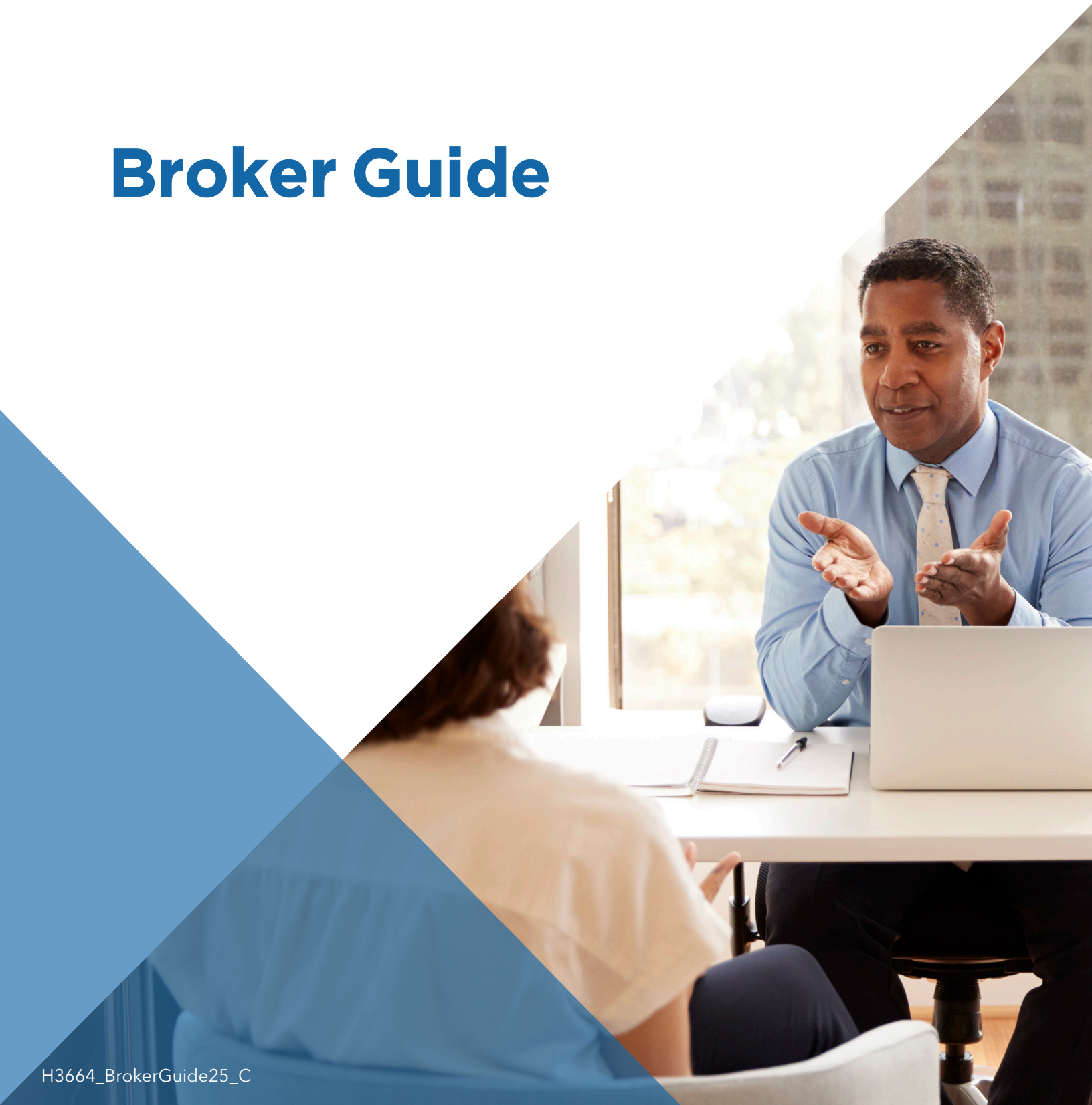
AULTCARE'S PRIMETIME HEALTH PLAN

Broker Guide



MARKETING PRACTICES

Marketing through unsolicited contact is prohibited.

