Member Enrollment and Eligibility

NOTE: Enrollment and Member eligibility is distinctly different for Medicaid and Medicare Members. Therefore, the first part of this section is for Medicaid Providers; policies and procedures for Medicare enrollment and eligibility is located at the end of this section.

Medicaid Member Enrollment

Medicaid eligibility is determined by a consumer's County Department of Job and Family Services county case worker.

The Ohio Department of Medicaid (ODM) provides eligibility information to CareSource on a monthly basis. ODM also notifies CareSource of some eligibility changes throughout the month. (New Members are effective on the first of the month except for babies born to existing Members).

ODM also notifies CareSource of some eligibility changes throughout the month.

Medicaid Member ID Cards

All new CareSource Members receive a Membership ID card, which replaces the state Medicaid card. New CareSource ID cards are not issued monthly like the state Medicaid ID cards. A new card is issued only when the information on the card changes, if a Member loses a card, or if a Member requests an additional card.

The Member ID card is used to identify a CareSource Member; it does not guarantee eligibility or benefits coverage. Members may disenroll from CareSource and retain their previous ID card. Likewise, Members may lose Medicaid eligibility at any time. Therefore, it is important to verify Member eligibility prior to each service rendered.

Therefore, it is important to verify Member eligibility prior to every service.

Providers may use our secure Provider Portal on our website to check Member eligibility, or call our Provider Services Department.

Provider Portal: https://providerportal.caresource.com/OH/
Click on "Member Eligibility" on the left, which is the first tab.

Provider Services Department: 1-800-488-0134

Members are asked to present an ID card each time services are accessed. If you are not familiar with the person seeking care and cannot verify the person as a Member of our health plan, please ask to see photo identification.

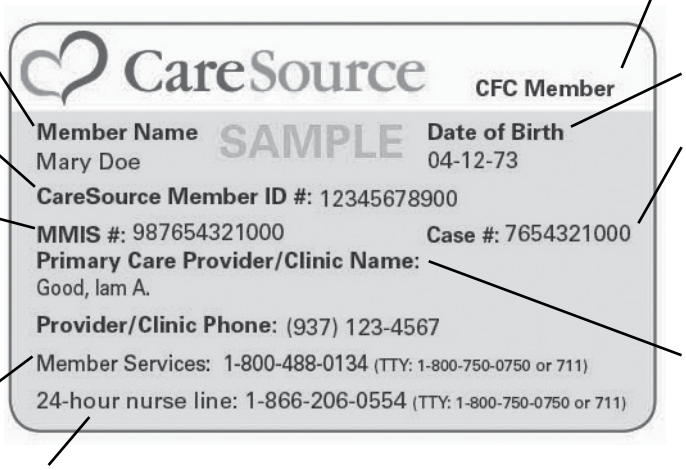
The Covered Families and Children (CFC) Member ID card is *light purple* and contains the following:

Member's Name

CareSource Member's ID #
Use this number on claims.

MMIS # *is the Member's State Medicaid ID number; please do not use this to bill CareSource.*

Member Services phone number *and TTY for the hearing impaired.*



Nurse Advice Line

Plan Identifier
Indicates the Member is CFC.

Member's Date of Birth

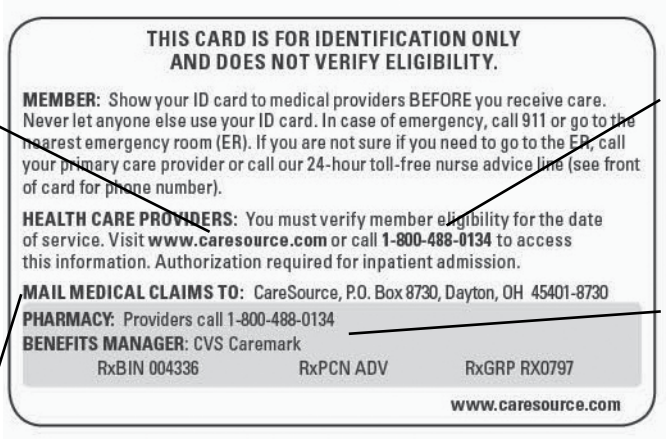
Case #
This number may be valid for multiple household Members. It is not the Member's ID number.

