[Molina Healthcare]

2025 Medicare Telephonic and Enrollment Call Guide – Inbound & Outbound

INTENT/PURPOSE:

This document was created to ensure [Molina Healthcare, Inc.] telephone representatives cover all required information Medicare beneficiaries need. As a representative of [Molina] your role is to help each beneficiary find the most suitable health plan for them and, for those who are ready for it, assist them in completing enrollment over the phone.

Everything in RED TYPE is model language and must be spoken exactly as written.

REMINDER:

You're speaking to someone who may be confused or even afraid. This is your chance to provide a positive experience and the best solution to protect their health. Please speak slowly with the same patience and kindness you'd want someone to give your own loved ones.

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SECTION 1:

NOTICE: SHARING ELIGIBILITY INFORMATION PRIOR TO VERIFYING PHI IS A HIPAA VIOLATION

Representatives are prohibited from disclosing Medicaid and/or Medicare information without proper HIPAA verification whether during Inbound or Outbound calls.
Please ensure the confidentiality of any sensitive information shared during interactions.

Verify three (3) of the following (8) parameters prior to releasing any PHI.

- **Full Name**
- **Date of Birth**

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- **Phone Number**
  - It is acceptable to ask beneficiary:
    - *"Is this number listed the best contact number for you?"*
    - *"Is there a better number where you can be reached?*
- **Full Address**
- **Medicaid Number**
- **Medicare Number**
- **Molina Member Number**
- **SSN**

Greeting

Inbound

Rep:

- Thank the person for calling in and let them know you appreciate talking to them
- My name is [NBA Name] and I am a [licensed][non-licensed] benefit advisor with [Molina Healthcare][Passport Whole Health][Senior Whole Health [of NY]] [MyChoice Wisconsin]
- Confirm the call-back number in the event you are disconnected

Outbound

NOTE: If applicable, ensure that the 48-hour rule meets SOA requirements.

- Thank the person for taking the call and let them know you appreciate them taking time to take our call.
- My name is [NBA Name] and I am a [licensed][non-licensed] benefit advisor with [Molina healthcare][Passport Whole Health][Senior Whole Health [of NY]] [MyChoice Wisconsin]

Voicemail Scripts

NOTE: Use as needed based on topic of the voicemail; add any additional relevant information, especially if you already have had conversation with the beneficiary.

Rep: Leave a message:

- Greet the person by their first and last name
- Tell them your first and last name and that you're a representative of [Molina Healthcare][Passport Whole Health][Senior Whole Health [of NY]] [MyChoice Wisconsin]
- Ask them to call you [(XXX) XXX-XXXX], TTY: [711] anytime [Monday through Friday] between [8] a.m. to [5] p.m.

Medicare Disclaimer

NOTE: Words in red are REQUIRED

Let them know, before you go any further, you need to say:

Rep: This call is recorded for quality assurance purposes. You are not required to provide any health-related information unless it will be used to determine eligibility for enrollment into a Health Plan. May I continue?

[If YES, continue below.]

[If NO, they do not consent to being recorded, skip to In-Home Appointment Offering (Pg 9).]
Benefits, premiums and/or copayments / co-insurance may change <2025 or Next Year>. To continue to qualify for Medicare Advantage, you must continue to pay your Medicare Part B premium in addition to any other premiums or penalties associated with your coverage. Plans with a Part B buy down reduce your Part B premium costs.
Medicare Part B premium is covered by Medicaid.

- Tell them you'd like the opportunity to help them understand how Medicare works.
- Explain that they may qualify for extra benefits with our Medicare Advantage Plans and additional allowances for vision, dental, transportation and hearing.

Determine Beneficiary
[Intentionally left blank]

Scope of Appointment (SOA) Scripting
(REQUIRED if currently no scope is on file; If scope on file, proceed to Section 2: Eligibility)
Rep: [Molina Healthcare] [Passport by Molina Healthcare] [Senior Whole Health][Senior Whole Health of New York] [MyChoice Wisconsin] offers Medicare Advantage plans. There is no obligation to enroll in our plans, and this phone call will not affect your current or future enrollment, or automatically enroll you in a Medicare plan. Today, <state the date>, we will discuss details of the plan you select for coverage.

