2020
Medicare Advantage Agent Compliance Training

Optima Health

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Welcome to Optima's Medicare Advantage and Part D Agent Certification Training Course

In this course, you'll review the following topics:

- Agent Certification Requirements
- Medicare
- MA and MA-PD eligibility
- Marketing Guidelines including Medicare Improvements for Patients and Providers Act (MIPPA)
- Marketing and Training Expectations
- Enrollment and Disenrollment Periods

Agent Certification

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- CMS requires that Agent Certification be done yearly. 
- Agents cannot discuss benefits or sell Optima Medicare plans until they successfully complete the certification course and exam.
- Annual training includes changes, additions, and deletions from CMS that you are required to know before beginning the selling season. The member services team is ready to assist with questions about your plan benefits

Section 1

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Medicare and CMS Regulations

Medicare

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- Medicare is a Federal health insurance program for individuals ages 65 or older, have certain disabilities, or have End Stage Renal Disease (permanent kidney failure).

- The Centers for Medicare and Medicaid Services (CMS) is the Federal agency which regulates Medicare and Medicaid.

- The Social Security Administration performs the administrative functions for the Medicare program, and provides general information.

Medicare Options

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- Original Medicare only or with a stand-alone PDP
- MA-PD
- MA or Cost Plan without stand-alone PDP
- Cost Plan with stand-alone PDP
- Private Fee for Service

Parts of Medicare

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- **Medicare Part A** (hospital insurance) mainly covers inpatient care in a hospital, skilled nursing facility, home health care or hospice program.
- Most beneficiaries do not pay for Part A.

- **Medicare Part B** (medical insurance) covers outpatient care, including physician services, diagnostic services, ambulance, certain limited drugs, and durable medical equipment.
- Beneficiaries will pay $144.60 for Part B in 2020. Upper income beneficiaries will pay more.

Parts of Medicare

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- **Medicare Part C** (Medicare Advantage) plans cover Part A and B benefits.
- Private plans contract with CMS to administer Part C plans.

- **Medicare Part D** benefits can be provided through:
  - Prescription Drug Plans (PDPs)
  - Medicare Advantage plans with Part D (MA-PD), or
  - Employer sponsored plans that are deemed creditable

- Medicare Advantage plans have uniform premium and cost-sharing amounts, except for limited income subsidy beneficiaries under Part D.

How Part D Works?

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Premium

A premium is the monthly cost to maintain coverage. If they choose an Optima Medicare Advantage plan, their Part D premium will be included in the overall premium.

Stage 1 Deductible

The amount paid for covered prescriptions before the plan begins to pay. Deductibles may apply only to certain types of drugs and/ or can vary from plan to plan or not apply a deductible which starts coverage immediately

Optima Medicare (HMO) plan deductibles are:

Optima Medicare Prime: $130 for tiers 4 and 5

Optima Medicare Value: $150 for tiers 4 and 5

How Part D Works?

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Stage 2 Initial Coverage

Your client and the plan share the cost of the yearly prescription drugs (copays) until total drugs costs reach $4,020. See below.

Drug Tier	Optima Medicare Prime	Optima Medicare Value
1	$0	$0
2	$8	$12
3	$45	$47
Deductibles	$130	$150
4	$90	$95
5	28%	%27

Optima Prime and Value deductibles applies to tiers 4 and 5.

How Part D Works?

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Stage 3 Coverage Gap

- During this stage, they pay 25% of the negotiated price for brand name drugs and 25% of the price for generic drugs.
- Beneficiaries may pay a portion of the dispensing fee and will continue in this stage until they reach the True out-of-pocket (TrOOP) maximum of $6,350.

* TrOOP are prescription drug cost that are used to calculate when beneficiaries leave the Coverage Gap (Donut Hole) stage and enter the Catastrophic Coverage stage.

How Part D Works?

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What portion of drugs cost counts toward TrOOP?

