Brand New Day

DocuSign through AGA will allow you to enroll a client remotely, you can also perform a telephonic enrollment verification with no client signature needed.

Telephonic Enrollment Verification

1. You are required to do a full presentation of benefits, review the provider network and formulary with the prospective member. You must read the Scope of Appointment and receive approval to proceed with the enrollment. You may do this by phone, FaceTime, Skype or another type of video conference.
2. Read the entire script below to the beneficiary. Disclaimers must also be read, these sections are noted by red text.
    - We recommend, reading the script over once before you are speaking to the beneficiary so it goes smoothly.
3. Fill out the entire enrollment application with the exception of the member's signature and date.
4. On the first page of the enrollment form (the page with the effective date & plan selection) write at the bottom of the page the best time for the Compliance Department to call the prospective member to confirm enrollment. You must also add the date and time you spoke to the prospective member.
    - *For example: "I spoke to prospective member on 3/23/2020 at 9:30am. Best time to call is between 8am-10am Monday -Wednesday."*
5. Submit the paper enrollment form and SOA to AGA's submissions team for processing.
6. Inform the prospective member that he/she will receive a call from Brand New Day to confirm that he/she intends to enroll into one of Brand New Day's plans.
    - BND must get a verbal confirmation to process the enrollment.
    - The Compliance Department will attempt to call the prospective member 3 times.
7. Please check your Brand New Day Broker Portal to see a list of processed applications or email Broker Support at Marketing@universalcare.com if you have any questions.

Important Notes

- No member data will be displayed in your GAIN agent portal if application is sent direct to BND

Script

#1 Required Statements

Rep States: “I understand that I am entering information to be used in the application process for ___(beneficiary name)_____and this is not a guarantee of enrollment or an online enrollment. I also agree that I have reviewed the Plan Summary of Benefits.

“<beneficiary name>, you are entering information for <Brand New Day Plan Name > with a premium of <Premium Amount If Any> _____. Brand New Day is a Medicare-approved MAPD Sponsor.” “Do you wish to apply for this plan?”

Yes = (Rep continue to Step #2) No = Rep States: “Let me know when you are ready.” (If participant wishes to discontinue the application, please end the call)

#2 Rep

States: “You are not required to provide health related information unless this information is needed to determine your eligibility to enroll in the plan. If you choose not to provide the requested health information, you may not be able to enroll in the plan.

If you intentionally provided false information on this application, you will be disenrolled from the plan. Do you certify that the information provided in this application is accurate?” Yes = (Rep captures information, then continue) No = (Rep cannot continue)

#3 Rep

States: “Will you confirm that you placed this call to me, <Agent Name>?”

Yes = (Rep capture information, then continue to Step #4) No = Rep States: “Due to the laws that govern the Medicare program, I am not allowed to take an application from an outbound call.” (Rep cannot continue reading, discontinue the enrollment call)

#4 Rep

States: “I may be compensated when enrolling you into this plan.” (Rep continue to Step #5)

#5 Authorized representative

Rep States: “Are you completing this application for yourself or on behalf of someone else?” (Rep will capture based on the following):

=I am completing the application for myself (Rep continue to Step #9)

=I am a Power of Attorney or authorized representative and I am completing this application for someone else (Rep continue to Step #7)

=I am a witness or translator and I am helping someone else complete this application (Rep continue to Step #8)

If there is a POA for the member, read the following:

#6 Authorized representative or POA information

Rep States: “Are you authorized to act on behalf of <Beneficiary Name>?This means that you have Durable Power of Attorney for health care decisions, or are a Court Ordered Legal Guardian, authorized to make health care decisions under State Surrogate Consent Laws, and you can provide proof of authorization upon Medicare’s request?”

“If you are not authorized to act as a legal representative, the application may be denied.” Yes = (Rep capture information below, then continue to next steo) No = (Rep cannot continue reading. Please discontinue the enrollment)

(Rep to capture responses) Rep States: “Please state your full name.” “Please state your permanent address, including your city, state and zip code.” (If a P.O. BOX is provided, Rep States: “A P.O. BOX is not acceptable. Please provide a permanent home address.” (Rep captures and continues. If not, Rep should discontinue the enrollment) “What is your phone number?” “What is your relationship to the applicant?” (Rep will proceed to next question).

#7 Name of applicant verification

Rep States: “Which do you have, Medicare or Railroad Retirement Board benefits?”

Rep States: “Please state your full name as it appears on your card.”

(Capture the salutation, first name, middle initial and last name)

Rep States: “Please state your gender.”

