Marketing/Sales Event Sample Verbiage

Marketing/Sales Event Sample Verbiage is one of several resources available to agents when conducting a formal marketing/sales event or meeting one-on-one with a consumer. These samples may help agents develop clear, simple, and compliant language to explain potentially complex and confusing concepts to consumers. While agents must explain many concepts and terms when presenting Medicare insurance options, the verbiage provided is not required, does not need to be read verbatim, and is not intended to be a script.

Note: Information in brackets "< >" indicate where you must insert plan specific or year specific information, such as the name of the plan you are presenting, dollar values or percentages, or have optional verbiage to consider.

Meeting Introduction

How do I say the required elements at the start of a formal marketing/sales event?

At the beginning of your event, you must provide your name, the name of the carrier you are representing, and the name and type of plan you will be presenting.
Note: Non-employee agents may also include the name of their agency.

Sample Verbiage:

Good morning, I am <*first name, last name*>, a licensed insurance agent representing UnitedHealthcare. Today I will present the <*exact name of plan, e.g., AARP® Medicare Advantage Plan*>, which is a <*plan type, e.g., Health Maintenance Organization, Preferred Provider Organization*>, or <*plan type abbreviation, e.g., HMO, PPO*> Medicare Advantage Plan.

At an in-person* event, how do I learn the make-up of my audience and how best to set up my meeting closure?

Get a sense of your audience by asking questions with a show of hands. The order of these questions is intentional and builds your recognition of who is attending in a way that leads to an effective meeting closure. Tailor the sample verbiage below to reflect your style and meet the needs of the consumers in attendance:

Sample Verbiage:

Now that you know more about me and our meeting today, I would like to know more about you, so I can best assist you as I go through the presentation today. If you are comfortable raising your hand:

- Who has their red, white, and blue Medicare card?
- All right, keep your hand raised if you are currently enrolled in a Medicare Advantage Plan.
- Keep it raised if you are enrolled in a UnitedHealthcare plan.
    - You want to identify current members in the room, who may have questions with their current plan. These questions are valuable however, to ensure a balanced discussion and give attention to consumers ready to enroll, we should manage the number of questions during the meeting. To manage the audience and stay on track, be sure to set clear expectations. Perhaps address current members:
        - Thank you for your business. Some of you may have questions specific to your current plan. I will be happy to address those items separately at the end of the meeting. **OR**
        - For those of you who have one of our plans, are you in need of having questions answered about your plan today?
    - Would you like to have your question answered now or would you like to attend the full meeting about our plans for this coming year?

      (Assumptions: 1. Meetings with high attendance are likely to have current members. 2. A second agent/sales leader will take this group to resolve issues in a breakout session. 3. Current members may be distracted from current plan information until they have answers.)
    - For those of you indicating you would like to hear about our plans for <20xx>, we will address your questions at the end of the meeting.
- Who lives in < *name of county*> county or in < *name of county*> county?
    - I noticed some of you did not raise your hand. Perhaps you are visiting the area and attending with a friend or relative. That is wonderful, I am glad you are here!

- You might want to add: The plan I am presenting today serves <*names of county/ies in the plan service area, e.g., Jackson and Washington*> county/counties. If you do not reside in this/these county/counties, I would be happy to discuss plans available in your area after the meeting.

- Who has coverage through an employee retirement program?
- Raise your hand if you currently have coverage through a spouse's work plan.
- How many of you expect that to change in the next 30 days? 90 days?
- How many people have considered making a decision to enroll today? **OR**
- How many people have already considered their options and are prepared to make a decision to enroll today?
- Thank you for sharing this important information!

When conducting an online event, asking consumers these questions may lead to disclosure of PHI/PII to other attendees (such as raising their hand or entering responses in chat) and is not recommended. To mitigate the risk of disclosure, consider rewording the sample verbiage if your goal is to get consumers to consider their individual circumstances when it comes to selecting a plan and/or timing their enrollment.

Plan Presentation – General Information about Medicare, Medicare Advantage, and Prescription Drug Plan

How can I describe when a consumer is eligible for Medicare?

Sample Verbiage:

You are eligible for Original Medicare--Parts A and B—if you are at least 65 years old, or you are under 65 and qualify based on a disability or another special situation, and you are a U.S. citizen or legal/permanent-resident who has lived in the United States for at least five consecutive years. There may be other situations in which you are eligible.

How can I describe when a consumer is able to enroll in a Medicare Advantage or stand-alone Part D Plan?