- Beneficiaries' payments made during the deductible, initial, and Coverage Gap stages.
- The cost portion of brand formulary drugs discount (not paid by beneficiaries) during the Coverage Gap is applied to TrOOP.
- Payments made by qualified 3rd parties on behalf of beneficiary (charities, family, friends).
- Low-income cost-sharing subsidies

How Part D Works?

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Stage 4 Catastrophic

Once they pay $6,350 for their covered prescription drugs, the plan will pay most of the cost for the rest of 2020 They will pay the greater of 5% of the cost for the drugs or $3.60 for generic drugs and $8.95 for all other drugs.

The Medicare Part D coverage cycles restart its stages at the beginning of each calendar year.

Section 2

Marketing Guidelines and MIPPA Requirements

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Contract with Agent

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To reach Medicare beneficiaries across the country, Medicare health plan sponsors frequently contract with agents to:

- Carry out marketing efforts;
- Disseminate information about their plans; and
- Sell Medicare health plan packages.

Plan Marketing Responsibility

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Plan sponsors are responsible for all of the marketing activities of third-parties contracted to carry-out Medicare health plan business including a person who is either:

- Directly employed by the organization;
- Under contract with the organization; or
- Downstream (hired by someone else) marketing contractor

Plan sponsors must use only a state licensed individual to perform marketing.

These guidelines apply to independent agents and internal sales staff.

Compliance

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Plan sponsors must establish clear provisions in the agent contracts stating that the organization is responsible for ensuring the contractors comply with:

- Applicable MA and/or Part D laws,
- Federal health care laws, and
- CMS policies and Marketing Guidelines.

Plan sponsors must conduct monitoring activities to ensure compliance.

Prohibited Activities

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The following activities are prohibited:

- May not market through unsolicited contacts.
- May not solicit door to door including leaving information on doors/cars.
- May not approach beneficiaries in common areas (hallways, lobbies).
- May not use unsolicited social networking sites, electronic voicemail messages on answering machines, text messages, unsolicited email contacts.
- May not send e-mails unless the beneficiary agrees to receive emails and has provided the address.
- May not rent, purchase or acquire e-mail lists or directories.

Prohibited Activities

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- May not e-mail prospective members at e-mail addresses obtained through friends or referrals.
- Call dis-enrolled or dis-enrolling members.
- Call beneficiaries to confirm receipt of mail or to confirm appointments made by third parties or independent agents.
- Follow-up calls or visits to beneficiaries who attend an event, without their express permission.
- Outbound marketing calls, unless requested.
- No bait-and-switch strategies - making unsolicited calls about other business as a means of generating leads for Medicare plans

Permitted Contacts

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Plans and Agents may do the following:

- Call former members to conduct disenrollment survey for quality improvement purposes. Disenrollment surveys may be done by phone or sent by mail, but neither calls nor mailings may include sales or marketing information.

- Under limited circumstances and subject to advance approval from the appropriate CMS Regional Office, call LIS-eligible members that a plan is prospectively losing due to reassignment to encourage them to remain enrolled in their current plan.

Permitted Activities

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- Agents who enrolled a beneficiary in a plan may call that beneficiary while they are member of that organization.

- May call beneficiaries who have expressly given permission for a plan or sales agent to contact them, for example by filling out a Sales Appointment Confirmation reply card or asking a Customer Service Representative (CSR) to have an agent contact them. This permission applies only to the entity from whom the beneficiary requested contact, for the duration of that transaction, or as indicated by the beneficiary.

Cross-selling is Prohibited

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- Effective 9-18-2008, marketing non-health care related products (Annuities or Life Insurance) during any sales activity is prohibited.

- CMS wants beneficiaries to be able to focus on Medicare coverage options without confusion.

Scope of Appointment

- Marketing representatives must specifically inform beneficiaries of all products that will be discussed prior to the in-home appointment.
- Beneficiaries must agree to the scope of the appointment, and this must be documented in writing or recorded prior to the appointment.
- For signed hard copies it is not feasible for the scope of appointment form to be executed prior to the appointment, an agent may have the beneficiary sign the form at the beginning of the marketing appointment.
- Appointments made over the phone must be recorded or electronically signed.
- Appointments made at a sales event must be written with a list of the products to be discussed and signed by the beneficiary.
- Additional products may not be discussed unless the beneficiary requests the information.