(Capture the response and continue)

Rep States: “Please state your date of birth.” (Required month, date, and year.)

(Rep captures information, then continue to next step.)

#8 Phone number and print type verification

Rep States: “May I have your telephone number?” (capture in 10 digits)

Rep States: “If available, do you want to receive your materials in a language other than English or in another format such as large print?” (Rep to capture response)

(Rep continue to next question)

#9 Email Address (optional)

Rep States: <“Is it OK to email you plan documents, notices, and disclosure information?”> Yes = Rep States: “May I have your email address?” (Rep will continue by entering email address, and then continue to next question)

No = (Rep will document the response and proceed to next question)

#10 Permanent residential address verification

Rep States: May I have your complete permanent home address including your city, state, zip code, and county?"

(Rep capture information, then continue to next question)

#11 Verification of secondary address/mailing address information

Rep States: "Do you have a mailing address that is different from your permanent home address?"

Yes = (Rep States: "May I have the alternate address including your city, state, zip code and county?"

(Rep captures information, then continue to next question)

No = (Rep continue to next question)

#12 Medicare Card Information

Rep States: "May I have your claim number?"

Rep States: "You need to be entitled to Medicare Part A and be enrolled in Medicare Part B to enroll in this plan. May I please have the Part A and Part B effective dates as they appear on your card?"

A and B = (Rep captures information, then continue to next step) No A and B = Rep States: "I'm sorry, but you cannot enroll in this plan since you must have Medicare Part A and Part B." (Rep must discontinue enrollment).

#13 Establishing Eligibility (Special Election Period)

Rep States: "We need to establish an enrollment period for you. Please indicate 'Yes' or 'No' if any of these apply to you."

(Rep will start at the top of the following list, and determine the first question that would receive a 'Yes' response, and ask only that question. Every other question will be left blank.)

Disclaimer:

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

If none of these statements applies to you or you're not sure, please contact [[Brand New Day]] at [[1-866-255-4795]] (TTY users should call [[711]]) to see if you are eligible to enroll. We are open [[Year Round Monday- Friday 8am-8pm and October 1- March 31 Monday -Sunday 8am -8pm]].]

<Are you new to Medicare?>

<I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).>

<I have a diagnosis that qualifies me for a Special Needs Plan (CSNP, DSNP or ISNP).>

<Are you now receiving Medicare Part B, after initially delaying this coverage?>

<I recently had a change in my Medi-Cal (newly got Medi-Cal, had a change in level of Medi-Cal assistance, or lost Medi-Cal). >

<I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.>

<Are you turning 65, but already enrolled into Medicare Part A and Part B due to gaining eligibility prior to age 65>

<Are you losing or leaving coverage you had from an employer or union?> <If yes, what was the date?>

<Are you enrolling during the Annual Enrollment Period, October 15th through December 7th?>

<Have you ever received a Medicare Entitlement Letter informing you of a retroactive Medicare determination?>

<Are you moving into, live in, or recently moved out of a Long Term Care Facility (example, nursing home)?> <If yes, as of what date?>

<Is your plan ending its contract with Medicare or is Medicare ending its contract with your plan?>

<Have you recently left a Program of All-Inclusive Care for the Elderly (PACE)?> <If yes, when did you leave?>

<Is your plan not renewing and you are enrolling between December 8th and the last day of February?>

<Are you enrolling during the General Enrollment Period with an effective date of July 1st?>

<Have you recently moved outside of your plan's service area or have you moved and this plan is a new option?> <If yes, what was the date?>

<Have you recently returned to the United States after living permanently outside of the United States?> <If yes, what was the date?>

<Do you have both Medicare and Medicaid or is your state helping to pay for Medicare premiums?>

<Are you no longer eligible for Medicaid?> <If yes, as of what date?>

<Are you getting Extra Help to pay for Medicare prescription drug coverage?>

<Are you no longer qualified for Extra Help to pay for Medicare prescription drug coverage? > <If yes, what date did you stop receiving Extra Help?>

<Do you have a severe or disabling chronic condition, and currently not a member of another Special Needs Plan serving the condition?>

<Were you enrolled in a Special Needs Plan but have lost the Special Needs qualification requirement to be in that plan?> <If yes, when?>

<Were you enrolled in a Chronic Special Needs Plan and not verified for the enrollment, and were disenrolled two months after the effective date?> <If yes, when?>

<Do you belong to a pharmacy assistance program provided by your state?>

<Have you recently been released from incarceration?> <If yes, what was the date?>

<Have you recently obtained lawful presence status in the United States?> If yes, what date did you obtain this status?>

