CMS & Medicare Advantage Organizations Marketing/Compliance Rules & Regulations

Marketing

These regulations & guidelines include, but are not limited to, ensuring that the materials do not mislead, confuse, or provide materially inaccurate information to current or potential enrollees. Agents/Agencies are responsible for ensuring that "***ALL***" materials, whether ***communications*** or ***marketing***, meet these requirements.

- Recently CMS issued clarification guidance on the definition of marketing and what types of advertising would fall under this definition. Content that includes or mentions any type of benefit covered by the plan and is intended to draw a beneficiary's attention to a plan or plans, influences a beneficiaries decision-making process when selecting a plan, or influences a beneficiary's decision to continue enrollment in a plan (retention-based marketing) is considered marketing. CMS further clarified, content that beneficiaries can receive such as dental, vision, cost-savings, and/or hearing services is sufficient information about plan benefits, benefits structure, or cost sharing to meet the content standards in the definition of marketing in 422.2260 and 423.2260. The use of these types of statements in advertisements and activities directed to Medicare beneficiaries clearly meets the intent standards. "***Any***" material or activity that is distributed via any means (e.g. mailing, television, social media etc.) that mentions any benefits will be considered marketing and requires upline, carrier, and CMS approval. Prior to final submission through the CMS HPMS system and approval process all material must have an opt-in status from a carrier/Lead Plan Sponsor (LPS).

If you are unsure if a piece is marketing versus communication, please submit the piece through our online submission tool. Also, all marketing material for review/approval process should be submitted through the same link. In the who is the intended audience section please let us know what type of approval you are seeking with any other details you feel are important to help us with our determination. ***A sampling of materials determined to be communications may be requested periodically for auditing purposes.***

- https://www.hfgagents.com/online-marketing-submission/
    - *See Review Process Requirements for further details on format after initial submission*

Materials That Need Review/Approve Process

CMS has also expanded the definition of television media types will also include social media videos. In addition to the normal upline and LPS approval CMS has implemented an additional 45-day review/approve timeframe for CMS approvals. Depending on content and number of revisions required prior to CMS submission this process will take 75 days before you would receive final approval.

- All materials that meet the definition of Marketing
- Prior to use/distribution agents/agencies are required to submit all marketing, telephonic scripts and select communications (e.g., television commercials, online videos, customized permission-to-contact forms both print and electronic) for review and approval prior to use.
- In addition, all MA tele marketed generated leads (scripts & ads), in bound live call transfer (scripts, ads, landing pages), enrollment scripts, business-reply-cards (BRC's), and any plan comparison materials or websites must be CMS approved prior to use.
- Agents/Agencies that use or purchase leads from a lead aggregator/vendor, must submit "all" lead aggregator/vendor marketing, communications, PTCs, BRCs used to generate the lead for review and approval prior to lead collection.
- If materials meet the marketing standards defined by CMS HFG will assign a SMID# that is unique to each piece or website for CMS file/approve status

When Working With Provider Offices/Networks For Grass Roots Marketing:

- If any of your materials mention or involve healthcare provider, the material must be submitted for approval by LPS prior to use. Most carriers require a "**Provider Intake Form**" to be completed with the material being reviewed.
    - *Best Practices when working with providers, use stock images and never show a specific provider or clinic. Any associated material text or voiceover for TV or SM ads should only describe only clinical, or educational information, and should not promotes the agent/agency, specific plans, or their covered services.*
- If material is co-branded with another entity, or mailed to clients of another entity, such as a bank, financial advisory firm, insurance company, non-profit organization or any other entity that is not currently with the agent/agency current book-of-business a completed "**Other Entity Intake Form**" must be completed with the submission for material review.