Scope of Appointment

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- Additional lines of business will require a separate appointment.
- Any such appointments must be scheduled at least 48 hours after the initial appointment unless the request for the appointment is made at a sales presentation.
- May discuss multiple products if notifies beneficiary prior to in-home appointment.
- Walk-ins must sign scope & Agent must document that person was a walk-in.
- May leave brochures regarding products not discussed, but must have separate appointment to discuss them.
- Appointments may not be rescheduled for 48 hours after the initial appointment unless the request is at a sales presentation.
- Appointments with beneficiaries in a long-term care facility can only be made upon beneficiary request.

Promotional Activities

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Drawings, Prizes, and Giveaways

- Cannot offer meals, cash, charitable contributions, gift certificates/ cards.
- May not use free gifts or prizes to induce enrollment.
- Must include a disclaimer on any statement concerning a prize or drawing that there is no obligation to enroll in the plan.
- Gift must be less than ***retail*** amount of $15 (no more than $75 per year) & must be offered to all members. Combined value cannot exceed $15 if more than one item given.
- May offer a prize over $15 ($1,000 sweepstakes on website), if offered to general public.
- Gifts must be offered to eligible members without discrimination.

Promotional Activities

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Reward Programs

- An organization can request referrals from active members including names and addresses, but not phone numbers. Information can be used for mail solicitation only.
- Agents may not use cash promotions as part of a referral program, but may offer thank you gifts of less than ***retail*** amount of $15.
- Thank you gifts are limited to one gift per member per year.
- A letter sent from an Agent to members soliciting referrals cannot offer a gift for a lead.
- Gifts for referrals must be available to all members that provide a referral and cannot be conditioned on actual enrollment of the person being referred.

Educational and Health Fair Activities

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- Health Fairs and Educational Events are social or educational meetings that do not include a sales presentations.
- Attendees can ask questions at the event which can be answered by the Organization's representative – no enrollment form or other marketing materials are distributed at the event.

May:

- Distribute materials that meet the CMS definition of education.
- Display a banner with the plan name and/or logo.
- Provide promotional items, including those with plan name, logo, and toll-free customer service number and/or website. Promotional items must be free of benefit information.
- May set up a future marketing appointment
- May provide a meal under education event criteria and complies with the nominal gift requirement.

Educational and Health Fair Activities

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May not:

- Include sales activities, distribute marketing materials, collect applications.
- May not discuss plan-specific premiums and/or benefits.
- Distribute plan-specific materials.
- Attach business cards or plan/agent contact information to educational materials.

Educational and Health Fair Activities

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Sales Events Meal Restrictions

- Plans **may not provide meals** (directly or indirectly) at meetings or events where plan benefits and materials are available to prospective members.

- Agents may provide light snacks, however, snacks cannot be “bundled” to provide a meal.

Acceptable Snacks:

- Fruit
- Raw vegetables
- Pastries
- Cookies
- Small dessert items
- Crackers
- Muffins
- Cheese
- Chips
- Yogurt
- Nuts

Marketing Activities

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Door-To-Door Solicitation Prohibited

Marketing agents may not:

- Solicit Beneficiaries door-to-door prior to receiving an invitation from the Beneficiary to provide assistance in their home.
- Return to a Beneficiary's home uninvited after an earlier "no show" appointment has occurred.
- Use telephonic solicitation, including text messages and leaving electronic voicemail messages.

Health Care Settings Marketing

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Marketing is permitted in common areas:

- Cafeterias, community or recreational rooms, conference rooms, or waiting rooms.
- In retail stores, areas other than where patients wait for service, pick up prescriptions or talk to pharmacy providers.

Marketing, Selling and/or Distributing or Accepting Enrollments NOT permitted in:

- Waiting rooms, exam rooms, hospital patient rooms, dialysis centers, pharmacy counter areas.
- Cannot conduct health screening or other like activities that could give the impression of "cherry picking."