Examples of Unsolicited Contact Include:

- Door-to-door solicitation.
- Leaving plan information at residences or on cars.
- Approaching potential members in common areas (parking lots, lobbies, retail stores, etc.).
- Telephonic or electronic (cold-calling, texting, etc.).
- Calling attendees of a sales event unless permission for a follow-up call is given. Permission must be documented.
- Calling a referral from a current member.

Examples of Permitted Marketing:

- Calling potential members when permission is given to call/contact.
- Giving your contact information to current members who want to refer a friend/relative.
- Calling your current Medicare Advantage (MA) enrollees to promote other Medicare plan types, or to discuss plan benefits.
- Calling current members to discuss/inform about general plan information, such as Annual Enrollment Period (AEP) dates, changes to plans, educational events, etc.
- Returning phone calls/messages or leaving information at a residence if an appointment you have pre-scheduled there becomes a no-show.
- Emailing potential members, provided all emails contain an opt-out function, and follow other generic marketing material guidelines.

Other Important Information

- Permission to call/contact is event-specific and does not include open-ended permission for future contact. Permission is valid for 12 months.
- Bait-and-switch strategies are prohibited.
- Referrals from current members do not give you permission to contact the referred person. You are only allowed to encourage the member to pass your contact information along.
- Marketing materials for the upcoming plan year cannot be distributed prior to October 1.
- As a rule of thumb, always obtain your marketing materials from your PrimeTime Health Plan representative.
- Only market PrimeTime Health plan benefits in the PTHP service area.
- Per Medicare guidelines the marketing of information about savings available that are based on a comparison of typical expenses borne by uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a Medicare beneficiary is prohibited.
- Cannot contact either former members or members in the process of disenrolling.
- Emailing potential enrollees is OK, as long as the email contains an opt-out option.

READY TO SELL CHECKLIST

- Confirm your Ohio license is up-to-date.
- Take and pass the PrimeTime Health Plan Miramar training.
- Agents: please be sure PrimeTime Health Plan has up-to-date contact information including:
  - > Agency or home address
  - > Email address
  - > Phone number
- Take a moment to verify this information and your National Producer Number (NPN) under your profile in this program, too. Incorrect information could delay your "Ready to Sell" status.

Staying CMS Compliant

According to the most recent guidance released by the Centers for Medicare & Medicaid Services (CMS) brokers and agents:

- Predominantly display the following 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 (SHIP) to get information on all of your options."
- Agents and brokers are required to record sales calls with their beneficiaries that pertain to marketing, sales, and enrollment. The recordings must be retained in a HIPAA compliant method for 10 years.
- Agents must notify enrollees annually, in writing, of the ability to opt out of phone calls regarding MA and Part D plan business.
- Required to state, "Every year, Medicare evaluates plans based on a 5-star rating system." Then, explain PTHP's current star rating, along with at least two examples CMS considers in establishing a star rating, as well as where the ratings are located in the current guide you are presenting or how to find the current ratings at www.medicare.gov.

Scope of Appointment (SOA)

Scope of Appointment Requirements

CMS requires agents to document the scope of a marketing appointment prior to any one-on-one sales (home, telephone, office, etc.) meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative).

This requirement is accomplished by completing an SOA form or a recorded oral agreement.

- SOA's should be completed at least 48 hours prior to the meeting.
- Walk-in appointment requests must also complete the SOA form, but the form should be noted as a walk-in.

The Sales Representative is bound to only discuss those products that have been agreed upon by the beneficiary. If during the conversation, the potential member indicates they want to speak about a different product, a second SOA form must be completed for the new product type before the appointment may continue.