Primary Care Provider/Clinic Name
Members choose a participating Provider to be their Primary Care Provider (PCP). If a choice is not made, a PCP is assigned.

(Back of CFC Member ID card)

Website *— Our website contains plan information, as well as special functionality: verify eligibility, check claims and prior authorization status, submit a prior authorization, check COB and more.*

Send Paper Claims To



Provider Services
The toll-free phone number for Providers who have questions or wish to verify eligibility over the phone.

Pharmacy Information

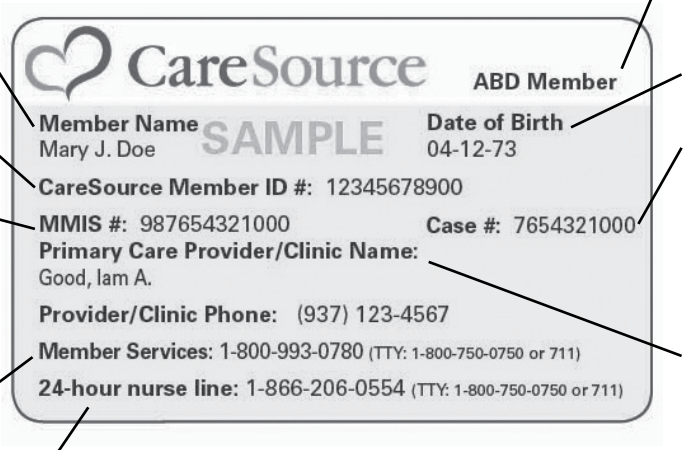
The Aged, Blind or Disabled (ABD) Member ID card is a *teal color* and contains the following:

Member's Name

CareSource Member's ID #
Use this number on claims.

MMIS # *is the Member's State Medicaid ID number; please do not use this to bill CareSource.*

Member Services phone number *and TTY for the hearing impaired.*



Nurse Advice Line

Plan Identifier
Indicates the Member is ABD.

Member's Date of Birth

Case #
This number may be valid for multiple household Members. It is not the Member's ID number.

Primary Care Provider/Clinic Name
Members choose a participating Provider to be their Primary Care Provider (PCP). If a choice is not made, a PCP is assigned.

(Back of ABD Member ID card)

Website *– Our website contains plan information, as well as special functionality: verify eligibility, check claims and prior authorization status, submit a prior authorization, check COB and more.*

Send Paper Claims To

THIS CARD IS FOR IDENTIFICATION ONLY
AND DOES NOT VERIFY ELIGIBILITY.

MEMBER: Show your ID card to medical providers BEFORE you receive care. Never let anyone else use your ID card. In case of emergency, call 911 or go to the nearest emergency room (ER). If you are not sure if you need to go to the ER, call your primary care provider or call our 24-hour toll-free nurse advice line (see front of card for phone number).

HEALTH CARE PROVIDERS: You must verify member eligibility for the date of service. Visit **www.caresource.com** or call **1-800-488-0134** to access this information. Authorization required for inpatient admission.

MAIL MEDICAL CLAIMS TO: CareSource, P.O. Box 8730, Dayton, OH 45401-8730

PHARMACY: Providers call 1-800-488-0134
BENEFITS MANAGER: CVS Caremark
RxBIN 004336 RxPCN ADV RxGRP RX0797

www.caresource.com

Provider Services
The toll-free phone number for Providers who have questions or wish to verify eligibility over the phone.

Pharmacy Information

Please note: CareSource may be notified by ODM that a Member has lost eligibility retroactively.

This occurs occasionally, and in those situations, CareSource will take back payments made for dates when a Member lost eligibility. The take-back code will appear on the next Explanation of Payment (EOP) for any impacted claims.

Medicaid Member Eligibility Verification

Before providing all services, EXCEPT emergency services, Providers are expected to verify Member eligibility.