Approved Marketing Required Materials

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- Agents must use only plan materials and scripts approved by CMS when speaking with prospective clients and describing benefits.
- Materials with agent's/broker's phone number should clearly indicate that calling the agent/broker number will direct them to a licensed insurance agent/broker.
- Plans/Part D Sponsors must submit agent/broker websites that reference specific MA/Part D products
- CMS reviews marketing materials submitted by the plan sponsor to ensure that the materials:
  - Are not materially inaccurate, not misleading
  - Engage in activities that could mislead or confuse beneficiaries or misrepresent the Plan/Part D sponsor.

Agent Compensation Agreements

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Compensation schedules must:

- Be specified in a written contract.
- Provide reasonable compensation that is in line with industry standards for services provided (Fair Market Value).
- Include commissions, gifts, and bonuses.
- Not include payments outside of the compensation schedule set forth in the written contract.

Rate of payment:

- Must be related to a reasonable measure of service provided.
- May vary among plans (e.g., MA plan, MA-PD plan, or a PDP).
- May not vary based on the health status or risk profile of a beneficiary.

Compensation Guidelines

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Compensation guidelines designed to:

- Reduce “churning” - the inappropriate movement of beneficiaries from plan to plan.
- Promote fair market value.
- Prohibit “cherry-picking”.
- Eliminate compensation that varies based on reaching enrollment targets.

Agent/ Broker Compensation

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- Initial Compensation paid at or below fair market value.
- Renewal Compensation is paid for each enrollment in Year 2 and beyond up to 50% of the current fair market value.
- New compensation structures subject to annual market commission caps as established by CMS, may be introduced by the Plan.
- Plans may not change compensation structures during the plan year.
- Any new sales where a beneficiary has moved between “like” plans (i.e. MA-PD to MA-PD) will be paid at the renewal level.
- CMS will give the final determination on new or renewal status of the beneficiary based on enrollment data.

Agent/ Broker Compensation (Charge-backs)

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Compensation Recovery Requirements:

CMS expects Plans/Part D sponsors to retroactively pay or recoup funds based on retroactive beneficiary changes for the current and previous calendar years. Plans must recover compensation for dis-enrollments occurring during the OEP.

Rapid Disenrollment

Applies when an enrollee makes any plan changes within the first 3 months of enrollment which includes OEP enrollment change.

It does not apply when a beneficiary enrolls effective the 1st of October, November, or December and using the AEP to change plans for January 1st effective date.

Agent/ Broker Compensation (Charge-backs)

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Rapid Enrollment Exceptions

Exceptions to the requirements for Plan/Part D sponsor to recover compensation may be granted when CMS determines that recoupment is not in the best interest of the Medicare program which are:

- Other creditable coverage (employer plan)
- Moving into or out of an institution
- Gain/drops employer/union sponsored coverage
- Plan termination, non-renewal, or CMS imposed sanction
- To coordinate with Part D enrollment periods or State Pharmaceutical Assistance Program
- Becoming LIS or dual eligible and dual eligible moving from a MA-PD to MMP
- Qualifying for another plan due to special needs

Agent/ Broker Compensation (Charge-backs)

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Rapid Enrollment Exceptions (continued)

- Due to auto, facilitated, or passive enrollment
- Death
- Move out of the service area
- Non-payment of premium
- Loss of entitlement or retroactive notice of entitlement
- Moving to a 5-star plan or from an LPI plan into a plan with 3 or more stars

Other Compensation Recovery

Plans/Part D sponsors must recover a pro-rated amount of compensation (initial and renewal) from agents/brokers when an enrollee dis-enrolls from a plan, equal to the number of months not enrolled. If a full initial compensation is paid, regardless of effective date, and the enrollee dis-enrolls mid-year, the total number of months not enrolled must be deducted or recovered from the compensation

State Reporting Laws

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The plan sponsor must report the following information to the State:

- The identity and other information of a Agent who is marketing the organization's plan(s).
- The termination for cause of a Agent's employment or contract.
- A suspected violation of a state's licensing, registration, certification, insurance, or other law.

