2019 Medicare Agent Reference Guide

For **Wellmark Blue Cross and Blue Shield** agent use only.
Not for use with the general public.

2019 MedicareBlue Supplement℠ Plans

	Plan A	Plan D	Plan F	HD Plan F	Plan G	Plan N
Basic Benefits	•	•	•	•	•	•
Skilled Nursing Facility		•	•	•	•	•
Part A Deductible		•	•	•	•	•
Part B Deductible			•	•		
Part B Excess Charge			•	•	•	
Foreign Travel Emergency		•	•	•	•	•
Plan Deductible				•		

Finding-cost effective solutions for clients: MedicareBlue Supplement High Deductible Plan F

How High Deductible Plan F (HD Plan F) works:

- Same benefits as Plan F begin once out-of-pocket expenses meet the calendar year deductible.
- Out-of-pocket expenses applied to the deductible are those expenses that would ordinarily be paid by the policy.
    - Includes Medicare deductibles for Part A and Part B, 20 percent coinsurance after deductible for Part B services.
    - Does not include the foreign travel emergency deductible.
- Medicare coverage and preventive services are available regardless of whether or not the plan deductible has been satisfied.

Members on Wellmark's MedicareBlue Supplement High Deductible Plan F will be allowed to move to Plan F without answering health questions:

- Members must have been enrolled in HD Plan F for 12 consecutive months.
- Members will be allowed to move during the Annual Enrollment Period (AEP). AEP runs Oct. 15 – Dec. 7 every year.
- Coverage changes made during AEP will be effective for Jan. 1 the following year.

Preferred premiums on MedicareBlue Supplement plans

Preferred premiums on MedicareBlue Supplement plans are available to:

- Individuals who are active and healthy.
    - Preferred premiums are available to anyone who can pass all the health questions on the application. Work with your clients to determine if he or she qualifies.
- Individuals within his or her initial enrollment period.
- Individuals within a guaranteed issue rights period.

2019 Dental, vision and hearing

Wellmark will continue offering members dental coverage through Blue Dental[SM] and vision and hearing coverage through Avesis and Amplifon Hearing Health Care.

Dental plan details

Plan details	Blue Dental 75	Blue Dental 100
Monthly premium	**$21.60**	**$33.50**
Annual benefit maximum (Calendar Year)	$1,000	$1,000
Annual deductible	$75 in network $150 out-of-network	$100 in network $200 out-of-network
Preventive and diagnostic	20% in network 40% out-of-network	0% in network 40% out-of-network
Basic restorative: Including cavity repair, tooth extraction, restoration of decayed or fractured teeth, oral surgery and anesthesia.	50% in network 60% out-of-network	20% in network 40% out-of-network
Endodontics (root canals)	50% in network 60% out-of-network	50% in network 70% out-of-network
Periodontics, major restorative and prosthodontics: Including gum and bone disease treatment, crowns, inlays, bridges and dentures	No Coverage	50% in-network 70% out-of-network

NEW in 2019: Tiered dental waiting periods will apply for coverage effective on or after Jan. 1, 2019. For more detailed information about waiting periods and other plan details, see M-5319359 available on the Marketing Toolkit.

Vision plan details

Plan details		Silver Vision & Hearing 100	Silver Vision & Hearing 130
Monthly premium		**$9.78**	**$15.90**
Diagnostic services	**Eye exam**	Covered in full after $10 copay, every 12 months; out-of-network up to $35.	Covered in full after $10 copay, every 12 months; out-of-network up to $35.
Eyewear products	**Frames**	Covered once every 24 months, after $25 materials copay; $100 retail allowance. Out-of-network up to $25.	Covered once every 24 months, after $10 materials copay; $130 retail allowance. Out-of-network up to $25.
	Standard plastic lenses	One pair covered in full after $25 materials copay, every 12 months. Single vision, lined bifocal, lined trifocal, lenticular. Progressive: $50 retail allowance, plus 20% off.	One pair covered in full after $10 materials copay, every 12 months. Single vision, lined bifocal, lined trifocal, lenticular. Progressive: $50 retail allowance, plus 20% off.