Sample Verbiage:

There are specific times when you can enroll in a Medicare Advantage or stand-alone Part D plan. Your Medicare Initial Enrollment Period occurs when you turn 65, or otherwise become eligible for Medicare. It begins three months before and ends three months after the month of your 65th birthday, giving you a seven-month window. If you have employer- or plan-sponsored coverage when you first become eligible, you generally will not need to enroll until you retire or otherwise lose that coverage.

The Annual Enrollment Period occurs annually from October 15 through December 7. During that time, you can add, drop, or switch your Medicare plan coverage.

The Medicare Advantage Open Enrollment Period occurs annually from January 1 through March 31. During this time, if you are enrolled in any type of Medicare Advantage plan, you can switch one time to another Medicare Advantage plan – even with a different carrier, or disenroll from your Medicare Advantage plan and go back to Original Medicare. If you go back to Original Medicare, you can enroll in a stand-alone Prescription Drug Plan even if your Medicare Advantage plan did not include drug coverage. Individuals that enroll in a Medicare Advantage plan using their Initial Coverage Election Period also have a Medicare Advantage Open Enrollment Period for the first three months they were eligible for Medicare Parts A and B.

In addition to those annual election periods, you may qualify for a **Special Election Period** if you:

- Retire and lose your employer coverage,
- Move out of the plan's service area,
- Receive assistance from the state or federal government (such as Extra Help, or gain (or lose) Medicaid coverage.,
- Have been diagnosed with certain qualifying disabilities or chronic health conditions, or
- Have other circumstances that qualify you for a Special Election Period.

I will help you use the election period that best suits your enrollment situation.

How can I review the Medicare insurance options a consumer might have?

Sample Verbiage:

It is important to review your choices when it comes to choosing Medicare coverage.

Step 1: enroll in Original Medicare when you become eligible.

Original Medicare--Parts A and B--covers some, but not all, of your hospital and medical expenses, and it does not include the cost of your prescription drugs.

Step 2: look at your needs and determine if you would like more coverage than Original Medicare.

You can add a Medicare supplement plan to Original Medicare to help cover some or all of the expenses not covered by Parts A and B for Medicare covered services.

You can also add a Part D plan to get prescription drug coverage.

Or, if you prefer, you can choose a Medicare Advantage plan, also known as Part C. Many Medicare Advantage plans include prescription drug coverage.

How can I explain Medicare Advantage?

Sample Verbiage:

Medicare Advantage is one single plan that combines Parts A and B and may include additional benefits and prescription drug coverage.

Medicare Advantage plans may offer you more coverage than Original Medicare. The payments we receive from Medicare help with the cost of the plan. Additionally, most Medicare Advantage plans have provider networks that provide covered services at a lower rate than if you see an out-of-network provider.

Plus, most Medicare Advantage plans may include one or more extra benefits that you would not get from Original Medicare, such as:

- Part D prescription drug coverage,
- Access to wellness programs,
- Gym membership discounts,
- Routine hearing, vision, dental coverage, and/or more.

Exact benefits will depend on the plans available in your area.

How do I explain that members of Medicare Advantage plans still belong in the Medicare program?

Sample Verbiage:

Even though Medicare Advantage plans are privately administered, Medicare Advantage plans must provide the same rights and protections as you would with Original Medicare.

Medicare Advantage plans must cover all Medicare-covered services and may offer additional benefits. It is important to know that hospice care is still covered under Medicare and not the Medicare Advantage plan.

Unlike Original Medicare, the Medicare Advantage plan's annual out-of-pocket maximum provides a safety net that limits the amount you will pay out-of-pocket in a plan year for Medicare-covered services.

How can I explain Special Needs Plans?

Sample Verbiage:

There are also Medicare Advantage plans for those with special needs:

- Dual-eligible plans for those with both Medicare and Medicaid;
- Chronic condition plans for those with ongoing medical conditions, like diabetes, cardiovascular disorders and/or chronic heart failure; and
- Institutional plans for those living in a contracted skilled nursing facility or who live in the community and meet level of care requirements.

I can explain these Special Needs Plans in more detail if you believe you might qualify.

How can I explain that Medicare Advantage and Medicare Supplement are different?

Sample Verbiage:

Medicare supplement plans are health insurance policies offered by private carriers with a variety of plan types and various benefits. Medicare supplement plans pay some or all expenses not covered by Original Medicare for Medicare covered services. Medicare Advantage plans combine Original

Medicare Parts A and B, and often Part D, into a single plan. Medicare Supplement plans cannot be used with Medicare Advantage plans.

How do I explain that members must continue to pay their Part B Premium?