Review Process

To help expedite the process during the review process be sure to do the following:

- When submitting Multiplan marketing or communications (can be used with multiple carriers) that contain carrier logo, brand name, plan information, or reference providers a completed intake form must be completed which includes a detailed description of provider, dates/year/selling season the material will be used. Missing or incomplete information will cause a delay with carrier/legal review of materials.
- Lead sources or forms including Television commercials and Social Media videos that may be communications must be submitted to LPS for review prior to use and collection of leads.
- *Content for carrier approval must be submitted in a proofread editable Word document format including any changes since last review redlined in tracking mode. Images/mock-ups/PDFs/Screen grabs should also be provided for visual reference. However, all verbiage content must be typed into Word. Images or PDFs of images containing text will not be accepted by carrier compliance/legal review departments. Editing non-Word formats causes significant delays to the process. For websites, the process flow must be described, and screen grabs must be included on the Word document in addition to the verbiage typed in Word. Include the URL, SMID# (if assigned) and summarize any changes (if previously reviewed) at top of page.*

- If a carrier logo is used, you must include images of the logo use/placement in context with the content. Carrier logo use requires prior approval from each carrier in writing.
- Wording cannot be adjusted or altered after filing without being redlined for changes and resubmitted for review/approve use.
- Marketing content that meets the CMS definition undergo both compliance and legal review at the LPS. Some rules on usage, branding, and logo size/placement may differ from carrier to carrier.
- Each submitted marketing piece should be in a final, completed, edited from utilizing all the required language, guidelines, and disclaimers.
- Plan your marketing strategy in advance and allow time for the approval process prior to needed/distributed date. Expedited request due to a lack of pre-planning or processing times may not be honored.

Standardized Material Identifiers (*SMID*)

SMID's are a unique, nontransferable identifying system that is used to identify CMS reviewed/approved marketing materials. Each SMID contains certain identifiable information to link each approved piece to the year approved, agency, type of marketing, and campaign number. SMID is the first thing CMS/ LPS, and secret shoppers look for when identifying marketing that is being used. SMID must be clearly displayed on any sales & marketing pieces, and websites that meet the TPMO Generic Marketing threshold.

Expectations for SMID Usage:

- SMID will appear on all marketing materials including websites once approved prior to use/distribution
- SMID will not be transferred or appear on materials that have "**not**" undergone formalized review/approval process
- Once material is approved, and a SMID is issued, material will remain unchanged unless submitted through the review/approve process again
- Any marketing material used that draws awareness to a product/company/contract through HFG and meets the criteria referenced in Section 1.1 must be submitted for review/approve process

The SMID should be on all materials with the exception of:

- **Envelopes**
- **Radio Ads**
- **Outdoor Advertisements**
- **Banners**
- **Banner-like Ads**
- **Social Media comments and posts**

The exceptions of SMID display on the referenced items above do not circumvent the review/approve process. If the material above meets the TPMO threshold and is considered marketing the material must go through the review/approve process. The exception "***only***" pertains to the display of the SMID on approved materials. However, the SMID must be provided upon request within a two business day period including any documentation on the approval, intended audience, length of approval time. E.g., AEP, OEP, Contract Year, or Evergreen

Required Disclaimer & Usage

CMS has "***updated"*** the required Third-Party-Marketing-Organization (TPMO) disclaimer.

- **If an agent/agency does "not" sell all available MA organizations and/or Part D sponsor in the service area the disclaimer statement is**: "We do not offer every plan available in your area. Currently we represent [insert number of organizations] organization which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options."

- **If an agent/agency does sell all available MA organizations and/or Part D sponsor in the service area the disclaimer statement is:** "Currently we represent [insert number of organizations] organization which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) for help with plan choices."

Disclaimer Usage:

1. *Verbally conveyed within the first minute of a sales call*
2. *Electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication.*
3. *Prominently displayed on agent/agency websites and*
4. *Included in any marketing materials, including print materials, television advertisements, social media videos, developed, used, or distributed by the agent/agency*
5. *The disclaimer may not be changed or modified in any way other than [bracketed info]*

Lead Generation

Agents/agencies are responsible for ensuring all lead sources used to solicit Medicare Products are compliant and meet CMS guidelines, carrier policies/procedures, and all state or federal laws, rules, and regulations. Agent/agencies must also ensure the process of obtaining the lead and the outreach is compliant. To ensure you are meeting this guidance with current and future vendors please utilize the HFG provided compliance department materials and online submission review methods.

Lead sources must abide by all CMS sales, communication, and marketing requirements.