		Specialty: corresponding standard lens reimbursement, plus 20% off. Out-of-network: standard plastic lenses up to $25, lined bifocal up to $40, lined trifocal up to $50, lenticular up to $80, progressives up to $40.	Specialty: corresponding standard lens reimbursement, plus 20% off. Out-of-network: standard plastic lenses up to $25, lined bifocal up to $40, lined trifocal up to $50, lenticular up to $80, progressives up to $40.
	Contact lenses	Conventional or disposable covered up to $110 retail allowance, every 12 months, in lieu of eyeglasses. Out-of-network: conventional or disposable up to $80, medically necessary up to $250	Conventional or disposable covered up to $110 retail allowance, every 12 months, in lieu of eyeglasses. Out-of-network: conventional or disposable up to $80, medically necessary up to $250
	Lens options	Up to 20% off polycarbonate, scratch-resistant coating, tint and UV protective coating.	Up to 20% off polycarbonate, scratch-resistant coating, tint and UV protective coating.
Hearing screening: A pass/fail evaluation to determine if additional testing is needed. **Hearing exam:** Comprehensive test to determine type and location of hearing loss.		Hearing screening at no charge, every 24 months. Out-of-network: no coverage	Comprehensive hearing exam covered up to $48 every 24 months. Out-of-network: up to $48 reimbursement
Hearing device, batteries, maintenance plan		• One year of follow-up care • Two years of free batteries (160 cells) • Three-year warranty from loss and damage protection	• $300 hearing device allowance per ear every 5 years, plus discounts above the allowance • One year of follow-up care • Two years of free batteries (160 cells) • Three-year warranty from loss and damage protection

For more detailed information about these vision plans, see M-2319324 available on the Marketing Toolkit.

These plans are available to Medicare supplement members who are residents of Iowa.

Note about Avesis and Amplifon:
Avēsis Vision is an independent vision insurance company that does not provide Wellmark Blue Cross and Blue Shield of Iowa products and services. Avēsis Vision is underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri. Hearing Discount Savings Plan provided by Amplifon. Amplifon is an independent company that does not provide Wellmark Blue Cross and Blue Shield of Iowa products or services.

Medicare Supplement Guaranteed Issue Rights

The information below outlines several types of events that could place an individual in a guaranteed issue rights period. Individuals enrolling in a MedicareBlue Supplement plan with Wellmark while in a guaranteed issue rights period will receive preferred premiums.

Guaranteed issue qualifying events — eligibility	Requirements for enrollment
Individual is enrolled in a Medicare Advantage plan, and the plan is leaving Medicare or will no longer be providing coverage in the individual's area, or the individual has moved out of the plan's service area.	The MedicareBlue Supplement application must be completed as early as 60 calendar days before the date coverage will end but no later than 63 calendar days after coverage ends.
Individual has Original Medicare and an employer group health plan that pays after Medicare pays, and that plan has stopped providing some or all health benefits (only applies to involuntary loss of coverage).	
Individual has Original Medicare and a Medicare Select policy, and the individual is moving out of the Medicare Select policy's service area.	
Individual joined a Medicare Advantage plan or Program for All-Inclusive Care for the Elderly (PACE) when first eligible for Medicare Part A or B at age 65, and within the first year of joining, the individual wants to disenroll (Trial Right).	
Individual cancelled his/her Medicare supplement policy to join a Medicare Advantage plan (or to switch to a Medicare Select policy) for the first time, has been in the plan less than one year, and wants to re-enroll in his/her original Medicare supplement policy (Trial Right).	
Individual has Medicare supplement insurance, and is losing his/her coverage because the insurance company went bankrupt, or his/her coverage is ending through no fault of his/her own.	
Individual is leaving a Medicare Advantage plan or Medicare supplement policy, because he/she has been notified the insurance company violated a provision of its contract with the individual or it has misled him/her.	

