**CY 2011 Outbound Enrollment Verification (OEV) - Model Education and Verification Script for All Plan Types**

**Purpose: Ensure that Medicare beneficiaries who enrolled via agents/brokers understand the product type and plan rules of the plan they chose. If during the course of the verification call, it appears that applicants do not clearly understand, the plan rules and product types, the plan should continue to educate the applicant about the plan he/she chose.**

**Model Script:**

**[Greet and identify yourself:]**

Hello, my name is [caller’s first and last name]. I’m calling from [**Insert plan name and type of plan; all but HMOs spell out the type of plan in addition to giving the acronym,** e.g., “Private Fee-For-Service (PFFS)], which is a [**Insert whichever is applicable:** *Medicare Advantage Plan or Medicare Advantage Prescription Drug Plan or Medicare Prescription Drug Plan or Medicare Cost Plan or Medicare Medical Savings Account* ].

**[Ask for the applicant:]**

We recently got a request from [applicant first name and last name] to enroll in this plan. Is this [Mr./Ms.] [applicant last name]?

**[If yes, skip ahead to “Explain purpose of the call”].**

**[If no, say:]** May I please speak with [him/her]?

**[If not available:] When is the best time to try to reach [applicant first and last name]?**

**(Document date and time called:)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[When applicant is on the line, say:]** Hello, my name is [caller’s first and last name from health plan]. I’m calling because we got your request to enroll in **[Insert plan name and type of plan;** all but HMOs spell out the type of plan in addition to giving the acronym, e.g., “Private Fee-For-Service (PFFS)**],** which is a [**Insert whichever is applicable:** *Medicare Advantage Plan or Medicare Prescription Drug Plan or Medicare Cost Plan or Medicare Medical Savings Account***]**.

**[Continue with “Explain purpose of the call”].**

**[Explain purpose of the call]**

Because [plan name] is a [**Insert type of plan**: HMOs say “a Medicare HMO”; all others spell out the full name of the type of plan], it has some rules you’ll need to follow. We want to help make sure you understand these rules before your enrollment becomes final.

That’s why I’m calling you today. I’d like to explain how [plan name] works and answer any questions you may have.

These calls usually take about [xx] minutes. Is now a good time to talk?

**[If yes, skip ahead to “Give Assurances”]**

**[If no, continue:]** That’s okay. When would be a better time to talk?

**[Arrange and Document for a date and time to call back:]**

Thank you for your time today. We look forward to speaking with you.

**[If no time will work, continue as follows:]**

Thank you for your time. We’ll send you a letter soon about your membership in our plan that explains how to use your coverage. Please read it carefully and call our Member Services if you have any questions. The letter will give you a number to call. **[End call.]**

**[Give assurances]**

Thank you. Before we start, I want you to know that I won’t be asking anything about your health. And if you happen to give me any information about yourself, it won’t have any impact on your enrollment in our plan.

**[Explain type of plan:]**

Okay, let’s get started. You can ask questions whenever you like. As I mentioned, we got your application to become a member of [plan name] and we’re reviewing it now. This is a [**Insert whichever is applicable***: Medicare Advantage Plan or Medicare Prescription Drug Plan or Medicare Cost Plan or Medicare Savings Account*]. [**Insert for Medicare health plans:** It’s not Original Medicare. And it’s not a Medigap or Medicare supplemental insurance plan].

Do you have any questions about this? **[Answer questions and then continue] & Document questions & answers**

**NOTE: [All MA plans must include the language that follows for “Using the plan’s member ID card,” “Cost sharing,” and “Providers to use”]**

**[Using the plan’s member ID card:]**

Enrolling in [plan name] means you’ll get your Medicare coverage through [plan name] and payment for your healthcare services will be processed through our plan.

We will send you a letter that verifies your enrollment in our plan, we’ll explain how you’ll get your Medicare coverage when you’re a member of [plan name].

Once you’re enrolled in our plan, we’ll send you a [plan name] member ID card. You must use this card whenever you get healthcare services.