For example:

- Cannot require age, date of birth, and health status questions on lead forms and websites used to generate MA/PDP leads
- Spouse information must clearly be marked as "**optional**"
- Ensure prospect is clearly informed and it is prominently displayed that completing and submitting the form will result in call(s) from a licensed sales agent(s)
- Business Reply Cards (BRC) and Permission to Contact (PTCs) expire after 12 months following the beneficiary's signature date
    - ***Do Not Call (DNC) policy is different than (PTC) a 12-month PTC window does not supersede the 90-day contact window for those registered on the National DNC list***

Agents/agencies when conducting lead generating activities must disclose to the beneficiary that his or her information will be provided to a licensed sales agent for future contact. The disclosure must be provided:

- *Verbally when communicating with a beneficiary through the telephone*
- *In writing when communicating with a beneficiary through mail or other forms of print material*
- *Electronically when communicating with a beneficiary through email, online chat, or other electronic messaging platforms*
- *Lead generation that requires call to be transferred must disclosure to caller they will be transferred to a licensed sales agent that can help enroll them into a new plan.*

Anti-Discrimination

Agents/agencies may "**not**"

- Discriminate based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, or geographic location.
- Engage in any discriminatory activity such as targeting potential enrollees from higher income areas, stating, or implying that plans are only available to senior rather than to all Medicare beneficiaries, or stating or implying that plans are only available to Medicaid beneficiaries unless the plan is a Dual Eligible Special Needs Plan (D-SNP) or Medicare Medicaid Plan.
- Target potential enrollees based on income levels unless it is a dual eligible special needs plan or comparable plan
- Target potential enrollees based on health status unless it is a special needs plan or comparable plan
- Deny, limit, or condition the enrollment into a Medicare Product based on any factor related to health status, including, but not limited to:
    - Medical condition(s), including both mental and physical
    - Claims experience
    - Receipt of health care
    - Medical history
    - Genetic information
    - Evidence of insurability, including conditions arising out of acts of domestic violence

Disability

Agents/agencies must ensure questions and language used in lead forms, plan comparisons, sales, and enrollment processes/scripts, do not directly, or indirectly, request or require this information.

All beneficiaries must have an equal opportunity to enroll in Medicare Products, whether the beneficiary requests accessible formats or alternate languages. Agents/agencies are required to provide information to beneficiaries in alternate languages or accessible/alternate formats, upon the beneficiary's request.

- ***Carrier and plan specific marketing materials and their alternates can be obtained via each carrier website***

Agent/agency materials that are plan specific and/or carrier branded, or that exclusively reference a carriers Medicare plan, must include the anti-discrimination notice. These notices can be obtained via the carrier website or from the local carrier market representative. The following material do "**not**" require the anti-discrimination notice:

- Radio or Television ads
- ID Cards
- Appointment/business cards
- Banner/banner-like ads
- Envelopes
- Outdoor advertising such as billboard ads

Unsolicited Contact

- Prohibited activities include door-to-door solicitation, approaching beneficiaries in common areas, outbound solicitation (cold calling), and calls to confirm receipt of mailed information
- Unsolicited door-to-door contact is prohibited. Agents/agencies must have an appointment at the beneficiary's home with applicable date/time/SOA and was previously scheduled at least 48 hours in advance. **The only exception to the 48-hour rule are walk-ins to an office and the last 4 days of a valid election period.**
- Unsolicited calls about other business even other health related products as a means of generating leads for Medicare plans are strictly prohibited. E.g., Bait and switch strategies pitching dental plans or life insurance to start a Medicare conversation on a Non-Medicare Advantage lead.
- Agents/agencies are only permitted to contact beneficiaries who have given their permission for a MA organization of agents/agencies to contact them regarding Medicare Advantage products through a completed BRC or PTC form
- Outbound contact based on referrals is prohibited
- Outbound contact to beneficiaries who attend an event is prohibited unless the beneficiary gave express, documented permission to contact

Email Communications

- Agents/agencies may initiate unsolicited email contact with potential enrollees but "must" provide an opt-out process on each communication for those who no longer wish to receive emails. Emails "**must**" include an Unsubscribe link.
    - Bulk/group email blast for MA lead generation should have a documented process that adhere to CAN-SPAM guidance
    - If phone numbers are provided with list and DNC scrubbed you are prohibited from calling unless the beneficiary request a call back/additional information as this would be considered an unsolicited contact. You should be familiar with the rules and laws that cover the calling area as some states have more stringent guidance than what is outlined in the federal DNC policy.
    - Text messaging and other forms of electronic direct messaging (e.g., social media platforms) would fall under unsolicited contact and are not permitted
- Once a beneficiary has utilized the opt-out option, agents/agencies are responsible for ensuring that the beneficiary no longer receives emails or other electronic communications.