For more information and details regarding guaranteed issue rights periods and qualifying events, please refer to the MedicareBlue Supplement Enrollment and Administrative Guide, available on Producer Connection.

2019 MedicareBlue℠ Rx (PDP) Plans

Important product information to note:

- A preferred pharmacy network remains in effect for both plan options. This means both plans offer preferred and standard cost-sharing amounts.
- The pharmacy network includes more than 67,000 pharmacies nationwide — 36,000 are preferred.
- For 2019, the Standard plan deductible is $0 on Tier 1 and Tier 2 and has increased to $415 on Tiers 3, 4 and 5.

	2019 Standard Option	2018 Standard Option
Premium	**$37.90**	$37.40
Deductible	**$0 on Tiers 1 and 2; $415 on Tiers 3, 4, and 5.**	$0 on Tiers 1 and 2; $405 on Tiers 3, 4, and 5.
Initial Coverage[2]	**Preferred[1]: $3 / $7 / 16% / 35% / 25%** **Standard: $15 / $20 / 25% / 48% / 25%**	Preferred[1]: $1 / $5 / 17% / 30% / 25% Standard: $15 / $19 / 21% / 41% / 25%
Initial Coverage Limit	**$3,820**	$3,750
Coverage Gap	**- 37% of the plan's costs for generic drugs** **- 25% of the plan's costs for all other brand-name drugs[3]**	- 44% of the plan's costs for generic drugs - 35% of the plan's costs for all other brand-name drugs[3]
Catastrophic Threshold	**$5,100**	$5,000
Catastrophic Coverage	**Member must pay the greater of 5% coinsurance OR a $3.40 copay for generic drugs and $8.50 copay for all other covered drugs**	Member must pay the greater of 5% coinsurance OR a $3.35 copay for generic drugs and $8.35 copay for all other covered drugs

	2019 Premier Option	2018 Premier Option
Premium	**$89.70**	$100.60
Deductible	**$0 (no deductible)**	$0 (no deductible)
Initial Coverage[2]	**Preferred: $0 / $0 / 17% / 45% / 33%[1]** **Standard: $15 / $20 / 25% / 50% / 33%**	Preferred: $0 / $0 / 17% / 45% / 33%[1] Standard: $15 / $20 / 25% / 50% / 33%
Initial Coverage Limit	**$3,820**	$3,750
Coverage Gap	**- $0 copay on Tier 1: Preferred Generic Drugs at preferred pharmacies ($15 copay at standard pharmacy)** **- $0 copay for Tier 2: Generic drugs at preferred pharmacies ($20 copay at standard pharmacy)** **- 37% of the plan's costs for generic drugs** **- 25% of the plan's costs for all other brand-name drugs[3]**	- $0 copay on Tier 1: Preferred Generic Drugs at preferred pharmacies - $0 copay for Tier 2: Non-preferred Generics drugs at preferred pharmacies - 44% of the plan's costs for generic drugs - 35% of the plan's costs for all other brand-name drugs[3]
Catastrophic Threshold	**$5,100**	$5,000

Catastrophic Coverage	**Member must pay the greater of 5% coinsurance OR a $3.40 copay for generic drugs and $8.50 copay for all other covered drugs**	Member must pay the greater of 5% coinsurance OR a $3.35 copay for generic drugs and $8.35 copay for all other covered drugs

[1] Lower member cost-share when member purchases drugs through a preferred network pharmacy.
[2] Member cost-sharing is for a 30-day supply at a retail pharmacy.
[3] The brand-name drug coverage in the coverage gap is subject to agreements between the Centers for Medicare & Medicaid Services (CMS) and drug manufacturers. Any brand-name drugs for which there is not a discount agreement cannot be on the formulary per CMS.

MedicareBlue Rx drug formulary

The formulary is the list of drugs the plan will cover. Medicare requires each plan to cover a minimum of two prescription drugs within each therapeutic classification.