SECTION 2: ELIGIBILITY

Determine Service Area
[Intentionally left blank]

Determine Medicare Status
[Intentionally left blank]

Determine Medicaid Status
We will check your Medicaid eligibility to see if you qualify for a dual eligible special needs plan. Your ability to enroll will be based on verification that you are entitled to both Medicare and Medicaid.

Determine Enrollment Period
[Intentionally left blank]

SECTION 3: PLAN PRESENTATION

Needs Assessment
[Intentionally left blank]

Benefits Coverage and Comparison

[Intentionally left blank]

Verify Provider Network

We will check our provider directory to make sure the doctors you see are in the network. We do not cover services by out-of-network providers. However, you do not need to use a network provider in emergency or urgent situations. Review the network and choose doctors. If beneficiaries' doctor isn't in network, then discuss need to choose a different doctor and select.

Continuity Of Care (COC) Disclaimer (If applicable)

Molina Medicare has a continuity of care policy that allows you continued access to non-contracted practitioners. If you are a new member, you may continue treatment for up to 90 days in the following situations:

1. You are in active course of treatment with non-contracted doctor/s at the time of enrollment
2. You have current durable medical equipment and need continued access to durable medical equipment and repairs from non-contracted providers.
3. If your doctor agrees to, Continuity of Care (COC).

REP: Molina Medicare will attempt to work with your non-contracted doctor to bring them into the Molina Medicare network within the 90-day Continuity of Care time period. If your doctor does not agree to the Continuity of Care terms, or agree to become part of the Molina Medicare network, you will be transitioned to a different Molina contracted Doctor.

Do you agree to move forward with enrollment knowing access to this doctor is not guaranteed?

If prospect agrees to move forward:

REP: You will receive your Member ID CARD with a different primary doctor listed. On the first of the month you are effective you will contact Member Services and request continuity of care for this/these doctor(s).

Next Steps

1. Assign a contracted PCP in DRX
2. Set up follow up to assist member with Continuity of Care request via Member Services

STATE & PLAN	COC PERIOD
ALL MAPD & DSNPs	90 Days

Verify Medications

[Intentionally left blank]

Verify Pharmacy Network

We will check to make sure the pharmacy you use for any prescription medicine is in the network.

- Review the pharmacy directory. If the pharmacy is not listed, beneficiary will likely have to select a new pharmacy for your prescriptions.

SECTION 4: ENROLLMENT PROCESSES

Telephonic Enrollment

Double Enrollment: ***If you are signing up a couple, you can obtain consent from one giving the other permission to go through the telephonic enrollment process on their behalf. 'Consent to Enroll' is different than 'consent to speak' on their behalf. Be sure to obtain consent to enroll.***

Confirm Intent to Enroll

Rep: You are interested in enrolling in [Plan Name] Medicare Advantage plan over the phone today, is this correct?
[IF DSNP PLAN: Dual Special Needs plans (sometimes called "HMO D-SNP") are for those who qualify for Medicare and Medicaid. By enrolling in this plan, you understand that you must remain enrolled in your state Medicaid program to remain eligible for this plan.]

Authorization

Rep: Am I speaking to the person who wants to enroll?
[If YES, skip down to the ***"Confirmation of Presentation"****]*
[If NO, refer to this flow chart]:

<table>
<tr><td colspan="3">Ask if they are authorized under state law to complete the enrollment application for the beneficiary…</td></tr>
<tr><td>If YES: Ask if they can send documentation of their authority to [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] [MyChoice Wisconsin].

See YES or NO below.</td><td colspan="2">If NO, See NO bellow</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>If YES, they can send documentation, tell them you must verify 1. Their first and last name and phone number and 2. Their relationship to [Beneficiary's Name].</td><td colspan="2">If NO, they can't send documentation, explain that you must get verbal authorization from the beneficiary to continue. Ask if the beneficiary is present.</td></tr>
<tr><td></td><td>If YES, the beneficiary is present, ask to speak to them. Follow the script below…</td><td>If NO, the beneficiary is not present, enrollment cannot be completed. End call.</td></tr>
</table>

Rep, to beneficiary: Hello [Beneficiary Name], my name is [Rep Name] with [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] [MyChoice Wisconsin]. [Authorized Individual's Name] is attempting to enroll you into our [Plan Name]. Do you understand this and does [Authorized Individual's Name] have your permission to release personal information on your behalf?