Permission To Contact

- Permission Contact (PTCs) and Business Reply Cards (BRC) are only valid for the 12 months following the beneficiary's signature date.
- TCPA guidelines, when requesting contact information from a consumer, agents/agencies must, at a minimum, disclose in a readable font that:
    - Call may be made by auto dialer, text, or robocall
    - Calls are for marketing purposes
    - Cellular carrier charges may apply
    - Providing permission does not impact eligibility to enroll or the provision of services, and
    - The consumer can change permission preferences at any time by contacting the agent/agency
- Additionally, it must be made clear up-front above the contact information fields that the respondent will be connected with a "licensed insurance agent" or "licensed sales agent"

Do Not Call (DNC**)**

Who is affected by these rules:

- *Any company/caller that places calls or sends text messages for marketing or sales purposes*

What can you do to protect yourself and your business from this?

There are provisions that have been implemented to protect callers and minimize violations. However, certain requirements must be met and maintained to enjoy the protections these policies afford. The Do Not Call (DNC) Safe Habor consist of having processes and procedures in place to comply with the DNC rules and being able to prove compliance adherence. The FTC and FCC recognize Safe Harbor as a defendable position. Both agencies (FTC & FCC) have demonstrated that the provisions of the Safe Harbor defense are strictly interpreted and enforced.

What is needed:

- *Have in place a written Do-Not-Call policy and compliance guide: the policy should include, but not limited to, how to handle and process DNC requests from consumers. The policy must be ready and made available on demand/request.*
- *Ongoing employee training and oversight: companies are required to train their employees in all written procedures and keep/maintain records of all training. Furthermore, all employes as a "condition of employment or continued employment" must attend the training and attest that they have read, understand, and agree to the polices rules and regulations.*
- *Maintain an internal company specific Do Not Call list: maintain a record list of all telephone numbers & names that your organization may not contact. Also, have in place a documented process to prevent telephone solicitations to the numbers on your company's internal DNC list. All DNC requests should be honored as soon as possible, but no later than 30 days after the initial request.*
- *Required purchase & use of the federal, state and any other DNC lists: The national DNC list must be purchased, downloaded, and scrubbed against every 31 days. The 12 state DNC lists must be purchased and downloaded according to the frequency required by each individual state. The wireless lists require telemarketers to abide by the wireless rules within 15 days after a wireless number has been ported from a wire line.*
- *Monitor & enforce compliance: Companies are required to monitor compliance, including 3rd parties acting on their behalf. Records of all compliance programs, audits and activity should be retained and archived, to prove due diligence. Any enforcement actions of violations should be well documented along with any corrective action plan (CAP) and its completion.*
- *Observe calling time restrictions: No calls to a person's home outside of the hours of 8 a.m. and 9 p.m. local time at the location called.*

To claim Safe Harbor while using a predictive or auto dialer:

- *Use technology that ensures abandonment of no more than three percent of all calls answered by a live person, measured over the duration of a single calling campaign, if less than 30 days, or separately over each successive 30-day period or a portion thereof that the campaign continues. Call abandonment: abandoned calls typically occur while using a predictive dialer or other similar types of autodialing equipment. Under TSR rules a call is considered abandoned if a call is not connected to a representative within two seconds of a completed greeting. Greetings that are fully automated and recorded, that have a sales pitch imbedded into the recording, violate the TSR automatically because it does not connect the person called within two seconds to a representative.*

- *Allows the telephone to ring for 15 seconds or four rings before disconnecting an unanswered call. These are considered early hang-ups. Safe Habor ensures that consumers have a reasonable amount of time to answer a call.*
- *Plays a recorded message stating the name and telephone number of the caller on whose behalf the call was placed whenever a live representative is unavailable within two seconds of a live person answering the call.*
- *Maintains records documenting adherence to the four requirements above related to dialers as well as the six elements contained in the "what's needed" section.*

It is up to each 1099 contracted agent/agency to implement their own policy and procedures as it relates to the "Do Not Call" list and removal process. However, at a minimum your policy should consider each element outlined above and incorporate them into a formalized documented process.