- Drugs not listed on the formulary are not covered, unless an exception request filed by the member and his or her physician is approved by the plan.
- Formularies are subject to change during the year as new drugs are approved by the FDA, as generic forms of brand-name drugs become available, or if a drug is recalled by the FDA.
- For an updated MedicareBlue Rx formulary, visit YourMedicareSolutions.com.

Understanding "TrOOP"

True Out-of-Pocket cost ("TrOOP") is the amount the Medicare beneficiary pays in covered drug costs, such as deductibles, coinsurance and/or copays. If a beneficiary pays out-of-pocket for a medication that is not a covered Part D drug, the cost is not applied toward TrOOP costs. Keep these tips in mind when calculating annual drug expenses for members. **Please note:** The figures below are based on the Federal Standard Part D plan design.

- The **Initial Coverage Limit** is when a member meets his or her deductible (if applicable) and their total drug costs reach $3,820 (in 2019).
    - The initial coverage limit is based on the total cost of drugs paid by both the **member and the prescription drug plan**.
- After reaching the initial coverage limit, members enter the **coverage gap** (or "donut hole"). In 2019, beneficiaries with the Standard plan who reach the coverage gap will pay:
    - 37 percent of the plan's costs for generic drugs, and
    - 25 percent of the plan's costs for brand-name drugs.
- After reaching the initial coverage limit, members enter the **coverage gap** (or "donut hole"). In 2019, beneficiaries with the Premier plan who reach the coverage gap will pay:
    - $0 copay for Tier 1 preferred generic drugs and $0 copay for Tier 2 generic drugs purchased at a preferred pharmacy ($15, $20 respectively at a standard pharmacy),
    - 37 percent of the plan's costs for other generic drugs, and
    - 25 percent of the plan's costs for brand-name drugs.
- Once the member has reached the **Catastrophic Threshold** of $5,100 in covered drug costs, the member reaches **catastrophic coverage**. The member will pay the greater of $3.40 for covered generics and $8.50 for all other covered drugs, OR 5 percent coinsurance.
    - The out-of-pocket threshold costs include **only** the money spent by the member and does not include the amount of money the plan has paid.

Low-income Subsidy (LIS) assistance

- Helping your LIS members

    - Subsidy-eligible LIS members who are currently enrolled in or elect a MedicareBlue Rx plan will pay the difference between their monthly subsidy amount and the total amount of the monthly premium for the MedicareBlue Rx plan in which they are enrolled.
- CMS communications to LIS beneficiaries
    - Every fall, CMS reviews eligibility for LIS and notifies beneficiaries if his or her Extra Help will be continued or changed, or if they no longer qualify. For more information on LIS, go to *CMS.gov/limitedincomeandresources*.

MedicareBlue℠ Rx Annual Compliance Requirements

Annual certification — compliance reminders

- Agents must successfully complete certification each year to continue to sell MedicareBlue Rx and service existing MedicareBlue Rx clients. Certification is comprised of two components: the product certification training and general Medicare basics training. Agents must hold certification for the product year they wish to sell.
- 2019 Medicare Basics and Product Training must be completed prior to marketing and selling 2019 products.
    - Marketing for 2019 products may begin Oct. 1, 2018, and sales for 2019 MedicareBlue Rx products may begin Oct. 15, 2018.
- Certification will only be conducted online for the 2019 product year. To complete online training, please visit Producer Connection.
- If you do NOT certify, and continue to sell:
    - The client will be moved to a Wellmark house account, and you will lose the business.
    - No commission will be paid on the sale of the contract to you or to your agency.
- **Important to remember**:
    - An uncertified sale may result in corrective actions, up to and including termination of the agent's appointment with Wellmark. The uncertified sale may also be reported to regulating agencies.
    - If you successfully complete the training certification for 2019, but not 2018, you cannot write applications with an effective date before Jan. 1, 2019.