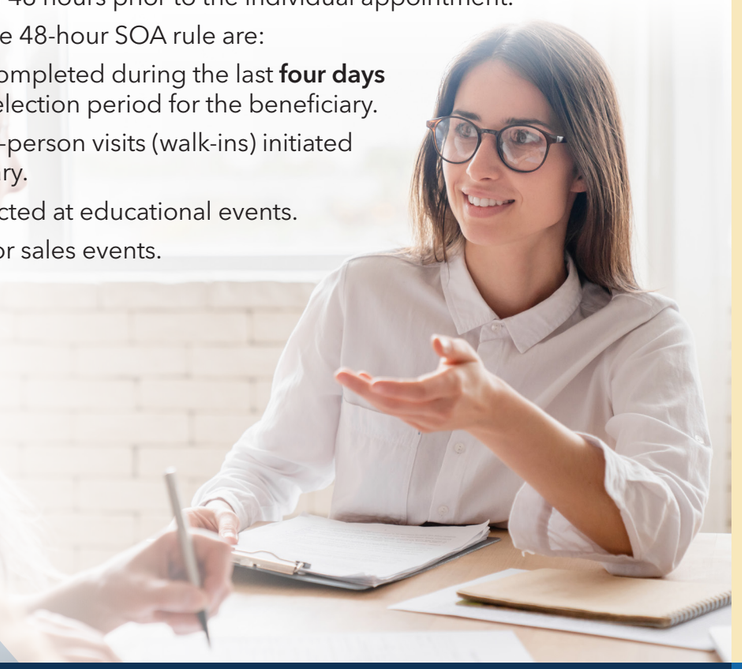
SOA forms are required for every attendee. This includes current members, potential members, and any additional people they bring to the appointment.

The Sales Representative is required to maintain the SOA documentation for 10 years. If you have an appointment with a potential member, whether the appointment results in a sale or not, you must retain a copy of the completed SOA form. You may be asked to present it during an audit.

When conducting marketing activities, in-person or telephonically, you may not market any healthcare-related products during a marketing appointment beyond the scope that the beneficiary agreed upon before the meeting with that individual.

Items to Remember

- SOAs are required for ALL sales appointments or personalized/individual appointments with existing or new/potential members.
- May only discuss products at an appointment that were agreed upon and documented in the SOA form.
- SOA must be completed prior to the meeting/appointment.
- Keep SOAs for at least 10 years and have them available upon request (even if you submit it with the application).
- SOAs are to be obtained 48 hours prior to the individual appointment.
- The two exceptions to the 48-hour SOA rule are:
  - SOAs that are completed during the last **four days** prior to a valid election period for the beneficiary.
  - Unscheduled in-person visits (walk-ins) initiated by the beneficiary.
- SOAs are not to be collected at educational events.
- SOA's are not required for sales events.



Making a Compliant PrimeTime Health Plan Presentation

Mention and adhere to these guidelines

- Indicate you do not work for Medicare.
  - > The use of the Medicare name, CMS logo, and products or information issued by the federal government must not be used in a misleading way. The Medicare card image is only permitted with CMS prior approval.
- Disclose that you may be compensated for this sale.
- Only discuss products agreed upon in the SOA.
- If the beneficiary requests to discuss other products not agreed upon in the original SOA, complete another SOA, and then continue the appointment.
- Verify that they are eligible (must be able to enroll for Medicare A & B; must live in PTHP's service area).
- Discuss enrollment periods/disenrollment.
- Mention ancillary services (i.e., Papa Pals, vision, dental, meal delivery service and over-the-counter (OTC) medications).
- Thoroughly review the pharmacy network and drug formulary.
- Confirm provider network and provider access.
- Explain role of primary care physician (PCP)/specialist referrals (if applicable).
- Carefully review plan benefits and premiums.
- Explain dental/vision benefits (if applicable).
- Explain that Part B premium must continue to be paid.
- Discuss out-of-pocket costs (office visits, urgent care, hospital, ER, or ambulance).
- Thoroughly review copayments and coinsurance.
- Explain prescription drug tiers, copays.
- Explain the situations when they will use their new card.
- Use the PrimeTime Health Plan brochure.
- Communicate the effective date of coverage.
- Provide customer service phone numbers.
- Provide your contact information.
- Make sure the application is filled out fully and accurately.
- Submit the applications the same day you receive them via fax: 330-363-209 unless filling out online via our website or through Connecture.
- Ask yourself: Is this the best plan for my client?
- Encourage the potential members to call you or PrimeTime Health Plan with questions or issues (Do not have them call Medicare).
- In accordance with Medicare guidance, agents must explain the effect of an enrollee's enrollment choice on their current coverage whenever the enrollee makes an enrollment decision.