During the time you’re a member of our plan, you must not use your red, white and blue Medicare card. This card is only used when you get coverage through Original Medicare, and our plan is different from Original Medicare.

So we tell our new members to keep your red, white and blue Medicare card in a safe place, because you might need it later if you return to Original Medicare. But during the time you’re a member of [plan name], be sure to only use your [plan name] member ID card. Otherwise, your care might not be covered and you’ll have to pay for it yourself.

Do you have any questions about this? **[Answer questions and then continue.]**

**[Cost sharing:]**

Just like with any Medicare coverage, you’ll need to pay your share of the cost for services you get. When you filled out the enrollment form, there should have been written information for you that tells what you pay for services you get as a member of [plan name].

Do you have any questions about your cost sharing as a member of our plan?

**[Answer questions. If applicable, offer to mail or email a copy of the information or tell how to visit the website and get this information]**

**[Providers to use:]**

My next topic is which doctors, hospitals, or other health care providers you can use while you’re a member of this plan.

**[All PFFS plans must include the following language:]**

[Plan name], the plan you’re enrolling in, is a Private Fee-For-Service plan. When you’re in this type of plan, you can get covered Medicare services from any doctor, hospital, or other healthcare provider in the United States, if the provider agrees to accept our plan’s terms and conditions of payment before they provide services to you, and if they’re eligible to provide services under Original Medicare.

To be sure your care will be covered, you must tell your doctors and other providers that you’re a member of [plan name] by showing them your [plan name] member ID card. You must do this before you get any health care services and you must do it every single time you go. Here’s why:

* With a Private Fee-for-Service plan, doctors and other health care providers are allowed to decide each time you go in for care whether they want to accept or refuse [plan name]’s terms and conditions of payment. Just because a doctor accepted our plan the last time you went in for care doesn’t guarantee the doctor will accept our plan the next time you go in.
* Emergency care is an exception to this rule. If it’s an emergency, you can get care without having the provider agree in advance to accept our plan’s terms and conditions of payment.
* To find out about our plan’s terms and conditions of payment, health care providers can use the [**Insert as applicable**: phone number or website] on your plan member ID card.
* If a provider agrees to accept our plan’s terms and conditions of payment, they will bill [plan name] for the services you get, and you’ll pay your share of the costs of your care.
* If a provider does not accept [plan name]’s terms and conditions of payment, they shouldn’t provide services to you. In this case, you’ll need to find another provider that will accept our plan’s terms and conditions of payment.

[**Partial and full network PFFS plans include:]**

Our plan has signed contracts with some providers to deliver covered services to members in our plan. These providers have already agreed to see our members. These providers are our network providers.

[**Full network PFFS plans include:]**

We have network providers for all services covered under Original Medicare **[*indicate if network providers are available for any non-Medicare covered services*]**. You can still get covered services from out-of-network providers (those who don’t have a signed contract with our plan), as long as those providers agree to accept our plan’s terms and conditions of payment. So, be sure to show your member ID card first to be sure they’ll accept our plan.

[**Partial network PFFS plans include:]**

We have network providers for **[*indicate what category or categories of services for which network providers are available***]. You can still get covered services from out-of-network providers (those who don’t have a signed contract with our plan), as long as those providers agree to accept our plan’s terms and conditions of payment. If there aren’t any network providers available for a certain service, you can get covered services from any provider who agrees to accept our plan’s terms and conditions of payment. So, be sure to show your member ID card first to be sure they’ll accept our plan.

[Partial and full network PFFS plans should describe whether or not the plan has established any higher cost sharing requirements if the member gets a covered service from a deemed (out-of-network) provider.][**Insert the following sentence if the plan includes such differential cost-sharing:**If you use a provider who isn’t one of our network providers, you may pay higher cost sharing amounts.]

[**Partial and full network PFFS plans include**]

For the most up-to-date information on our network providers, you can either check our website or call [**Insert:** Member Services/Customer Service].