Agent responsibilities

- All agents selling MedicareBlue Rx for Wellmark are considered to be a first tier, downstream or related entitiy (FDR) by the Centers for Medicare and Medicare Services (CMS) and are referred to by Wellmark as Agent FDRs.
    - CMS has certain compliance requirements for all FDRs, including Wellmark's Agent FDRs.
- As a Wellmark agent who sells MedicareBlue Rx, you are required to comply with certain Medicare compliance functions. Wellmark is committed to providing you with all the information and tools you need to make sure your Medicare compliance responsibilities are met.
- **For more information** about Agent FDR compliance requirements and what tasks agents must complete to show compliance, log in to the Producer Connection, go to the Individual Over 65 section and click on Medicare Compliance.

MedicareBlue℠ Rx Scope of Appointment Form, Application Submission & Compliance Reminders

Scope of Appointment form

- CMS requires that *prior* to **any face-to-face marketing appointment**, the beneficiary must agree to the scope of appointment in writing, and that agreement must be documented with a signed Scope of Appointment form.
- Agents may not document the Scope of Appointment by a recorded phone call.
- As a sales person you may only discuss products that have been agreed upon by the beneficiary 48 hours in advance of the meeting and documented in the Scope of Appointment form. If the beneficiary requests to discuss other products, a second Scope of Appointment form must be completed for the new product type before continuing the marketing appointment.
- Agents must retain and be able to produce documentation of Scope of Appointment forms at the request of CMS for a total of 11 years (ten years plus the current year).
- A beneficiary cannot agree to the Scope over the phone and then sign documentation at the beginning of the sales appointment.
- A beneficiary may sign a Scope of Appointment form at a marketing presentation for a follow-up appointment.
- In the case of a walk-in, or when a beneficiary visits a plan or an agent office on his/her own accord, the agent or broker should complete a Scope of Appointment form, and secure the beneficiary's signature prior to discussing PDP plans. Agents should note on the Scope of Appointment form that the beneficiary was a walk-in. In these instances, the 48-hour waiting period does not apply.
- The form applies only to the beneficiary who signed it. If other beneficiaries are brought to a sales discussion, every beneficiary must complete and sign a Scope of Appointment form before the sales discussion begins. You should note on the Scope of Appointment form the circumstances of the sales discussion and why additional beneficiaries were present.
- If you go to an in-home appointment expecting to meet with one beneficiary and find additional beneficiaries have been invited, have each of the other beneficiaries complete and sign a Scope of Appointment form prior to the sales discussion. Note on the form(s) that you had scheduled an appointment with the first beneficiary and were not aware of others being invited until you arrived. If the new participants are not eligible for Medicare, they do not need to sign the form.
- If a Scope of Appointment form is not completed by the agent or available for review when requested, it will result in corrective action.

Downloading the Scope of Appointment form

The Scope of Appointment Form (M-23573) is available on the Wellmark Marketing Toolkit.

MedicareBlue Rx application requirements

Sales persons are not allowed to mail completed paper applications via standard United States Postal Service (USPS) to MedicareBlue Rx and must submit all paper applications within two calendar days of receiving the member signed application. *All enrollment forms must be received by TMG Health, INC. within four days of the agent signature date*. Sales persons must submit enrollments for MedicareBlue Rx using one of the following methods:

Online — Enter enrollment information electronically at YourMedicareSolutions.com:

- With the member present, or
- Using the Agent Attestation box located under the enrollee signature on the application

Overnight Delivery — Send paper forms to the MedicareBlue Rx enrollment center. Send to:

TMG Health, INC.
Attn: Mailroom
25 Lakeview Drive
Jessup, PA 18434

Fax — Fax paper enrollment forms to MedicareBlue Rx:

- **855-874-4702**

Please note: Please write legibly or type your cover sheet content. Each fax cover sheet must include the following information:

- Name of the beneficiary on the enrollment form
- Medicare number for the beneficiary
- The sales person's name and contact information

Wellmark has a customizable fax cover sheet available on the Wellmark Marketing Toolkit, which can be populated and faxed in with the enrollment form.

- PDP Fax Coversheet: 00C134

You must keep a copy of the original application, Scope of Appointment form and a copy of all confirmations (fax, online, overnight receipt) for 11 years (ten years plus the current year) as verification.