- Log on to **www.caresource.com** and select **Provider Portal** from the menu options. Using our secure **Provider Portal**, you can check CareSource Member eligibility up to 24 months after the date of service.
- You can search by date of service plus any one of the following: Member name and date of birth, case number, Medicaid (MMIS) number, or CareSource Member ID number. You can submit multiple Member ID numbers in a single request.
- Call our automated Member eligibility verification system at **1-800-488-0134** from any touch-tone phone and follow the appropriate menu options to reach our automated Member-eligibility verification system. The automated system, available 24 hours a day, will prompt you to enter the Member ID number and the month of service to check eligibility.

Each month, Primary Care Providers (PCPs) can view a list of eligible Members who have chosen them or are assigned to them as of the first day of that month. The list also includes other important information, such as date of birth and indicators for patients who are due for a Healthchek exam (please review the "Member Support Services and Benefits" section of this manual). Log onto our secure **Provider Portal** to view or print your list.

Eligibility changes can occur throughout the month, and the Member list does not prove eligibility for benefits or guarantee coverage. Please use one of the above methods to verify Member eligibility on date of service.

Newborn Enrollment for CFC Members

Newborns whose mothers are Members of the CareSource CFC Medicaid plan on the newborn's date of birth, normally are covered by CareSource effective on their date of birth. The newborn will appear on the PCP's Member eligibility list after they are added to the CareSource system.

To verify eligibility for a newborn, please use the secure Provider section of our website at **www.caresource.com** and select "Provider Portal" from the menu options. Once you enter the mother's case number, you should be able to view all eligible Members of the household.

Member Disenrollment

Members may disenroll from CareSource for a number of reasons. If Members lose Medicaid eligibility, they lose eligibility for CareSource benefits.

Disenrollment may be initiated by the Member, CareSource or ODM.

Reasons for Member Disenrollment

- Unauthorized use of a Member ID card
- Use of fraud or forgery to obtain medical services
- Disruptive or uncooperative behavior to the extent that it seriously impairs the ability to provide services to the Member or others

Please notify the CareSource Care Management Department if any of the situations listed above occur. Review the "Member Support Services and Benefits" section for more information. Please see the section below for procedures for dismissing non-compliant Members from your practice. We can counsel the Member, or in severe cases, initiate a request to ODM for disenrollment. ODM will review each of our requests for Member disenrollment and determine if the request should be granted. Disenrollment from CareSource will always occur at the end of the effective month.

Disenrollment from CareSource will always occur at the end of the effective month.

Procedures for Dismissing Non-Compliant Members

Participating health care Providers can request that a CareSource Member be involuntarily dismissed from their practice if a Member does not respond to recommended patterns of treatment or behavior. Examples include: non-compliance with medication schedules, skipping scheduled appointments or failure to modify behavior as requested. Any time a Member misses three or more consecutive appointments, Providers are asked to notify our Care Management Department for assistance.

Any time a Member misses three or more consecutive appointments, Providers are asked to notify our Care Management Department for assistance.

CareSource requires that a Provider's office make at least three attempts to educate the Member about non-compliant behavior and document them in the patient's record. Please remember that CareSource's outreach staff can assist you in educating the Member. After three attempts, Providers may initiate the dismissal by following the guidelines below.

- The Provider office must notify the Member of the dismissal by certified letter.

- A copy of the letter must be sent to CareSource at the following address:
  Mail:
  CareSource
  Attn: Member Services Manager
  P.O. Box 1947
  Dayton, OH 45401-1947
  Fax: (937) 396-3095

For PCPs Only: The letter must contain specific language stating that:

- The Member must contact the CareSource Member Services Department to choose another PCP.
- The dismissing PCP will provide 30 days of emergency coverage to the patient from the date of dismissal.

Please call the CareSource Provider Services Department at **1-800-488-0134** if you have questions about disenrollment reasons or procedures.

Automatic Renewal of Membership

If CareSource Members lose Medicaid eligibility, but become eligible again within 60 days, they are automatically re-enrolled in CareSource and assigned to the same PCP if possible.

If CareSource Members lose Medicaid eligibility, but become eligible again within 60 days, they are automatically re-enrolled in CareSource and assigned to the same PCP if possible.

Member Enrollment and Provider Marketing

It is common for health care Providers to inform their patients about their affiliation with managed care plans. *Advocating enrollment in a specific health plan, however, is not permitted.* As a Medicaid health plan and a health insuring corporation licensed by the Ohio Department of Insurance (ODI), CareSource is responsible for upholding these laws. Through your contract with CareSource, you and your practice are required to comply with these regulations, as well.