<Are you switching to a 5 Star Rated Plan in your area?>

<Have you recently involuntarily lost creditable prescription drug coverage (as good as Medicare's)?> <If yes, what was the date?>

#14 <Additional Questions for CSNP Enrollment (Only applicable for CSNP)>

Rep States: “You are not required to provide any health related information. However, this information is needed to determine your eligibility to enroll in the plan. If you choose not to provide the health requested information you may not be able to enroll into the plan. Have

you ever been diagnosed or are currently being treated for Diabetes, Cardiovascular Disorder, Chronic Heart Failure, Dementia, Alzheimer's, or Mental Illness?”>

No = (Beneficiary is not eligible for the SNP and a new plan will need to be discussed, stop enrollment process for this plan) Yes = (Capture response and proceed)

Rep States: “Your doctor will be contacted to complete a verification form”

“Please provide your physician’s contact information including name, phone number and full address”

(Rep capture to fill out the Pre-Enrollment Qualification Form)

“Please provide your specialist’s contact information including name, phone number and full address”>

(Rep capture and continue to next question)

#15 ESRD Qualifier

Rep State: “Do you have End-Stage Renal Disease, also called Chronic Renal Failure or Stage 5 Kidney Disease?”

No = (Rep continue to next question)

Yes = (Rep States: “If you have ESRD and have not had a successful kidney transplant, you cannot enroll in the plan unless you are already enrolled as a member of <Brand New Day>. If you do not need regular dialysis anymore or have had a successful kidney transplant, you will need to submit a note or records from your doctor to that effect.”

Rep States: “Are you currently a member of <Brand New Day>? (Rep will record Yes or No.) Yes = Rep States: “May I have your identification number?”(Rep will capture information, then continue to next step)

#16 Health insurance coverage question

Rep States: “Will you have other drug coverage when this plan becomes effective?”

(Rep will provide examples if needed because the retiree is uncertain or seems unclear. Rep may state: “For example, other private insurance, Tricare, Federal Employee Health Benefits coverage, Veterans Affairs (VA), or State Pharmaceutical Assistance Programs”.)

No = (Rep captures information, continue to next question)

Yes = (Rep continue to next question)

#17 Other Prescription Drug coverage answered as “ YES”

Rep State: “What is the name of the plan?” (Rep capture)

“What is your identification (ID) number for this coverage?” (Rep capture)

“What is your policy group number for this coverage?” (Rep capture)

(Rep captures information, then continue to next question)

#18 Long-Term Care verification

Rep States: “Do you live in a long-term care facility, such as a nursing home, but not an assisted living facility?”

No = (Rep captures information, then continue to next question)

Yes = (Rep continue to next question)

#19 Long-Term Care answered as “YES”

Rep States:

“What is the institution name?” (Rep capture)

“What is the address of the institution?” (Rep capture)

“What are the city, state and zip code?” (Rep capture)

“What is the facility phone number?” (Rep capture)

(Rep captures information, continue to next question)

#20 Medicaid question

Rep States: “Are you currently enrolled in a State Medicaid Program?”

No = (Rep continue to next step)

Yes = Rep States “What is your Medicaid identification number?” (Rep will

capture, proceed to next step)

#21 Employment Question

Rep states: “Do you or your spouse work?”

Yes or No= (Rep capture and continue to next question)

#22 Physician & Medical Group Selection

Rep States: <“A Medicare Advantage plan requires that you choose a primary care physician (PCP). If you need a PCP for this plan and you do not choose one now, the plan may select one for you, but you can change doctors at any time by calling Brand New Day. Can you state the name of your PCP or Clinic?”>

#23 Late Enrollment Penalty Disclaimer

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. 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 Railroad Retirement Board. DO NOT pay Brand New Day the Part D-IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at

http://www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. If you don't select a payment option, you will get a bill each month.

#24 Review

Rep States: “By completing this enrollment application, you agree to the following: < Plan name> is a MEDICARE ADVANTAGE WITH PRESCRIPTION DRUG plan with a Medicare contract. Enrollment in this plan depends on contract renewal.” “You understand that this plan is in addition to your coverage under Medicare; therefore, you will need to keep your Medicare Part A and Part B coverage.” “You can only be in one Medicare Advantage plan at a time, and you understand that your enrollment in this plan will automatically end your enrollment in another Medicare health plan or prescription drug plan. However,

it will not automatically terminate a Medicare Supplement enrollment." "It is your responsibility to inform Brand New Day of any prescription drug coverage that you have or may get in the future."

