Physician (PCP) Required
- **POS:** Explain that out-of-network care may result in higher health care costs. Some non-network providers may choose not to treat or not to bill Dean Health Plan. In that case the member would be responsible for the entire cost.
- Explain Provider Directories and Dean Health Plan's online provider search tool

Sales presentation checklist

Health Plan Costs

- Clearly state the plan's premium of if there is no monthly premium
- Review deductibles, copayments, coinsurances, and MOOP's for all plans presented

Benefits/ Product Overview

- Provide and review contents of pre-enrollment kit
- Present and explain Summary of Benefits
- Explain covered services/cost sharing
- Explain the plan's provider network, how to select a provider, and when members must use network providers
- Explain the Dean Advantage Medicare Advantage Dental & Vision, and other Supplemental Benefits and costs
- Discuss Plan Star Ratings

Prescription Drug Coverage (If covered under plan)

- Review copays and coinsurance
- Explain prescription drug coverage stages
- Explain Tiers (preferred and non-preferred generics (Prior Authorizations, Quantity Limits, Transition Fill, Step Therapy, Exception Requests)
- Explain online formulary
- Explain network pharmacies and mail order
- Explain Extra Help Program (Low Income Subsidy)
- Explain Late Enrollment Penalty

Enrollment Process

- Explain enrollment options and timeframes
- Short Enrollment Form may be used for current members switching to a different Dean Advantage Medicare Advantage Plan
- Long Enrollment Form for all other enrollments
- Verify the PCP selection prior to entering it in the Provider Information section of the enrollment form
- Explain cancellation and disenrollment process
- Use of the Dean Advantage Medicare Advantage ID card instead of their Medicare Red, White and Blue card
- Explain when members can expect to receive confirmation letter, welcome kit, and ID card

Prohibited Actions

- Providing cash or cash equivalents to beneficiaries
- Providing gifts with a fair market value greater than $15 per person
- Offering food and/or beverages that could be considered a meal
- Require beneficiaries to fill out Permission-to-Call cards or sign-in sheets
- Discussing plans not included on event registration in HPMS
- Use of the word "Free" to describe zero dollar premium plans
- Using non-approved marketing materials that do not contain a valid and current CMS approval ID #

- Convey the false impression that you, the business, or product is approved or endorsed by Medicare or any other government agency
- Use of unsupported superlatives (absolute or qualified), statements, or statistics about the Plan or making inaccurate or misleading statements regarding the product and/or benefits
- Conduct sales activities in healthcare setting except in common areas
- Conducting sales presentations or marketing activities during the Open Enrollment Period (OEP)- unless beneficiaries qualify for another election period
- Intimidation or pressure to enroll
- Directly comparing competitor's plans or disparaging remarks about competitors

Additional Tips for a Compliant Event

- Arrive at least 30 mins prior to the event's start time and remain at least 15 minutes after the start time (in the event of no-shows) to allow for late comers
- Remember you are the face of Dean Health Plan

Agent/broker enrollment discussion checklist tool

Purpose:

To ensure that, prior to an enrollment, CMS' required questions and topics regarding beneficiary needs in a health plan choice are fully discussedReview deductibles, copayments, coinsurances, and MOOP's for all plans presented.

Questions to Ask/Topics to Cover	
Beneficiary Specific Information	
	Discussed (Y/N/NA)
What kind of health plan does the beneficiary wish to enroll in (such as low premium and higher copay or vice versa?	
Check to see if beneficiary's PCP and Specialists are in network. If not, explain that they will need to choose new ones or pay out of pocket.	
Check to see if the beneficiary's prescriptions are on the formulary and their pharmacy is in network. If not, explain that they will need to choose a new pharmacy or may have to pay the full price of the prescription.	
Does the beneficiary require hearing, dental, and/or vision coverage?	
Does the beneficiary have any other health care needs, such as needing durable medical equipment, physical therapy?	
Check to see if the beneficiary's preferred hospital is in-network. If it is not, explain they will need to pick a new one.	
Are there other preferred facilities that need to be in-network?	
Does the beneficiary have any other specific health care needs?	
The right to cancel this enrollment as well as the specific date through which cancellation may occur.	
Premiums, Cost-Sharing, Limitations	
Go over premiums, including Part B premium, {insert dollar amount} per month/quarter/year. [This one only applies if there is a premium >$0.]	
If applicable, review current premium vs. another plan premium.	
Review beneficiary cost-sharing such as deductibles, copays, and coinsurances. Go over deductible cost, PCP copay, Specialist copay, inpatient hospital copay, and any other copays for services/items beneficiary needs.	
Discuss the costs/limitations on dental, vision, and hearing.	

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Questions to Ask/Topics to Cover	
Networks, Coverage	
	Discussed (Y/N/NA)
Review coverage for out-of-network providers and services (e.g., except in emergency or urgent situations, plan does not cover services by out-of network providers (i.e., doctors who are not listed in the provider directory)).	
Review coverage outside the United States.	
Impact on Current Coverage, Plan Specifics, Plan Resources	
Explain the potential effect that enrolling in this plan will have on other current coverage, which may in some cases mean the individual is disenrolled from the beneficiary's current health coverage (e.g. another MA plan, Medigap).	
Explain that this is not a hearing/dental/vision "rider" but a full plan.	
Explain that plan operates on a calendar year basis, so benefits may change on January 1 of the following year.	
Explain that Evidence of Coverage provides all of the costs, benefits, and rules for the plan.	
Review how to file a complaint.	
Items Applicable to Certain Plan Types	
Review POS, PPO or PFFS out-of-network coverage.	
Review need to qualify for chronic/disabling condition requirement for C-SNPs.	
Review need to have Medicaid to qualify for D-SNP.	
Review need to remain in institutional skilled nursing facility in order to qualify for I-SNP.	
Review need to maintain trust/custodial account in order to remain enrolled in MSA.	

Questions? Connect with us

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