Our licensed marketing representatives are available to visit your office and speak with patients about their option to join CareSource. They can also share ODM-approved materials for distribution at your office. In addition, they can help you with any questions regarding acceptable written educational materials and marketing materials.

Correspondence to any Medicaid participant that refers to your participation with CareSource must be approved in advance. Please contact your Provider Relations Representative, and if necessary we will submit your materials to ODM for approval on your behalf.

For your convenience, the sample Provider letters included on the next page have been approved by ODM for use with your patients. If you plan to use this sample letter, or need assistance with your correspondence as noted above, please contact your CareSource Provider Relations Representative.

Please remember that any materials CareSource may give to you for distribution in your office or facility are pre-approved by ODM. Please contact us if you would like a supply of CareSource brochures. Some of our materials may be available in other languages.

Sample CFC Provider Form Letter – Requires CareSource Review Before Using

IMPORTANT INFORMATION FOR FAMILIES THAT QUALIFY FOR:
COVERED FAMILIES AND CHILDREN MEDICAID, INCLUDING HEALTHY START AND HEALTHY FAMILIES

Dear Patient:

Thank you for choosing (Provider name) for your (type of care) care. We believe in providing quality (type) care for you and your entire family.

We are pleased to let you know that we are now accepting CareSource for those who qualify for Covered Families and Children Medicaid, including Healthy Start and Healthy Families. *(We are also affiliated with (other plan[s]).

CareSource is a managed care plan that serves Medicaid consumers in (region name) Region. CareSource contracts with the Ohio Department of Medicaid to provide comprehensive health care to families that qualify.

For information about your health care, please call us at (XXX) XXX-XXXX.

For information about CareSource, please call 1-800-488-0134
(TTY: 1-800-750-0750 or 711).

Sincerely,

_____
(Provider name)
*Sentence will be included if applicable

Sample ABD Provider Form Letter – Requires CareSource Review Before Using

IMPORTANT INFORMATION FOR FAMILIES THAT QUALIFY FOR:
AGED, BLIND OR DISABLED MEDICAID

Dear Patient:

Thank you for choosing (Provider name) for your (type of care) care. We believe in providing quality (type) care for you.

We are pleased to let you know that we are now accepting CareSource for those who qualify for Aged, Blind or Disabled Medicaid. *(We are also affiliated with (other plan[s]).

CareSource is a managed care plan that serves Medicaid consumers in

(region name) Region. CareSource contracts with the Ohio Department of Medicaid to provide comprehensive health care to individuals that qualify.

For information about your health care, please call us at (XXX) XXX-XXXX.

For information about CareSource, please call 1-800-993-0780
(TTY: 1-800-750-0750 or 711).

Sincerely,

_____
(Provider name)
*Sentence will be included if applicable

MEDICARE MEMBER ENROLLMENT AND ELIGIBILITY

CareSource Advantage® (HMO SNP)

CareSource Advantage® (HMO SNP) is a special needs health care plan committed to helping Members get the care they need. CareSource Advantage is a Coordinated Care Plan with a Medicare Advantage contract and a contract with the Ohio Medicaid program, available to those who are eligible for Medicare Part A and Part B, as well as full Medicaid.

Member Enrollment and Eligibility

The Centers for Medicare and Medicaid Services (CMS) determines eligibility for Medicare. CareSource verifies a Member's eligibility for Medicaid and Medicare Part A, and enrollment in Medicare Part B, before the applicant can be enrolled in CareSource Advantage. New Members are effective on the first day of the month.

The Centers for Medicare and Medicaid Services (CMS) determines eligibility for Medicare.

To be eligible to receive services through CareSource Advantage, a person must:

- Be entitled to Medicare Part A and enrolled in Part B
- Have full Medicaid benefits
- Not have end-stage renal disease (ESRD)
- Live in our CareSource Advantage service area (CareSource Advantage is available in all 88 counties in the state of Ohio)
- Choose CareSource Advantage during a valid election period
- Agree to the rules of the CareSource Advantage plan
- Continue to pay Medicare Part B premiums if not paid by Medicaid or another third party

Medicare Member ID Cards

Each new CareSource Advantage Member receives a Member ID card. As a person dually eligible under Medicare and Medicaid, a Member should present their CareSource Advantage ID card and their Medicaid Fee-For-Service (FFS) ID card when receiving all health care services.