(Rep continue to next step)

#25 Review cont'd

Rep States: "Enrollment in this plan is generally for the entire year. Once you enroll, you may only leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period, October 15th through December 7th, unless you qualify for certain special circumstances."

(Rep continue to next step)

#26 Review cont'd

Rep States: "The plan serves a specific service area. If you move out of the area that the plan serves, you need to notify the plan so you can enroll in a new plan in your new area." "Once you are a member of the plan, you have the right to appeal plan decisions about payment or services if you disagree. The plan's Evidence of Coverage document—also called the Member Contract or Subscriber Agreement--will include the rules you must follow." Rep States: "You understand that you must use network pharmacies except in an emergency when you cannot reasonably use the plan's network pharmacies."

(Rep continue to Step #27)

#27 HMO Disclaimer

Rep States: "Beginning on the effective date of coverage, you must get all of your health care from the plan, except for emergencies, urgently needed services, or out-of-area dialysis services. Services authorized by the plan and other services contained in the plan's Evidence of Coverage document will be covered. Without authorization from the plan, neither Medicare nor the plan will pay for the services."

(Rep continue to Step #28 for DSNP/CSNP PLANS)

#28 HMO SNP Disclaimer

For Dual Eligible Plans:

Rep States: "<plan name > is a coordinated care plan with a Medicare Contract and a contract

with the state Medicaid Program. Enrollment in the plan depends on contract renewal. This plan is available to anyone who has both Medical Assistance from the State and Medicare. Premiums, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details. All Medicaid eligibility is based on information provided today and is subject to change. As required by Centers for Medicare & Medicaid Services, Brand New Day makes the final determination for enrollment based on information provided on this application.">

For Chronic Care Plans:

Rep States: "Brand New Day is a Coordinated Care plan with a Medicare contract. Enrollment in this plan depends on contract renewal. In addition to this questionnaire, Brand New Day requires that your doctor completes a verification form. This form will be sent to you for completion by your doctor. This plan is available to individuals with certain chronic conditions. To qualify for a Chronic Disease Special

Needs Plan, physician diagnosis of the disease must be verified. Enrollees who do not have the condition will be dis-enrolled.”>

(Rep continue to next step)

#29 Disclaimer of Enrollment:

If you currently have health coverage from an employer or union, joining Brand New Day could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Brand New Day. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their

communications. If there isn’t any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

By completing this enrollment application, I agree to the following:

Brand New Day is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I 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.

Brand New Day serves a specific service area. If I move out of the area that Brand New Day serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Brand New Day, I have the right to appeal plan decisions about payment or services if I disagree. I will read either the Member Handbook or Evidence of Coverage document from Brand New Day when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren’t usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Brand New Day coverage begins, I must get all of my health care from Brand New Day, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Brand New Day and other services contained in my Brand New Day Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR BRAND NEW DAY WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Brand New Day, he/she may be paid based on my enrollment in Brand New Day.

Release of Information:

By joining this Medicare health plan, I acknowledge that Brand New Day will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Brand New Day will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my

knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read

and understand the contents of this application. If 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 from Medicare.

#30 <If Beneficiary Has an Authorized representative or POA information>

Rep States: “Are you authorized to act on behalf of <Beneficiary Name>? This means that you have Durable Power of Attorney for health care decisions, or are a Court Ordered Legal Guardian, authorized to make health care decisions under State Surrogate Consent Laws, and you can provide proof of authorization upon Medicare’s request?”

“If you are not authorized to act as a legal representative, the application may be denied.” Yes = (Rep capture information below, then Rep continue to next step)

No = (Rep cannot continue with enrollment)

(Rep to capture responses) Rep States: “Please state your full name.” “Please state your permanent address, including your city, state and zip code.” (If a P.O. BOX is provided, Rep States: “A P.O. BOX is not acceptable. Please provide a permanent home address.”

(Rep captures and continues. If not, Rep continue to next step) “What is your phone number?” “What is your relationship to the applicant?”

#31 Verbal Signature

Rep States: “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 means that you understand the contents of this application.” “Please provide your verbal signature by stating 'I agree’” (If the rep does not receive a response of “I agree” to the above disclaimer, then read script below.)

Rep States: “The application cannot continue unless you state that you agree. Do you agree with the statements that I have just read to you? If so, please state; “I agree.” No = (Rep cannot continue reading, discontinue enrollment.) “I agree” = (Rep continue to next step.)

#32 Completed Application

Rep States: “You have completed an application for <Plan Name> from Brand New Day on <MONTH, DATE, YEAR> at <TIME>. This completes the < Medicare Advantage Prescription Drug> portion of your enrollment.”