***Per Medicare guidelines, marketing events cannot occur within 12 hours of an educational event at the same location.**

Enrollment

Methods of Enrollment

1. Paper enrollment (enrollment form included in the marketing brochure)
2. Online enrollment (Visit www.pthp.com)
3. Electronic enrollments (For Field Marketing Organizations (FMO's) will follow your FMO's guidelines/software)

The potential member must also receive Star Ratings information, the Summary of Benefits, and the Multi-Language/Non-Discrimination insert. PrimeTime Health Plan supplies these materials with the marketing brochure or online for online enrollments.

When completing a PrimeTime Health Plan Paper Enrollment Form

- Completely fill in the form.
- Either insert the beneficiary's Medicare number, attach a copy of the beneficiary's Medicare card, or include the letter from Social Security Administration or Railroad Retirement Board.
- Indicate how the member would like to pay their premium.
  - > Payment options include: Receive a monthly paper bill (choose this option to pay online), electronic fund transfer (EFT) from a checking account, or deduction from Social Security check or Railroad Retirement Benefit check.
  - > If choosing Social Security withdraw or Railroad Retirement Board (RRB) deduction, make sure the member is aware that it may take two or more months to begin after Social Security or Railroad Retirement Board (RRB) approves the deduction. The member may receive an invoice, to please pay the invoice, which they should pay until the withdrawal is effective.
  - > If the member wants to change their payment option after enrollment, they should contact PrimeTime Health Plan's Customer Service.
- Confirm the enrollment period being used to enroll (Ex: Annual Enrollment Period or Special Enrollment Period).
- Potential member must sign and date.
- Agent must sign, insert their writing code (which is assigned at the completion of the training program), and date in the space designated as "Agent/Broker Use Only."
  - > Agent should sign the same day as the beneficiary.
- Deliver the enrollment form to PrimeTime Health Plan within 24 hours of the broker's signature. You can fax to PrimeTime Health Plan Eligibility Department (330-363-2091). Faxed copies will be acknowledged via email response.

Online Enrollment

Online enrollment is available at www.pthp.com. Click on the 'Find a Plan' link and select the "beneficiary's chosen plan."

Scroll down the page to view the options to enroll. There will be links to download an application to print, or you can click the button to complete online enrollment.

If completing an online application, please complete all of the information. At the end of the enrollment form, check that you are an agent/broker, and confirm that your agent information is on the applications.

Once completed, you will be able to submit enrollment and you will receive a confirmation number. After CMS accepts the enrollment, the agent will receive a confirmation email.

Outbound Enrollment Verification (OEV)

PrimeTime Health Plan is required to conduct Outbound Enrollment Verification (OEV) for enrollments effectuated by agents/brokers to ensure enrolled individuals understand the plan rules.

As an agent, you must:

- Inform the applicant that they will be receiving a communication to complete this requirement.
- PrimeTime Health Plan is required to contact the applicant by telephone, email, or letter within 15 calendar days of receipt of the application.

Cancelled Applications

A cancelled application is defined as a submitted application that is cancelled by the member before the application's effective date.

Top Reasons for Cancelled Applications:

- Inaccurate provider network information.
- Inaccurate drug formulary information.
- Inaccurate cost or benefit information.
- Unsuitable plan enrollment.
- Client confusion with the plan.