[Beneficiary must clearly state Yes in order to continue. Now you can proceed call with Authorized representative]

Confirmation of Presentation

Rep: Can you please confirm that I explained the health plan benefits, and checked our formulary to verify your prescription drugs are covered?
Rep: Can you please confirm that I verified that your primary care physician and specialists are participating in [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] [MyChoice Wisconsin]'s network?

- Are you an existing patient?
- PCP/Health Center
- NPI
- Medical Group/IPA
- PCP Address

Verify Demographics

[NOTE: If HIPAA verification was successful, representative can read this information back to the Beneficiary to confirm]
Rep: Please confirm the info I have is correct:

- Medicare has your first name as:
- Medicare has your last name as:
- Medicare has your date of birth as:
- Medicare has your gender has:
- Would you like to provide a phone number for us to have on file? (This is optional.) Is this a mobile number?
    - [If YES] By providing a mobile number you consent to be called or texted by us regarding plans, benefits and healthcare information. Text messages are not encrypted and can be read by unauthorized persons. Message and data rates may apply. Please refer to our SMS Terms and Conditions on our website for more details.
- Would you like to provide an e-mail address (This is optional)?
    - [If YES] *Providing an email address authorizes us to contact you via email. Your email address will be handled consistent with our Privacy Policy.*
- The physical address you have on file with Medicare is [say address]. Is this the same as your mailing address? [Update address in DRX if needed]
- Would you like to provide an emergency contact? (This is optional)

Verify Eligibility

[NOTE: If HIPAA verification was successful, representative can read this information back to the beneficiary to confirm]
Rep: Please confirm I have the following correct:
Rep:

- **[If DSNP Plan] We confirmed you have active Medicaid**
- **Your Medicare ID number (MBI), is (say number)**

- **Your Medicare part A Effective date is (say date) and Part B effective date is (say date)**

Rep: You qualify to enroll for a [state proposed effective date] because of [state the election period that was identified].

Rep: Some individuals may have other coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State Pharmaceutical assistance programs. Will you have other Prescription drug coverage in addition to [Plan Name]?

Ethnicity and Race

Rep: Mr/Mrs [Name], Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.
Rep: What is your race? Select all that apply.

Other Information

Rep: Do you or your spouse work?
Rep: Would you prefer us to send you information in a language other than English?
Rep: Would you prefer it in another format, such as audio or large print?

Enrollment Disclosures

Full LIPS (PCT = 100) prospects don't need any of the following disclosures read to them (Extra Help, Part D-IRMAA, Pate Enrollment Penalty):

Partial (PCT is less than 100) or No LIPS read all discourses:
-Extra Help, Part D - (IRMAA), Late Enrollment Penalty

Extra Help

Rep: People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify for Extra Help, Medicare will pay all or part of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. For more information about this Extra Help, you can apply for Extra Help online (www.ssa.gov), at your local Social Security office, or call Social Security (1-800-772-1213. TTY users should call 1-800-325-0778).

Part D-IRMAA

Rep: If you are assessed a Part D-Income Related Monthly Adjustment Amount, (Part D-IRMAA), the Social Security Administration will notify you. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board (RRB). Do NOT pay [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] [MyChoice Wisconsin] the Part D-IRMAA.

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Late Enrollment Penalty

Rep: Do you have a Late Enrollment Penalty?

If no, skip to Agreement

If they don't know what a Late Enrollment Penalty is, explain.

Rep: You may owe a Late Enrollment Penalty (LEP) if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and if you didn't have other prescription drug coverage that met Medicare's minimum standards; OR if you had a break in coverage of at least 63 days.

Agreement

Rep: We are processing this application for an effective date of [state effective date].