The individual state may take action against marketing representatives and insurance producers for alleged violations of state marketing representative licensing laws.

This requirement applies to any individual performing marketing on behalf of a PDP sponsor or MA organization, whether they are an employee, independent agent contracting with a PDP or MA organization, or a downstream contractor.

Continuous Oversight

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Plan sponsors have developed ways to monitor Agent performance and compliance. These may include:

- Telephone calls to new members to ensure that they understand the terms of the Part D plan;
- Agent phone call monitoring and review to ensure compliance with appropriate marketing practices;
- Targeted “ride-a-longs” conducted by plan sponsor employees based on complaints;
- Attending community meetings to evaluate presentations; and/or
- Monitoring of disenrollment rates and complaints for each Agent.

Disclosure Requirements

CMS requires both MA and PDP plans to disclose plan information to Beneficiaries:

- At the time of enrollment
- 15 days prior to the Annual Election Period (AEP)

Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) documents distributed to members by September 30 of each year.

Marketing Materials

ALL marketing materials must be approved by Optima and CMS.

Marketing materials include:

- general circulation brochures
- enrollment & disenrollment forms
- member handbooks
- newsletters
- letters or notes to members about anything (including handwritten thank you notes)

Selling Optima Medicare Plans

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- Agents may schedule appointments with beneficiaries beginning in October, and Agents may leave an enrollment form with the beneficiary, following a sales presentation.
- Agents cannot take a completed enrollment form from a presentation until October 15th.

- Agents can submit enrollment forms to Optima beginning October 15th.
- If a beneficiary mails a completed enrollment form to Optima prior to October 15th, we will process as a October 15th submission date.
- The earliest effective date a member may have during AEP is January 1, 2020.

Section 3

Marketing and Training Expectations

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Marketing and Training Expectations

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- CMS takes Agent training, the sales process and compliance very seriously. Optima is required to monitor and train Agents similar to the process that internal sales employees are monitored and trained.
- This means that training and testing must take place prior to the agent/broker selling the product. In addition, agents/brokers must obtain a passing score of at least eighty-five percent (85%) on the test.
- In order to comply with CMS expectations, Optima will monitor and inform Agents of problems detected during the sales process.
- All Agent marketing errors are communicated to the Agent and recorded in the Agent file.

Marketing Errors

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The following marketing errors will result in immediate termination from the program:

- Forgery
- High pressure tactics
- Fraudulent misrepresentation
- Door to door solicitation
- Offering gifts or payments to induce enrollment
- Failure to process cancellation
- Using advertising that is not approved by Optima and CMS

If 5 Agent errors are detected within a 12 month period, the Agent will lose appointment privileges to sell Optima plans.

Marketing Errors

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When an Agent has 3 errors, a written report will be generated. The report includes:

- the number of sales the Agent has generated,
- if the Agent is making repeated errors,
- how many Agent sales terminated within 90 days
- documentation of Optima's verbal discussion with the Agent.

Upon attending another certification class, the Agent may resume selling Optima plans.

All of this information is available to CMS during the auditing process.

Marketing Errors

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The following Marketing errors may cause Optima to contact a Agent:

- Not certified to sell Optima plans.
- Neglect to sign as 3rd party individual who assisted with the enrollment form.
- Proposed effective date unavailable due to improper processing:
- Enrollment form is received more than 7 days after the signature date
- Missing appropriate Power of Attorney or Translator Witness Form

Marketing Errors

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Marketing errors that causes formal contact to the Agent:

- Applicant states that the Agent misrepresented the Optima plan.
- Applicant does not qualify for the plan for reasons such as the Applicant does not live in the service area or has not enrolled in Medicare Part B.
- Enrollment form changes have not been initialed by the applicant.