Sample Verbiage:

In addition to any plan premium, you must continue to pay your Medicare Part B premium directly to Medicare. Medicare then applies your Part B premium to your Medicare Advantage plan to help pay for your additional coverage.

How do I explain that enrolling in a Medicare Advantage plan could affect the consumer's current coverage?

Sample Verbiage:

If you have existing coverage or employer-provided health insurance and plan to work past 65, check with your employer's plan administrator to see how enrolling in a Medicare Advantage plan would affect your coverage or covered family members.

For individuals already enrolled in a Medicare Advantage or stand-alone prescription drug plan, enrolling in a Medicare Advantage or stand-alone prescription drug plan will automatically disenroll you from your current plan.

How do I explain that many plans require the use of network providers?

Sample Verbiage:

Use of network health care and pharmacy providers may be required. Using providers outside of the network may cost you more. A new in-network provider may be chosen or you may have to pay some or all of the costs for benefits and services received outside of the network, depending on your plan. For HMO plans, you must use in-network providers to receive covered benefits except in emergencies. For PPO, RPPO and HMO-POS plans, you can use out-of-network providers for covered services if they accept Medicare and the plan, but it usually costs more than using in-network providers. Keep in mind that non-contracted providers are under no obligation to treat our members, except in emergency situations.

How do I explain Low Income Subsidy or Extra Help?

Sample Verbiage:

Depending on your financial situation, you may qualify for help paying your Part D plan premiums or the cost of your Part D medications. This is known as Extra Help. I can assist you with the Extra Help application process or you can apply for Extra Help through the Social Security Administration.

How do I explain the Late Enrollment Penalty?

Sample Verbiage:

If you go without Part D coverage for longer than 63 days in a row after your Initial Enrollment Period, an additional amount will be added to your Part D premium. This penalty is required by Medicare and is assessed regardless of what plan you have. Medicare Advantage plans that include Part D coverage meet Medicare coverage requirements. If it is determined you owe a Late Enrollment Penalty, Medicare will calculate the amount and that amount will be added to your monthly plan premium amount.

How do I explain that Medicare Advantage members must use their member ID card?

Sample Verbiage:

Medicare Advantage members must present their member ID card, not their Medicare card, when receiving plan services. The member ID card includes our customer service number. Keep your Medicare card in a safe place.

How do I explain Medicare Part D?

Sample Verbiage:

Prescription drug coverage is an important factor for many people when choosing a plan. I will be reviewing this in more detail, and this information is also included in your Clarity Guide.

- First, I will take a moment to clarify some terms. **Total drug cost** is the total amount you AND the health plan pay for your medications.
- **True out-of-pocket costs** are the amounts you (and others on your behalf) have paid for your Medicare-covered medications, which include any deductible, copayments, and coinsurance. It does not include your plan premium.

- Some plans have an **annual deductible** before drug coverage begins, other plans may have a deductible only for specific drugs, or no deductible at all.
- If your plan has an **annual deductible**, you pay the total cost of your drugs until you reach the deductible amount set by your plan.
- You then move into the **initial coverage stage**. During the Initial Coverage stage, you pay a copayment, a set dollar amount, or coinsurance, a percentage of the cost, for each prescription. Your plan pays the balance of the costs until what you and the plan have paid reaches <*$*>.
- Once your total out-of-pocket costs reach <*$*>, you move into the **catastrophic coverage stage**, where you only pay a small copayment or coinsurance amount, and the plan pays the balance. You stay in this stage until your policy renews on January 1. You'll pay $0 for Medicare-covered Part D medications in the Catastrophic phase.
- You can obtain your prescriptions at a **network pharmacy** simply by presenting your UnitedHealthcare member ID card.
- You may be able to receive discounts by using a **preferred retail pharmacy** or by using the **mail order pharmacy** service to have your prescriptions delivered right to your mailbox.
- Each plan has a list of covered drugs, called the **drug formulary**. Before enrolling in a plan, make sure any medications you are currently taking are covered by the plan.
- Many plans use **drug tiers** to group covered drugs according to cost. For example, the tier one group includes <*insert description here*>, tier two includes <*insert description here*>, tier three includes <*insert description here*>, tier four includes <*insert description here*>, and tier five includes <*insert description here*>.
- UnitedHealthcare wants to help you save money on your prescriptions. One way is by offering lower-cost drugs that can treat the same medical condition as your current drug. You may be asked to try one or more of these lower-cost drugs before the plan will cover the drug you are currently taking. This is called **step therapy**.
- If you need a drug that is not currently covered by your plan, you may ask the plan to cover your drug, even if it is not on the formulary. This is known as a **formulary exception**.