(Sample) <u>Do Not Call Policy</u>

If you don't want to receive sales calls from <agent/agency>, you can ask us to place your telephone number on our "Do Not Call" list. In compliance with federal and state laws, we'll document your request immediately. Please allow up to 30 days for your telephone number to be removed from any sales programs that are currently underway.

- Your request can be in writing or by phone, and must include, at a minimum, your telephone number.
- If you have multiple telephone numbers, tell us all the numbers you would like included.
- You'll remain on our "Do Not Call" list for five years unless you ask to be removed.
- If your telephone number ever changes, you must give us your new information for your "Do Not Call" status to remain in effect.

When we solicit/market to prospective new customers, we also honor "Do Not Call" requests on behalf of consumers listed on the National Do Not Call Registry maintained by the Federal Trade Commission and various state-agency lists. Many state "Do Not Call" regulations permit companies to contact their own customers even though they are on the "Do Not Call" lists. Therefore, if you are a customer, you may be contacted by us even though you are on a state or the national "Do Not Call" list. If you do not want to be contacted by <agent/agency> even though you are a customer, simply follow the steps above to be placed on the <agent/agency> "Do Not Call" list and your request will be honored.

Being on the <agent/agency> "Do Not Call" list means that you won't receive sales calls by anybody representing <agent/agency>. We may still contact you, however, for non-solicitation purposes. This would include like things surveys, billing, and other service-related matters.

All employees that engage in outbound telephone solicitation are trained in this policy and are made aware of these procedures before they are allowed to place calls to consumers. Management reviews the policy with these employees on a regular basis. The methods and procedures in this "Do Not Call"

policy is reviewed by <agent/agency> on a quarterly basis. If a consumer requests a copy of our "Do Not Call" policy, we will send a copy via U.S. mail or electronic mail. The "Do Not Call" policy is also posted on our <agent/agency> website.

Prohibition on Open Enrollment (OEP) Marketing

Agents/agencies are prohibited from "**knowingly**" targeting or sending unsolicited marketing materials to any beneficiary during the Open Enrollment Period (OEP) (January 1 to March 31).

*During the OEP, agents/agencies "**may**":*

- Conduct marketing activities that focus on other Special Enrollment Period opportunities, such as new to Medicare, 5-star plans, marketing to Dual-eligible Special needs plans
- At the request of the beneficiary, have one-on-one meetings with a sales agent, send marketing materials or provide information on the OEP
- Include educational information, excluding marketing, on their website about enrollment periods, including the existence of OEP, as long as it is educational in nature, and a call to action is "**not**" present

*During the OEP, agents/agencies may "**not**":*

- Send unsolicited materials advertising the ability/opportunity to make an additional enrollment change or referencing the OEP
- Specifically target beneficiaries who are in their OEP because they made a choice during the Annual Enrollment Period (AEP) by purchase of mailing list or other means of identification

Prohibition on Marketing New Plans Prior to Oct. 1st

- *Agents/agencies must not communicate about following year's Medicare plans prior to October 1st of the previous year*
- *May "**not**" solicit or accept enrollment applications for a January 1st effective date October 15th of the preceding calendar year unless the beneficiary is entitled under another enrollment period*

Marketing for Rest of Year (ROY) and Special Election Period (SEP)

- If you are marketing Medicare products outside of AEP to the general public, only a small percentage of beneficiaries will be newly eligible, have recently moved, or have a SEP qualifying condition. Agents/agencies may not mislead beneficiaries into believing they could change their respective plans outside of AEP.
- When marketing plans during ROY, materials must include language clarifying that a beneficiary may "apply, choose or enroll" in a plan only if they are eligible via an SEP and include necessary qualifiers that speak to those who may be aging in, new to Medicare, losing coverage, or another SEP qualifying event, so as not to violate the prohibition of "knowingly" targeting or sending unsolicited marketing material outside of AEP.
- "**Don't**" use the word "**NEW**" in a context that gives the impression that new plans are being released by MA organizations outside of AEP