Examples of Errors:

- Name on the front of the application is different than the signature of the applicant
- Name of the beneficiary is incorrect or missing
- HIC # and/or Medicare effective dates are missing or incorrect
- Applicant did not initial section 3 or 4 of the enrollment form
- Health history question section is incomplete
- Incorrect or missing residential address, zip code, birth date, gender, phone number

Agent Disclosure Requirements

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When conducting marketing to enroll beneficiaries, Agents must disclose *in writing* to beneficiaries that they are:

- Contracted with the sponsor they are representing; and
- Compensated based on the their enrollment in the plan.

Section 4

Enrolling In Medicare Advantage and Part D Plans

PDP Enrollment Restrictions

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- A Medicare beneficiary may be enrolled in only one Part D plan at a time.
- If enrolled in an MA coordinated care plan (Optima Medicare) includes Medicare prescription drugs, the enrollee may not enroll in a PDP unless he dis-enrolls from the HMO or PPO plan.
- The Medicare prescription drug benefit of MA-PD is only available to members of the MA-PD plan.
- If a beneficiary is already enrolled in a MA-PD plan, the enrollee must receive their Medicare prescription drug benefits through that plan.

Who May Enroll?

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Decisions to enroll in a plan must be made by individuals of sound mind who are capable of understanding the plan benefits.

Presentations must be made directly to the **prospective enrollee**, and/or his **legal representative**.

CMS recognizes State laws that authorize persons to enroll or dis-enroll a Medicare beneficiary:

- Court-appointed legal guardians,
- Persons with durable power of attorney for health care decisions, or
- Individuals authorized to make health care decisions under state surrogate consent laws, provided they have authority to act for the beneficiary in this capacity.

Who May Enroll?

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A spouse or family member cannot decide for and/or sign for another without legal authority.

If both spouses cannot attend the sales presentation, only the spouse present may be enrolled. A follow-up appointment must be made for the absent spouse.

A Translator Witness is needed when enrolling the hearing or visually impaired or non-English speaking individual.

Beneficiary Information

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It is important to be aware of your individual client's circumstances. For example:

What is the client interested in?

- Medicare Advantage, Medicare Advantage with prescription drugs, or stand-alone prescription drug coverage

What health coverage do they have now?

- Original Medicare, with or without Medigap,
- Medicare Advantage plan,
- Medicaid, or
- Employer/union sponsored plan.

Do they currently have drug coverage?

What is the current coverage effective date?

Has the client already made plan changes for the current calendar year?

Election Periods

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Beneficiaries may only enroll in or change plans during an election period that occurs at specific times of the year. Previous Medicare health plan elections will impact what Medicare choices are now available.

- **Initial Election Period** (IEP)
- **Annual Election Period** (AEP)
- **Medicare Advantage Open Enrollment (**MA OEP)
- **Special Enrollment Period** (SEP)

Initial Election Period

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- Beneficiary dependent – based on date the beneficiary becomes eligible for Medicare.
- Generally concurrent with IEP for Part B - during the period that starts three months before the month he/she turns age 65 or disabled and ends three months after the month he/she turns age 65 or disabled.
- If a beneficiary does not join during the IEP and does not have current creditable drug coverage, he/she may have a penalty. The premium cost will go up at least 1% per month for every month that he/she waits to join. Like other insurance, the individual will have to pay this penalty as long as they have Medicare prescription drug coverage.

Note * Low Income Subsidy members are not subject to the Late Enrollment Penalty and individuals have one IEP to use, once enrollment is effective, the IEP is used.

Annual Election Period

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Annual Election Period (AEP)

- October 15 – December 7
- Beneficiaries may add or drop MA and/or drug coverage.
- Beneficiaries may switch to a different plan offering drug coverage:
  - From a PDP to a different PDP,
  - From MA-PD to a different MA-PD,
  - From a PDP to an MA-PD or vice versa, or
  - To a Cost Plan offering Part D

* Beneficiaries have one AEP to use; once the enrollment is effective, the AEP has been used.