Do you have any questions about what you need to do to make sure the health care services you get are covered under [plan name]?

[All **HMO** plan types must include the following language:]

[Plan name], the plan you are enrolling in, is a [type of plan]. It has a network of doctors, specialists, hospitals, and other providers that provide healthcare services to plan members. You need to know which providers are part of our network because you [**Insert whichever is applicable**: must use or may be required to use] the providers who are in our network to get your healthcare services.

There are only four situations when [plan name] will cover healthcare services you get from providers who are not part of the plan’s network. These are:

* If you’re having an emergency.
* If you have an urgent need for care and network providers aren’t available to give you this care.
* If you need kidney dialysis that isn’t available from the plan’s network.
* If you asked for and received permission from [plan name] to use a provider who isn’t in the plan’s network.

***[HMO plans that offer a POS benefit can include the following along with a brief description of their POS benefit or a reference to where that information can be obtained.*]** Under our point of service benefit we allow you to get care from providers not in our network under certain conditions.

[**For SNPs only:** SNPs with arrangement with the State may revise this language to reflect, when applicable, that the organization is providing both Medicaid and Medicare covered benefits].

**[For All plan types use the following language]**

The health care providers in the plan’s network can change at any time. For the most up-to-date information on the network of providers, check our website or call [**Insert:** Member Services/Customer Service].

Do you have any questions about which health care providers you can use when you’re a member of [plan name]?

[All **Cost Plans and PPOs** **must include the following language:]**

[Plan name], the plan you’re enrolling in, is a [type of plan]. It has a network of doctors, specialists, hospitals, and other health care providers you can use to get your covered services.

**[Cost plans insert**: While you’re a member of our plan, you must see your [plan name] doctors for the plan to fully cover your medical services. You can get medical services not provided or arranged by [plan name], but you’ll be responsible for paying all Medicare deductibles and coinsurance, as well as any additional Medicare charges].

[**PPOs insert:** You can also use health care providers who are not in [plan name]’s network, but you may have higher cost sharing if you do].

The health care providers in the plan’s network can change at any time. For the most up-to-date information on the network of providers, check our website or call [**Insert:** Member Services/Customer Service].

Do you have any questions about which health care providers you can use when you’re a member of [plan name]?

[All **Medicare** **Medical Savings Account** **Plans must include the following language:]**

[Plan name], the plan you’re enrolling in, is a Medical Savings Account Plan (called an MSA). It’s a type of Medicare Advantage plan that combines a high-deductible health plan with a medical savings account. You can use your savings account to help pay for health care, and then you’ll have coverage through a high-deductible insurance plan once you reach your deductible. This gives you more control over your health care while still providing coverage against catastrophic health care expenses. You must have Medicare Part A and B to be enrolled in an MSA plan.

You should be aware of the several things while enrolled in a MSA plan:

A **Medicare MSA Savings Account** is the first part of a Medicare MSA plan, which is a special type of savings account. Medicare pays a set amount of money to the private companies that offer these plans. The plan deposits the money from Medicare into your savings account at the beginning of each year. You can’t deposit your own money into the account.

* A MSA trustee account must be opened in your name when you enroll, so that the plan can fund it with the deposit for the plan year.
* If you disenroll from the plan in the middle of the year, the Medicare Advantage Organization will keep part of your account deposit on Medicare’s behalf.
* You can use the money in your account, and it's tax exempt when you use it for “qualified medical expenses” as outlined by the IRS. (See IRS Publication 969.) You need to keep track of your medical expenses during each calendar year.
* Medicare Part A and Part B expenses will count towards the MSA plan deductible. Report your Medicare expenses to the MSA plan (if the provider isn’t already submitting claims to the plan) to ensure your expenses are counted. Show your plan ID card to the provider whenever you get care.
* You should never be asked to pay more than the Medicare- allowed amount for Medicare Part A or Part B covered services.