Application timeliness — compliance reminders and implications

CMS defines the application date for an enrollment form as the date that the enrollment form is received by the plan. This is considered to be:

- The date the sales person signs and dates the enrollment form
- The earlier of the date stamp and/or signature date of the sales person or the agency
- The plan sponsor's mailroom receipt date if there is no sales person signature on the enrollment form

Online and telephonic submissions are electronically date-stamped to identify the application date. Paper enrollment forms mailed by a beneficiary directly to enrollment processing centers are date stamped the day they are received.

Because CMS considers sales persons to be an extension of the plan sponsor, **receipt of an enrollment form by a sales person is considered receipt by the plan,** and that date is the application receipt date. For this reason, it's important that you submit applications immediately. If you are unable to submit the application immediately, it must be submitted **no later than two days after the agent has signed the application**. It's also important that you do not sign and date the application before the beneficiary has signed it. Applications received five or more calendar days after the agent signature date will result in corrective action.

Paper enrollment forms received by sales persons must be faxed or submitted by overnight delivery to the enrollment processing center immediately and include documentation of "application date." Paper enrollments may also be entered online immediately after receipt if the beneficiary has given permission for this by checking the authorization box below the enrollee signature on the form.

Please make sure all applications are fully completed, including the agent eight-digit identification number. Any application that is not complete will not be processed.

Election Periods for People Changing Coverage

Beneficiaries enrolled in Medicare supplement

Individuals who wish to change to a more benefit-rich Medicare supplement plan may do so at any time of the year by answering the health questions on the application. Individuals who wish to change to a less benefit-rich Medicare supplement plan may do so any time of the year but will not need to answer health questions.

Beneficiaries enrolled in a Medicare Prescription Drug Plan

The calendar below outlines all the election periods for individuals who wish to make a change to their current coverage for an effective date of Jan. 1, 2019 (or after for MADP only).

The **Annual Election Period (AEP) for 2019 products** occurs between **Oct. 15 and Dec. 7**, and allows enrollment into or disenrollment from a Medicare Advantage, Medicare Advantage Prescription Drug Plan, or Prescription Drug Plan.

- Marketing for AEP may begin on Oct. 1, 2018. All agent certifications must be complete prior to marketing.
- The effective date of the elected coverage is Jan. 1, 2019.
- The last enrollment or disenrollment choice made during this election period, determined by the application date, will be the choice that becomes effective Jan. 1, 2019. The application date is defined as the date the enrollment request is received by the plan, which includes receipt by a sales person.
- If Medicare-eligible beneficiaries do not make a change to their plan, their current coverage continues into the next year with an applicable premium or benefit design adjustments.

The **Medicare Advantage Open Enrollment Period** will occur Jan. 1 through March 31. This enrollment period allows people to:

- Switch to another Medicare Advantage plan (with or without drug coverage) if they're currently in a Medicare Advantage plan (with or without drug coverage).
- Disenroll from their Medicare Advantage plan and return to Original Medicare. If beneficiaries choose to do so, they'll be able to join a Prescription Drug Plan.
- Change to another Medicare Advantage plan (with or without drug coverage) or go back to Original Medicare with or without drug coverage. This is only valid if a person is enrolled in a Medicare Advantage plan during their Initial Enrollment Period and switching within the first three months they have Medicare.

This enrollment period does not allow people to switch from Original Medicare to a Medicare Advantage plan, join a Prescription Drug Plan if they're in Original Medicare, or switch from one Prescription Drug Plan to another if they're in Original Medicare.

Special Enrollment Periods (SEP)

Special Enrollment Periods occur for various reasons, and allow beneficiaries to enroll in a Medicare Advantage or Prescription Drug Plan outside of the enrollment periods listed above. A few common reasons SEPs can occur are:

- **Loss of employer-sponsored coverage**
  - This SEP is two months long for Medicare Advantage and Prescription Drug Plans, and begins the month after employment ends or the group health plan coverage ends, whichever happens first.
  - Usually a beneficiary does not have to pay a late enrollment penalty during this SEP.
- **Current plan closing**
  - If the beneficiary's plan closes and is no longer available to them, an SEP occurs.
  - For Medicare supplement plans, this would result in the beneficiary receiving Guaranteed Issue Rights (see information on page 4).
- **Change of residence**
  - If a beneficiary moves into or out of a service area, an SEP occurs.