(continued)

An ID card for CareSource Advantage is issued when a Member joins CareSource. Members can continuously use the same CareSource Advantage ID card as long as they maintain eligibility. CareSource will issue a new ID card only when the information on the card changes, if a Member loses a card, or if a Member requests an additional card. Because ID cards do not guarantee eligibility, Providers must verify a Member's eligibility on each date of service.

Billing CareSource Advantage
Members should not present their red, white and blue card for Original Medicare. If a CareSource Advantage Member uses their red, white and blue Medicare card instead of their CareSource Advantage card and you bill the Medicare program instead of CareSource, the Medicare program will not pay for these services.

Please bill CareSource for the Medicare portion of services. CareSource is the primary payer for CareSource Advantage Members, and Medicaid FFS is the secondary payer. After you receive payment from CareSource, if the service is eligible for any additional payment through Medicaid, you must bill Medicaid FFS for the unpaid balance.

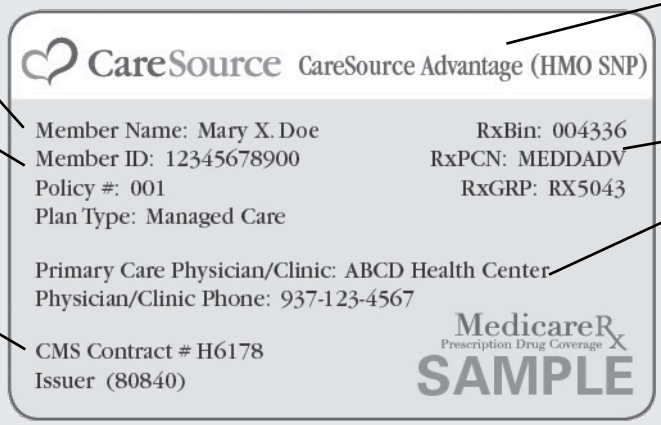
Members are asked to present a CareSource ID card each time services are accessed. If you are not familiar with the person seeking care as a Member of our health plan, please ask to see photo identification. If you suspect fraud, please contact our Special Investigations Unit by calling **1-800-488-0134** and follow the appropriate menu options to report fraud.

The CareSource Advantage Member ID Card:

Member's Name

Member ID Number
This CareSource ID number should be used on claims.

CMS Contract #
The CMS number for the Ohio CareSource Advantage plan.



Plan Identifier
Indicates CareSource Advantage Member.

Pharmacy Benefit Manager
CVS Caremark

Primary Care Provider's Name and Phone Number
Members choose a participating Provider to be their Primary Care Physician (PCP). If a choice is not made, a PCP is assigned.

(continued)

The back of the CareSource Advantage Member ID Card contains the following information:

Provider Services
The toll-free phone number for Providers who have questions or wish to verify eligibility over the phone.

Pharmacy Help Desk: Information About Our Pharmacy Program

Send Paper Claims To


MEMBER CONTACT INFORMATION:
Member Services: 1-800-708-8729 (TTY: 1-800-750-0750 or 711)
24-hour toll-free nurse advice line: 1-866-206-0569 (TTY: 1-800-750-0750 or 711)
In case of an emergency, call 911 or go to the nearest emergency room.

PROVIDER CONTACT INFORMATION:
Provider Services: 1-800-488-0134
Eligibility verification: www.caresource.com
Providers must verify eligibility for date of service.
Authorization is required for inpatient admission.
Pharmacy questions: 1-888-527-0014

MAIL MEDICAL CLAIMS TO:
CareSource
P.O. Box 8730
Dayton, OH 45401-8730

MAIL PHARMACY CLAIMS TO:
CVS Caremark
P.O. Box 52066
Phoenix, AZ 85072-2066

Nurse Advice Line

Website
Our website contains information about CareSource Advantage as well as special functionality: verify eligibility, check claims and prior authorization status, submit a prior authorization, check COB and more.