Medicare Advantage Open Enrollment Period

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Medicare Advantage Open Enrollment Period (MA-OEP)

- From January 1 through March 31- Medicare Advantage plan enrollees may enroll in another MA plan or dis-enroll from a MA plan and return to Original Medicare.
- Individuals may add or drop Part D coverage during MA-OEP.
- Individuals enrolled in either MA-PD or MA only plans can switch to:
  - MA-PD
  - MA-only
  - Original Medicare (with or without a stand-alone Part D plan)

Note * Qualified individuals may make only one election during the MA-OEP. MA-OEP is not available to Original Medicare enrollees or people with MSA or cost plans and/or PACE.

Special Enrollment Period (SEP)

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Special Enrollment Periods are based on a beneficiary's circumstances.

An SEP generally allows an individual to:

- Dis-enroll,
- change plans, or
- sometimes to enroll.

CMS has identified a number of circumstances in which a beneficiary can have a special enrollment period.

Misrepresentation:

- CMS may grant the individual an SEP if a plan representative materially misrepresented the plan during marketing.

Special Enrollment Period (SEP)

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Dual-eligible and other LIS Eligible Individuals

- Individuals who have Medicare Parts A and B and receive any type of assistance from Medicaid program.

•Full benefit **•Partial duals** (who have cost sharing) **•Qualify for LIS (Extra Help)** (but do not qualify for Medicaid assistance)

This SEP begins the month the individual becomes dually-eligible and exists as long as they receive Medicaid benefits. Dual-eligible individuals are allowed to enroll in, or dis-enroll from, in a MA plan once per calendar quarter during the first nine months of the year. This SEP can be used once during each of the following time periods:

January - March **April - June** **July - September**

It may not be used in the 4th quarter of the year (October- December). The SEP is considered "*used*" based on the month the election is made (the application date of the enrollment request).

SEP Circumstances

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Moving:

- If a person is in a service area based plan (MA, MAPD, PDP) and moves outside the service area, he/she can apply the month prior to the move and up to 2 months after the move.
- The individual may choose an effective date up to 3 months after the month in which the enrollment form is received, but may not be earlier than the date of the permanent move.

Involuntary loss of creditable coverage (comparable to Medicare):

- Involuntary loss, including a reduction in the level of coverage.
- Begins with the month in which the individual is advised of the loss of creditable coverage and ends 60 days after either the loss occurs or the individual received notice, whichever is later.

SEP Circumstances

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Institutionalized Individuals:

- **For an individual who moves into, resides in or moves out of a:**
  - Skilled nursing facility (SNF) or nursing facility (NF);
  - Intermediate care facility for the mentally challenged (ICF/MR);
  - Long-term psychiatric hospital or unit;
  - Rehabilitation hospital or unit; or
  - Long-term care hospital or swing-bed hospital.

Effective dates: first of the month following the month in which the enrollment/disenrollment request is received, but not prior to the month residency begins. Up to 2 months after he/she moves out of the facility.

Enrollment Guidelines

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- Health questions may not be asked unless it is a question of eligibility.
- Plans and Agents cannot work with a provider to direct a beneficiary to a particular plan, e.g., only the healthier members of a medical practice.
- All *paper enrollment* forms must be signed.
- If the beneficiary is not competent, a legal representative must sign the enrollment form. The legal representative must attest on the form that he has the legal authority to make healthcare decisions.
- If an Agent helps the beneficiary fill out the enrollment request, he must sign the enrollment form and indicate his relationship to the individual.

Agents must not:

- Give advice on legal documents;
- Give in to pressure from a family member who wants to enroll a beneficiary without legal authority.

Medicare Plan Premium Payments

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Agents cannot collect plan premiums at the time of enrollment

Post Enrollment Member Materials

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After the plan receives the application, the plan provides the member with:

- A notice acknowledging receipt of the completed enrollment request providing the expected effective date of enrollment;
- A copy of the completed enrollment form;
- The plan sponsor's Evidence of Coverage - which includes the members rights and responsibilities;
- ID card or information about how to obtain services prior to the receipt of an ID card.

Compliance Test

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Thank you for completing the Optima Compliance Certification Course. You are now eligible to take the examination. You may now begin the Optima Medicare Agents Exam.

Good Luck!