The customer has to call to cancel the application. The application cannot be cancelled by the broker.

Tips for Reducing Cancelled Applications

- Verify the provider network and double check to ensure the member's provider is still participating in the plan.
- Offer to verify all: member medications are covered by the plan.
- Explain all costs associated with the plan accurately and thoroughly to make sure the member fully understands all costs involved.

- Discuss all benefits and make sure the member understands what benefits are covered and what is not covered. (Examples: dental, vision, gym memberships, etc.)
- Make sure the plan you are marketing/selling is the best option for the member. If it is, they should have no reason to cancel/switch plans.

Rapid Disenrollments

A rapid disenrollment is the voluntary disenrollment of a member from an MA/PDP (Prescription Drug Plan) plan within the first three calendar months after their initial enrollment effective date.

Top Reasons for Rapid Disenrollments:

- Inaccurate provider network information.
- Inaccurate benefit/coverage information (Examples: copayment/coinsurance, dental/vision, etc.).
- Incorrect drug formulary information.
- Unsuitable plan enrollment.
- Inaccurate plan description.

Tips for Reducing Rapid Disenrollments

- Confirm enrollee's providers are participating.
- Provide and thoroughly explain the plan's benefits and coverages (especially dental/vision benefits), its limitations and rules, including copayments, coinsurances, provider network, coverage gap, and Part D penalty.
- Verify enrollee's medication coverage. Use online search tools or reference www.pthp.com.
- Ensure the chosen plan is the best option for the member and the correct plan is chosen on the enrollment form.
- Explain enrollee is not joining a supplement plan.
- Review the next steps at the time of the enrollment.

Late Applications

PrimeTime Health Plan requires the completed enrollment form be submitted within 24 hours of the day the agent receives the application.

Tips for Reducing Late Applications

- Submit applications the same day you receive them.
- Submit the whole, completed application (no missing pages or information).
- Use the correct application.
- Fax your applications to PrimeTime Health Plan at 330-363-2091.

Member Complaints

Top Causes for Member Complaints:

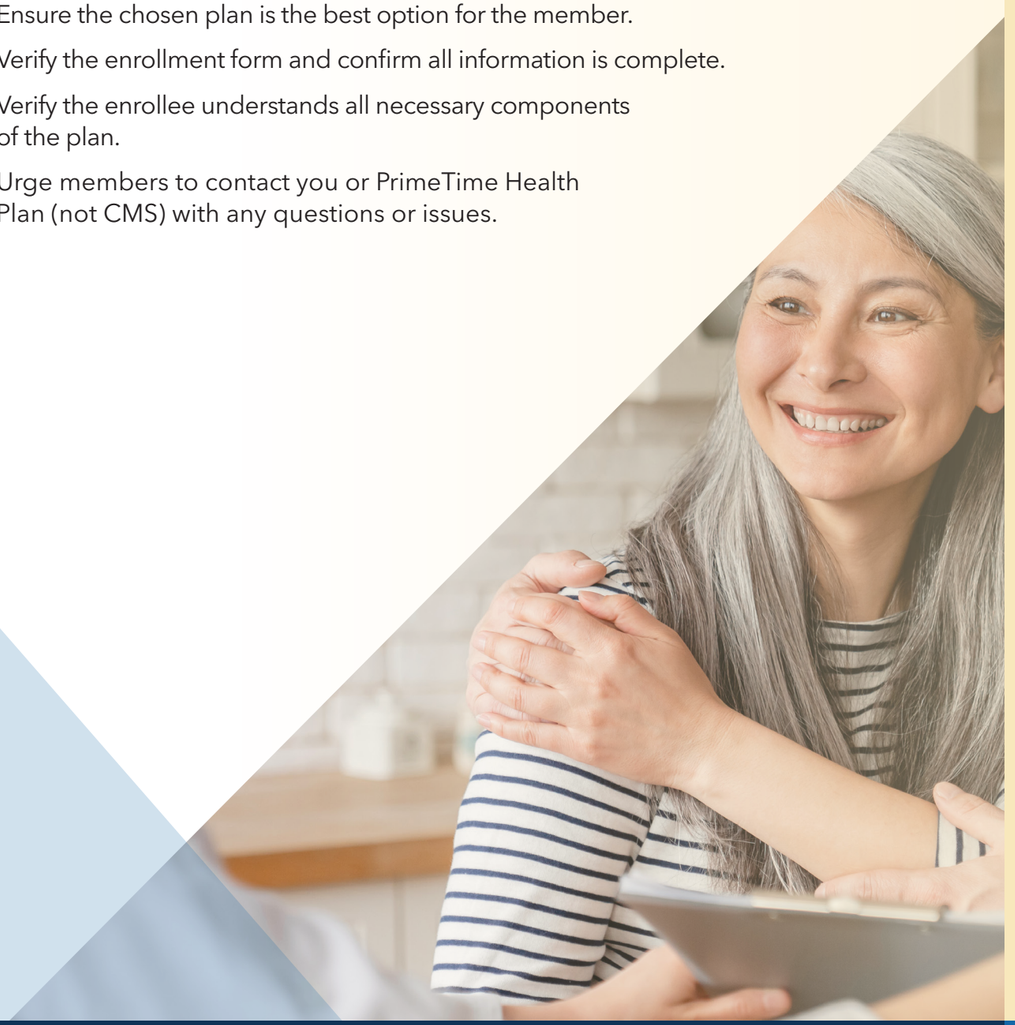
- Inaccurate benefit/coverage information.
- Inaccurate copayment/coinsurance information.
- Inaccurate provider network.
- Inaccurate plan description.
- Unsuitable plan enrollment.