The Pharmacy Benefit Manager for CareSource Advantage is CVS Caremark. Please refer to the CareSource website, **www.caresource.com**, for the most current information.

The Member ID card is used to identify CareSource Advantage Members. Because Member ID cards do not guarantee eligibility, we encourage Providers to visit our secure **Provider Portal** to view up-to-date Member eligibility information. Providers can also call our Provider Services Department at **1-800-488-0134** and follow the appropriate menu options to use our automated Member eligibility verification system. Members must be eligible with CareSource Advantage on the date of service in order for services to be covered.

Member Eligibility Verification

To verify Member eligibility, please use one of the following methods:

- **Provider Portal:** Log on to **www.caresource.com** and select Provider Portal from the menu options. You can check CareSource Member eligibility up to 24 months after the date of service on our Provider Portal. You can search by date of service plus any one of the following: Member name and date of birth, Medicare number or CareSource Member ID number.
- **Phone:** Call **1-800-488-0134** and follow the appropriate menu options to reach our automated Member eligibility verification system 24 hours a day. The automated system will prompt you to enter the Member ID number and the month of service to check eligibility.

PCPs can obtain a monthly list of eligible members who have chosen them or were assigned to them from the CareSource Provider Portal. This list does not prove eligibility for benefits or guarantee coverage. Please use one of the above methods to verify Member eligibility. Log onto our Provider Portal to view or print your list.

(continued)

All health care Providers should always verify Member eligibility before rendering services except in an emergency. This helps prevent unpaid claims.

Medicare Member Disenrollment

A Member may request disenrollment at any time, for any reason, by notifying CareSource Advantage. Refer Members to the CareSource Ohio Advantage Member Services Department at **1-800-708-8729** if they need information on disenrollment. The Member's termination of enrollment will take effect on the first of the month following the receipt of this written request by CareSource Advantage. Members are advised to continue to use their CareSource Advantage ID card and to coordinate all services through their PCP until their disenrollment becomes effective.

If you learn that a Member plans to disenroll, you may avoid payment delays by reminding the Member to notify CareSource Advantage, and validating eligibility with CareSource Advantage on the date of each visit.

CareSource Involuntary Termination

Each Member's enrollment is generally in effect as long as the Member retains eligibility and chooses to stay with CareSource Advantage. The Plan cannot and will not terminate a Member because of the amount or cost of services.

CareSource can terminate Members with CMS's approval for the following:

- If the Member loses entitlement to Medicare Part B coverage
- If the Member loses entitlement to Medicare Part A coverage
- If the Member loses entitlement to Medicaid coverage for more than 90 consecutive days
- If the Member permanently moves or resides outside the service area
- If the Member is temporarily absent from the service area for more than six consecutive months
- If the Member is incarcerated
- If the Member has committed fraud
- If the Member has abused the CareSource Plan Beneficiary ID card and/or benefits
- If the Member has demonstrated disruptive behavior that interfered with care for the Member or others

Please notify CareSource if any of the situations listed above occur so we can discuss the disenrollment request with the Member and, if necessary, initiate a request to CMS for Member disenrollment. CMS will review all cases and determine whether or not the Member should be disenrolled from CareSource Advantage, but Members have the right to appeal the cancellation of coverage.

(continued)

Procedures for Dismissing Non-Compliant Members

Participating health care Providers can request that a CareSource Advantage Member be involuntarily dismissed from their practice if a Member does not respond to recommended patterns of treatment or behavior. Examples include non-compliance with medication schedules, no-show office policies, or failure to modify behavior as requested. Any time a Member misses three or more consecutive appointments, Providers are expected to notify our Care Management Department for assistance.

It is strongly recommended that your office make at least three attempts to educate the Member about non-compliant behavior and document them in the patient's record. Please remember that CareSource's outreach staff can assist you in educating the Member. After three attempts, Providers may initiate the dismissal by following the guidelines below.

Please remember that CareSource's outreach staff can assist you in educating the Member.