- **5-Star rating enrollment period for MedicareBlue Rx**
    - Plans with a 5-star rating from CMS may enroll beneficiaries **throughout the year**, beginning the month after the plan receives the 5-star rating.
    - Plans will notify agents and brokers if/when 5-star enrollment periods occur.

For more information about SEPs and what may cause them, visit CMS.gov.

Election Periods for People New to Medicare

Election Periods for a Beneficiary Turning 65	
4 months prior to 65th birthday	• Beneficiary already getting Social Security benefits receives a letter from Medicare showing Medicare Beneficiary Identifier (MBI) and effective dates. (Those not already receiving Social Security benefits must contact Social Security to sign up.) • MedicareBlue Supplement applications can be signed and submitted in **Iowa.**
3 months prior to 65th birthday	• MedicareBlue Rx applications can be signed and submitted.
Month of 65th birthday	• **First day of birth month** — Earliest effective date available for enrollment in a MedicareBlue Rx and MedicareBlue Supplement plan (if 65th birthday is on the first, the effective date can be the first of the previous month).
3 months after month of 65th birthday	• Last month to submit MedicareBlue Rx applications. Part D plan applications must be signed and submitted by the end of the month to avoid a penalty. If the beneficiary does not enroll by the end of the third month, he/she won't be allowed to enroll in a plan until the next Annual Election Period (unless there is a SEP).
6 months after 65th birthday (or older) and/or Part B enrollment	• MedicareBlue Supplement applications must be submitted by end of the month to avoid answering health questions.

Medicare Supplement Initial Enrollment Period (IEP)
Acceptance is guaranteed during the six-month guaranteed enrollment period that begins the first day of the month the beneficiary is age 65 or older and enrolled in Medicare Part B (medical insurance).

MedicareBlue Rx Initial Enrollment Period If a beneficiary is newly eligible for Medicare, he or she qualifies for an Initial Enrollment Period (IEP). During the IEP, a beneficiary can enroll in a Prescription Drug Plan, a Medicare Advantage Plan or a Medicare Advantage Plan with Prescription Drug coverage, three months prior to, the month of, or three months after his or her 65th birthday, or after his or her 24th month of receiving disability benefits.

Marketing Guidelines

Using approved marketing materials

- Wellmark provides approved marketing materials for agent use. These can be found in the Wellmark Marketing Toolkit accessed through Producer Connection.
- Agents should verify that the materials they are using are still compliant by making sure they are identical to the material(s) posted on the Wellmark Marketing Toolkit. Marketing guidelines change frequently, so a previously approved piece may become obsolete at any time.
- CMS holds plans responsible for all activities of their agents and requires plans to monitor and control the materials being used by agents. This includes, but is not limited to, all materials, sales activities, and scripts used to facilitate a sale of a Wellmark Medicare product.
- Wellmark will provide you with the most up-to-date information on Insurance Division and CMS regulations and compliant marketing material availability through *Blue Briefings*.
- Contact your authorized agency with questions about the Medicare Marketing Guidelines.

Sales and marketing events — seminar guidelines

- Any presentation or seminar that includes *plan or carrier-specific information* is considered a sales and marketing event.
- All sales and marketing events must be formally filed with Wellmark 30 days in advance of the event. This can generally be done by reporting the event to your authorized general agency, who will then communicate this information to Wellmark. Wellmark must then file all sales and marketing events with CMS.
- Any presentation used at sales and marketing events must be filed and previously approved by CMS. If any advertising is used to promote the event, those materials must be filed and approved by CMS prior to use.

Meaningful Access and Non-discrimination

Remember to follow the Meaningful Access and Non-discrimination (MAND) guidelines when communicating with members. More information is available on Producer Connection.

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