Rep: By completing this enrollment application, you agree to the following:

Rep: [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] [MyChoice Wisconsin] is a Medicare Advantage plan and has a contract with the Federal Government. You will need to keep your Medicare Parts A and B. You can only be in one Medicare Advantage plan at a time. It may also impact you if you have health coverage from an employer or union. You could lose your employer or union health coverage if you join. Read the communications your employer or union sends you or contact your benefits administrator for help.

Rep: Once you enroll, you may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example October 15 – December 7 of every year), or under certain special circumstances. Visit Medicare.gov anytime to learn about when you can sign up for a plan.

Rep: You understand that when your [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] [MyChoice Wisconsin] coverage begins, you must get all ~~of~~ your medical and prescription drug benefits from [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] [MyChoice Wisconsin].

The Evidence of Coverage document is a complete list of benefits and all covered services, provided by [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] [MyChoice Wisconsin] (also known as a member contract or subscriber agreement) that will be covered. Neither Medicare nor [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] [MyChoice Wisconsin] will pay for benefits and services that are not covered.

Rep: You understand that you must use network pharmacies to get prescription drug benefits.

Rep: It is important to review plan coverage, costs, and benefits before you enroll. Visit MolinaHealthcare.com. A Summary of Benefits and Star Ratings sheet is also available to you through our website. Some services require prior authorization. Without authorization (if applicable), neither Medicare nor [Plan Name] will pay for the services.

Rep: Do you understand and agree to these statements?

Release of Information

Rep: You understand that you are enrolling in [Plan Name] plan. By joining this Medicare health plan, you acknowledge [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] [MyChoice Wisconsin] will release your information to Medicare, who may use it to track your enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of information. The information on this enrollment form is correct to the best of your knowledge. You understand that if you intentionally provide false information on this form, you will be disenrolled from the plan.

Rep: You understand that your verbal signature (or the verbal signature of the person authorized to act on your behalf under the laws of the State where you live) on this application to enroll means that you understand the contents of this application. If verbally signed by an authorized individual (as described above), this signature certifies that:

1. This person is authorized under State law to complete this enrollment, and
2. Documentation of this authority is available upon request by Medicare.

Rep: Do you understand and agree to these statements?

SECTION 5: CONCLUSION

Rep:

- Thank the person for speaking to you
- Tell them the confirmation number: [Your confirmation number for this application is [Confirmation #].
- Inform them they will receive acceptance or denial in roughly [7 to 10 business days].
- Ask if they have friends or family members that could benefit from the plan
    - If so, let them know the friend or family can contact you through your direct number [Give Direct Inbound Dial (DID)] or toll-free number: [(866) 533-1050]
    - Give them the number: [(866) 533-1050] ext [XXXXXX], TTY: [711]
    - Tell them the days and times you're available
    - *Provide appropriate plan Member Service toll-free number.*

In-Home Appointment

Offering

Rep:

- Let them know you understand Medicare can seem complicated if they're not familiar with it but we're here to make it easy to understand
- In fact, there's a representative near them who is really great at explaining it all in person and even walking them through setting it up a Medicare plan
- Ask which day of the week works best for the rep to come help them?
    - If beneficiary elects to schedule an appointment, find a time/date that works for them and the external representative
    - Document and proceed to SCOPE OF APPOINTMENT
    - If beneficiary does NOT want to schedule an appointment, go to **Enrollment Materials**

Scope of Appointment (SOA)

(SCRIPTING REQUIRED)

Rep: I also want to confirm your name is [Beneficiary Name] and that your Phone Number is [Phone Number], is this information correct? **[Set up IMA]**

Rep: During this appointment for [date/time/address],[External Representative Name] will discuss [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] [MyChoice Wisconsin] Medicare Advantage plans with you. There is no obligation to enroll and this meeting will not affect your current or future enrollment, or automatically enroll you in a Medicare plan. Do you confirm and understand?

Rep: Thank you. *[Beneficiary will confirm yes or no; correct information if needed and Proceed]*

Enrollment Materials

Rep: If you would prefer, I can send you our benefits packet and schedule a follow up call to make sure you have received it and answer any questions you may have. Would you like me to send you a benefits packet and schedule a follow up phone call with you?
Rep: Would you like me to send this by mail or by e-mail?
Thank you and have a wonderful day!