**A High Deductible Health Plan** is the second part of a Medicare MSA plan. Your MSA benefit must cover all Medicare Part A and Part B services. MSA plans may or may not have contracted providers, but MSA plans can’t restrict your access to a network of providers.

* After you meet the yearly plan deductible, the MSA plan will cover your Medicare costs. Only Part A and Part B expenses count towards the plan deductible. Show your plan ID card to the provider whenever you get care.
* After you reach the plan’s out-of-pocket spending limit, the plan will cover all costs (this is also known as “catastrophic coverage”).
* You don’t pay a monthly premium to the MSA plan. But you still must pay your monthly Medicare Part B premiums to Medicare.

You should be aware that:

* MSA plans don’t offer Medicare Part D prescription drug coverage.
* If you want drug coverage, you can join a stand-alone Medicare Prescription Drug Plan (PDP). If you join a PDP, any MSA savings account withdrawals you make to pay for drugs covered by the plan will count towards the drug plan’s out-of-pocket spending limit.

Do you have any questions about which health care providers you can use when you’re a member of [plan name]?

[**All PDPs and all other plan types offering Part D coverage must include the following language**:]

[Plan name] has a network of pharmacies. In most situations, we’ll only pay for your prescriptions if you use a pharmacy in our network. To get more information, including the most up-to-date list of pharmacies in the plan’s network, you can either check our website or call Member Services.

If you have limited income and resources, you may be able to get Extra Help to pay for your prescription drug premiums and costs. It’s free to apply for Extra Help, and there’s no obligation. If you want to learn more about this, and see if you qualify to get Extra Help, I have some phone numbers you can call. Would you like me to give you those phone numbers?

**[If yes:** You can call Medicare. That number is 1-800-Medicare (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day, 7 days a week. Or, call the Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778. You may also call your State Medicaid Office].

**[All plans must include the following language below:]**

**[Any questions?:]**

Do you have any questions about the things I’ve been explaining?

**[If yes, answer the questions. Repeat explanations as needed until the applicant understands].**

If you have questions later on, after we finish talking, you can always call our Member Services. Would you like to have the number to call?

**[If yes, give the phone number (give TTY number if applicable). Include the calling hours and days of operation].**

**[Enrollment cancellation policy:]**

If you decide you don’t want us to finish enrolling you as a new member, you have the right to cancel your enrollment request. If you already know that you do not want to become a new member of [plan name], you can tell me now and we’ll stop processing your enrollment.

If you need more time and you decide to cancel your enrollment request later, you’ll need to call [plan name] [**Insert:** Member Services/Customer Service] at [**Insert:** phone number]. You can call [**Insert** calling hours and days of operation]. Tell the person who answers that you want to cancel your enrollment in [plan name]. You can call [**Inser**t: calling hours and days of operation]. Or you can call 1-800-MEDICARE for help exploring other enrollment options.

Should I repeat any of the numbers to call so you can write them down?

It’s important for you to know that in order for us to cancel your enrollment, you must call us at the number I just gave you no later than **[Insert one of the following depending on the situation:**

[**Insert this language when the enrollment received is not part of the Annual Election Period (AEP) enrollment requests:** date must be either 7 calendar days from the date of this letter or the last day of the month in which the enrollment request was received, whichever comes later.]

**[Insert this language when the enrollment received is part of the Annual Election Period (AEP) enrollment requests** (except MSAs): December 31.

**Insert for Medicare MSA only:** date must be either 7 calendar days from the date of this letter or December 15 to cancel your enrollment.]

If you decide you want to cancel your enrollment request and you don’t call us before **[Insert date used in previous sentence]**, we won’t be able to cancel your enrollment.

Unless you call to cancel your enrollment, we will continue processing your enrollment. You’ll get a letter shortly with more information about your enrollment.

Do you have any questions about this? **[Answer questions and then continue.]**

**[Close:]**

[Mr./Ms] [Applicant last name], thanks for talking with me today. **[End call.]**