Avoiding Member Complaints

- Review the Summary of Benefits page by page with the member.
  - > Throughly review copayment and coinsurance amounts.
  - > Advise the member whether or not the particular benefit plan has an annual limit on the maximum out-of-pocket amount of cost sharing for in-network and out-of- network services (if applicable).
- Review all benefits, including customized features, cost sharing (deductibles, copayments, and coinsurance); and all plan terms, conditions, and limitations.
  - > Discuss with the member what benefits they are looking for, what benefits are important to them, and clearly inform the member whether or not those benefits are covered by the plan.
- Review Low Income Subsidy (LIS).
  - > If a member receives Medicaid or Low Income Subsidy (LIS) cost-sharing help, do not guarantee a particular copayment or coinsurance cost to the consumer.
  - > Advise them the state will determine the level of cost-sharing help.
- Explain the PrimeTime Health Plan service area, prescription drug formulary, coverage gap, catastrophic coverage, and tiers.
- PrimeTime Health Plan is a Health Maintenance Organization (HMO), Health Maintenance Organization Point-of-Service (HMO-POS), network of doctors, specialists, hospitals, and pharmacies. The Point of Service option gives a member the additional flexibility to use a Medicare-approved provider not found within the PrimeTime Health Plan network for certain covered services, such as vision, routine dental, and lab services (except for genetic testing).
- Verify that the potential member's provider is in the PrimeTime network by visiting www.pthp.com.

Tips for Avoiding Complaints

- Confirm the potential member's providers are participating in PrimeTime Health Plan's network.
- Thoroughly explain plan's benefits, coverages, limitations, and rules including copayments, coinsurance, provider network, coverage gap, and Part D late enrollment penalty.
- Verify enrollee's medication coverage. Access www.pthp.com. Click on member resources; then click on PrimeTime Health Plan Drug Comparison in order to access the Optum® Cost Comparison Tool. Provide tier level and any restrictions (i.e. prior authorization, quantity limit, step therapy). Also, explain preferred vs. standard pharmacy, as well as mail order, if applicable.
- Verify the premiums, copay amounts, and maximum out-of-pocket amounts.
- Ensure the chosen plan is the best option for the member.
- Verify the enrollment form and confirm all information is complete.
- Verify the enrollee understands all necessary components of the plan.
- Urge members to contact you or PrimeTime Health Plan (not CMS) with any questions or issues.