- The Provider office must notify the Member of the dismissal by certified letter.
- A copy of the letter must be sent to CareSource at the following address:

  Mail:
  CareSource
  Attn: Member Services Manager
  P.O. Box 1947
  Dayton, OH 45401-1947

  Fax: (937) 396-3095

For PCPs only, the letter must contain specific language stating that:

- The Member must contact the CareSource Advantage Member Services Department to choose another PCP.
- The dismissing PCP will provide 30 days of emergency coverage to the patient from the date of dismissal.

Please call the Provider Services Department at **1-800-488-0134** if you have questions about disenrollment reasons or procedures.

If a Medicare Member Loses Medicaid Eligibility

If a CareSource Advantage Member loses Medicaid eligibility, but retains their Medicare eligibility, CareSource will continue to cover their Medicare benefits for up to 90 days.

Member Enrollment and Provider Marketing

It is common for health care Providers to inform their patients about their affiliations with managed care plans. However, advocating enrollment in a specific health plan is unacceptable according to the CMS Medicare Marketing

(continued)

Guidelines. CMS allows Providers to discuss participation under specified circumstances.

CMS holds plans responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting Providers. The plan sponsor must ensure that any Providers contracted (and its subcontractors, including Providers or agents) with the plan sponsor comply with the requirements outlined in the Medicare Marketing Guidelines.

The plan sponsor must ensure that any Providers contracted (including subcontractors or agents) with the plan sponsor to perform functions on their behalf related to the administration of the plan benefit, including all activities related to assisting in enrollment and education, agree to the same restrictions and conditions that apply to the plan sponsor through its contract. In addition, the plan sponsor (and subcontractors, including Providers or agents) are prohibited from steering, or attempting to steer an undecided potential enrollee toward a particular Provider, or limited number of Providers, offered either by the plan sponsor or another plan sponsor, based on the financial interest of the Provider or agent (or their subcontractors or agents). While conducting health screenings, Providers may not distribute plan information to patients since both activities are prohibited marketing activities.

Provider Marketing

Providers should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions. Providers may not be fully aware of plan benefits and costs, and it's important that beneficiaries receive the right information needed to make an informed decision about their health care options.

Providers should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions.

It is Inappropriate for Providers to be Involved in any of the Following Actions:

- Offering sales/appointment forms.
- Accepting Medicare enrollment applications.
- Making phone calls or directing, urging or attempting to persuade beneficiaries to enroll in a specific plan based on financial or any other interests.
- Mailing marketing materials on behalf of plan sponsors.
- Offering anything of value to induce plan enrollees to select them as their Provider.
- Offering inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Accepting compensation directly or indirectly from the plan for beneficiary enrollment activities.
- Distributing materials/applications within an exam room setting.
- Health screening is a prohibited marketing activity.

(continued)

Providers Contracted with Plan Sponsors (and their Contractors) are Permitted to Do the Following:

- Provide the names of plan sponsors with which they contract and/or participate.
- Provide information and assistance in applying for the low income subsidy.
- Make available and/or distribute plan marketing materials including Provider affiliation materials for a subset of contracted plans only as long as Providers offer the option of making available and/or distributing marketing materials from all plans with which they participate. CMS does not expect Providers to proactively contact all participating plans to solicit the distribution of their marketing materials. Rather, if a Provider agrees to make available and/or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plan sponsors with which it participates. To that end, Providers are permitted to:
  - Provide objective information on plan sponsors' specific plan formularies, based on a particular patient's medications and health care needs.
  - Provide objective information regarding plan sponsors' plans, including information, such as covered benefits, cost sharing and utilization management tools.
  - Make available and/or distribute PDP enrollment applications, but not MA or MA-PD enrollment applications for all plans with which the Provider participates.
- Refer their patients to other sources of information, such as SHIPS, plan marketing representatives, their State Medicaid Office, local Social Security Office, the CMS website at **http://www.medicare.gov** or 1-800-MEDICARE.
- The "Medicare and You" Handbook or " Medicare Options Compare" (from **http://www.medicare.gov**), may be distributed by Providers without additional approvals.

There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plan sponsors and Providers without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries. Plan sponsors should advise contracted Providers of the provisions of these rules.

NOTE: A Provider should not attempt to switch or steer plan enrollees or potential plan enrollees to a specific plan or group of plans to further the financial or other interests of the Provider.