- Some drugs have **quantity limits**, where the plan will cover only a certain amount of a drug for one copayment or for a certain number of days. These limits may be in place to ensure safe and effective use of the drug. If your doctor prescribes more, or thinks the limits are not right for your situation, you or your doctor can ask the plan to cover the additional quantity.
- To make sure a drug is used correctly for a medical condition covered by Medicare, your doctor may be asked to provide more information before the plan covers it. You may be required to try a different drug before the plan will cover the one your doctor prescribed. This is known as **prior authorization.**
- You may also ask to waive coverage restrictions or limits on your drug. This is called a **utilization exception**.

How do I explain the Medicare Prescription Payment Plan?

Sample Verbiage:

- First, I would like to take a moment to explain how the Medicare Prescription Payment Plan works.
- Effective January 1, 2025, the Inflation Reduction Act requires all Medicare prescription drug plans (Medicare Part D plans) to offer this payment option, which includes both standalone Medicare prescription drug plans and Medicare Advantage plans with prescription drug coverage.
- The Inflation Reduction Act offers you the option to pay out-of-pocket prescription drug costs in the form of capped monthly installment payments throughout the year instead of all at once at the pharmacy.

How do I state the Star Rating for the plan I am presenting?

Sample Verbiage:

This plan, <*plan's name*>, received a Star Rating of <#> out of 5 stars from the Centers for Medicare & Medicaid Services, CMS. Medicare uses a five-star rating system to measure how well plans perform in different categories. These ratings help consumers and members compare plans based on quality and performance. CMS uses one to five stars to determine a plan's performance in a category; one star denotes poor quality, and five stars represent excellent quality. Find information about this plan's rating on page <##> of the plan's Enrollment Guide. You can find additional information at Medicare.gov.

How do I explain the consumer's right to submit an appeal or register a grievance?

Sample Verbiage:

Even though Medicare Advantage plans are privately administered, you still have the same rights and protections as with Original Medicare. As a member, you can refer to the Evidence of Coverage document for your plan to learn how to file an appeal, if you are having trouble getting the medical care or prescription drugs you think are covered by our plan, or a grievance, if you have a complaint about quality of care, waiting times, customer service or other concerns.

How do I explain the consumer's right to cancel their enrollment request or disenroll once they are in the plan?

Sample Verbiage:

If you change your mind about enrolling once your application is submitted, you should call the customer service number in the Enrollment Guide to request your application be cancelled. However, you must make that request prior to the plan effective date. Once your plan becomes effective, you can only disenroll if you have a valid election period, such as the Medicare Advantage Open Enrollment Period or a Special Election Period. All disenrollment requests must be made in writing.

Meeting Close

How do I give an 'Action Close'?

An action close might include immediate enrollment, one-on-one appointment, or providing attendees with the opportunity to share your contact information with others.

The following verbiage gives you some ideas of how to obtain positive outcomes at the conclusion of an in-person marketing/sales event. Tailor the sample verbiage to reflect your style and meet the needs of the consumers in attendance.

Sample verbiage:

Over the past hour, we have covered a lot of information related to your health care coverage planning decisions. When we started, I asked several questions, and some of you indicated you came today to make an enrollment decision. We are here to make sure we take care of that today.

Some of you may need an additional conversation to discuss very specific health care coverage planning needs. I am here to make sure to help you with that as well during a private appointment.

Others here today may already be thinking of their friends, neighbors, or family members they wish were here. Do others a favor by letting them know you attended this <*workshop, meeting, presentation etc.*> and share with them what you learned. You can take two specific actions: take my business card to share with others and please ask them to contact me.

For those who want to enroll, please meet <*me, other agents*> <*in the back of the room or place you or other agents will be located*>.

For those who want to set up a personal appointment to discuss your needs, please see me to set up an appointment for us to meet.

If you would like additional business cards to share with your friends, I will give those to you before you leave.

On behalf of UnitedHealthcare, I want to thank you for attending today. These are important decisions, and you have made a great decision to find time to learn more about your options. I am grateful for your interest and look forward to assisting you in making the plan selection that meets your needs!

When conducting an online marketing/sales event, an enrollment is not an available option. Tailor your action close to reflect the available options, which may include an electronic Permission to Contact form. If your online meeting hosting service (e.g., Zoom WebEx) has appropriate functionality to privately obtain an individual consumer's permission to contact, make sure you indicate providing their name and contact information is optional. Refer to other event resources for recommendations when constructing an online permission to contact form.

Contact

Direct questions related to using these samples to your local UnitedHealthcare Market Manager. Submit compliance-related question to Compliance_Questions@uhc.com.