Do's and Don'ts

DO	DON'T
Clearly identify the products to be discussed and ONLY discuss those agreed upon in the SOA.	Discriminate in any way including discouraging enrollment based on a potential member's disabilities.
Announce you don't work for Medicare and you could be compensated for this sale.	Attempt to enroll someone with a diminished capacity to understand.
Clearly review the premium amounts, maximum out of pockets, and copay amounts for each service	Say you or PrimeTime Health Plan is CMS-endorsed or recommended by the federal government.
Hold meetings in handicapped-accessible facilities.	Use misleading, conflicting, or confusing statements, or language such as, "best plan", or the word, "senior."
Communicate to non-English speakers in a way they will understand.	Engage in high-pressure sales or scare tactics.
Advise the client how to use the formulary.	Collect financial information during pre-enrollment activities.
Use only materials that meet CMS requirements.	Imply Medicare is only available to seniors.
Complete enrollment forms ONLY for those who are unable to do so themselves.	Ask to see a prospect's prescriptions unless they ask for help.
Record all sales calls that pertain to marketing, sales, and enrollment. Store records for 10 years.	Offer monetary or promotional gifts to induce enrollment or to compensate based on use of services.

Broker Assistance

Broker Personal Assistance

For customer service related assistance , please contact our designated representative Lisa Bowling-Shaffer, at lbowing-shaffer@aultcare.com or 330-363-2206.

By contacting our designated representative, brokers will have access to our most experienced representative. The representative will become familiar with brokers and/or their assistants (if properly appointed). Additionally, our representative will have direct access to all other departments in case special issues need to be addressed.

When calling, brokers must provide the following information:

- Broker Name
- AultCare Writing Number
- Member Name
- Member ID (or full address)
- Member DOB

**Per Medicare guidelines, we need to confirm the agent of record and verify three pieces of information for the member.

**Effective 1/1/2020 per CMS, a member's social security number cannot be used as an identifier.

Allowed Broker Inquiries:

- Claim Status
- Member ID Number
- Benefits
- Eligibility
- Billing
- Status of an organization determination, coverage determination, or appeal
- Request for ID cards be mailed to the member

Prohibited Broker Inquiries:

- Request an organization determination
- Request a coverage determination
- File a grievance
- File an appeal
- Request anything as urgent
- Change member address

Broker Oversight/Broker Auditing

Following CMS requirements, PrimeTime Health Plan will conduct broker oversight monthly. PrimeTime Health Plan sales representatives will contact selected brokers, letting them know they have been selected for an audit. The sales representative will ask for the SOA, any sales recordings and any other pertinent questions regarding the enrollment. The sales representative will review, discuss with the broker and note their findings on the audit form for their signature. This needs to be done in a timely manner.

Oversight Responsibilities (performed by PTHP representative):

- We must oversee agents to ensure they are compliant with CMS requirements.
- We must verify timely submissions of applications.
- We must verify the accuracy of all submitted applications.
- We must verify SOA forms are accurate.
- We must review complaints (allegations) made by any members.
- We must listen to recorded sales calls (if applicable).

Possible Outcomes of Non-Compliance:

- Coaching or monitoring sessions.
- Verbal or written warnings.
- Retraining and testing.
- Suspension or probationary period with or without commissions.
- Contract termination, with or without cause.
- Formal reporting to the Department of Insurance.

Staying Compliant: Pre-AEP
(October 1 – October 14)

There are many interpretations of the marketing regulations during Pre-AEP. Knowing what you can and cannot do during this period (October 1 – October 14) can be very confusing. Here are a few tips to help keep you compliant.

- Educate potential members by providing plan information.
- Conduct marketing activities as long as you do not "receive" or "solicit" an application.

During Pre-AEP, you cannot:

- Receive/accept/solicit enrollment forms prior to October 15.
- Write your name or writing code on an application prior to October 15.
- Strongly urge or pressure a potential member to fill out an application now.

Prior to October 1, agents may:

- Contact existing members to schedule a plan review prior to October 1.
- Schedule an appointment for October 1 or later.

Prior to October 1, agents may not:

- Conduct marketing activities for an upcoming plan year.
- Solicit or accept enrollment applications for a January 1 effective date prior to the start of the Annual Election Period (AEP), unless the potential member is entitled to another enrollment period (i.e. Special Enrollment Period).

During the Pre-AEP period, from October 1-14,

- Agents can market for the upcoming plan year, but cannot solicit or accept enrollment applications until October 15.

Event Compliance

Educational Event

An education event is an event designed to inform Medicare beneficiaries about Medicare Advantage, Prescription Drug, or other Medicare programs. It does not include marketing activities (i.e. the event sponsor does not steer or attempt to steer potential members towards a specific plan or limited number of plans).

What can you do at an Educational Event?

- Educate consumers about Medicare, Medicare Advantage, Prescription Drug, or other Medicare Programs.
- Offer promotional items as long as they are of nominal value and free of benefit information. These items can display the plan name, logo, toll-free number, and/or website.
- Display a banner with the plan name and/or logo (as long as it does not include any specific product information).
- Distribute business cards and contact information for beneficiaries to initiate contact.
- Answer questions asked by potential members (provided the response does not go beyond the scope of the question asked).
- Provide meals, snacks, or gifts, to everyone (as long as they meet the nominal value requirement of $15 or less, based on the retail value of the item.

What can you NOT do at an Educational Event?

- Collect or distribute scope of appointment forms.
- Distribute plan-specific materials.
- Distribute plan-specific premiums/benefits.
- Distribute enrollment forms or mandatory sign-up sheets.
- Discuss plans offered.
- Collect or distribute plan applications.
- Hold events at in-home or one-on-one settings (must be held in a public venue and must be advertised as Educational).
- Conduct a sales event immediately following an educational event in the same general location.
- Hold a marketing event within 12 hours of an educational event at the same location.

PrimeTime Health Plan Product Details

The PrimeTime Health Plan website, www.pthp.com is a useful tool when presenting information on PrimeTime Health Plan.

- The summary of benefits, provider directory, pharmacy information and annual notice of change can be found under the current year's plan information, then clicking general health information. Members can also utilize a drug comparison tool on www.pthp.com. This can be a helpful resource when looking up the cost of a drug on a specific plan.
- Our pharmacy network is extensive and includes pharmacies that offer preferred cost sharing and those that offer standard cost sharing.
  - > Cost sharing may be less by going to a preferred pharmacy than a standard pharmacy. Some examples of preferred pharmacies are: Giant Eagle, Marc's, Walgreens, and Walmart.
  - > An example of a standard pharmacy would be CVS.
  - > Mail order is also available. OptumRX® is our mail order vendor. Depending on the tier, either a 30- or 90-day supply is available via mail order.

PrimeTime Health Plan Contact Information

Phone: 330-363-7407 | 1-800-577-5084 | TTY: 711

Address: PrimeTime Health Plan | Morrow House | 2600 Sixth Street SW Canton, OH 44710

Walk In Hours of Operations: Monday – Friday 8:00 am – 4:30 pm

Website: www.pthp.com

AULTCARE'S PRIMETIME HEALTH PLAN

For more information, please contact PrimeTime Health Plan at 330-363-7407 or 1-800-577-5084 or TTY users can call 711, Monday-Friday from 8:00 a.m. to 8:00 p.m. (October 1 – March 31, we are available 7 days a week from 8:00 a.m. to 8:00 p.m.), or visit www.pthp.com. For accommodation of persons with special needs at sales meetings, call 1-800-577-5084 or for TTY users 711.