Nominal Gifts

- Agents/agencies may not offer gifts to beneficiaries unless the gifts are nominal value, are offered t similarly situated beneficiaries without regard to whether the beneficiary enrolls and are not in the form of cash or other monetary rebates.
- Prior to use agents/agencies must submit any materials or processes that propose offering nominal gifts to beneficiaries for review before implementation, with details regarding the retail value of nominal gifts proposed and any related activities.
- Gifts may "**not**" be any of the following:
    - In the form of cash, rebates or gift cards that could be considered cash equivalents such as VISA, AMEX, MasterCard, Amazon, or gift cards to big box stores like Best Buy, Walmart, and Target. Gift Cards in general may not be used as nominal gifts for Medicare beneficiaries
    - Drug or health benefits (e.g., free checkup), including optional mandatory supplemental benefits
    - Tied directly or indirectly to the provision of any other covered item or service

Educational and Sales/Marketing Events

Educational events "**must**" be advertised as "**educational**"

Educational events must be designed to generally inform beneficiaries about Medicare, including Medicare Advantage, Prescription Drug Plans, or any other Medicare program. Educational events are meant to provide generic, factual, non-biased information about different coverage options, rather than information designed to persuade beneficiaries to enroll in a particular type of plan (for example, MA, MAPD, PDP or Medigap), or in a plan offered by a specific organization.

The following requirements apply to educational events:

- Educational events must be explicitly advertised as educational
- Activities permitted at educational events:
    - Provide communication materials
    - Answer beneficiary-initiated questions pertaining to MA plans
    - Make available and receive beneficiary contact information, including Business reply Cards (BRC)
    - Meals may be provided to beneficiaries, as long as the educational event meets all CMS regulations and falls under the CMS definition of communications
- Activities "**not**" permitted at educational events:
    - Market specific MA/PDP plans or benefits
    - Distribute marketing materials, including plan applications
    - Conduct sales/marketing presentations
    - Distribute or collect Scope of Appointment forms
    - Set up future permitted marketing appointments

Sales/Marketing Events

Sales/Marketing events are group events that fall under the definition of marketing.

- Activities permitted at sales/marketing events:
  - Provide marketing materials
  - Provide refreshments and light snacks to beneficiaries, as long as the items provided could not be reasonably considered a meal and/or that multiple items are not being "bundled" and provided as if a meal
  - Distribute and accept plan applications
  - Collect Scope of Appointment (SOA) forms for future personal marketing appointments; and
  - Conduct marketing presentations
- Activities "**not**" permitted at sales/marketing events:
  - Require sign-in sheets or require attendees to provide contact information as a prerequisite for attending an event
  - Conduct health screenings, health surveys or other activities that may be perceived as, or used for, "cherry picking" or target a subset of members
  - Use information collected for raffles or drawings for any purpose other than that; and/or
  - Providing meals to beneficiaries regardless of value
- Invitations to educational events must clearly state "**educational**" and invitations to sales/marketing events must clearly state "**sales**" on the materials themselves
- If advertising for both educational and sales/marketing events on the same material, the educational events must be clearly labeled as educational and details regarding the date, time and location of each must be specific on the material, so it is clear when and where each event is taking place
- ***Beginning September 30, 2023, sales agents may not schedule sales/marketing events to take place within 12 hours of an educational event at the same location. The same location is defined as the entire building or adjacent buildings***
- Educational information may be presented at a sales/marketing event, but the sales/marketing event must be accurately identified as sales/marketing

Personal/Individual Marketing Appointments

Personal marketing appointments are those appointments that are tailored to an individual or small group (i.e. married couples). Personal marketing appointments are not defined by location and may be in-person, telephonic, or conducted via a virtual meeting platform

- Agents/agencies "**must**" obtain a valid Scope of Appointment (SOA) from a beneficiary at least 48 hours prior to scheduled personal marketing appointment or meeting, except in the following situations, where an SOA must be obtained, but the 48-hour waiting period would not be required:
  - When a beneficiary request an appointment within four days of the end of a valid election period including the AEP, OEP, SEP, ICEP or the month, based on eligibility
  - When a beneficiary initiates an in-person meeting, such as walking into an agent's office, visiting a kiosk, or any other walk-in

    - ***CMS provided verbal clarification and confirmation of information provided in a third-party report on May 10,2023, that the 48-hour waiting period does "not" apply to inbound calls made to a sales agent by a beneficiary but does apply to outbound calls made by a sales agent to beneficiaries***
    - An SOA must be completed for all personal marketing appointments, including in the exceptions/scenarios noted above
- Completed SOA forms must be retained and made available upon request for a period no less than 10 years (i.e. paper forms, recorded for telephonic, or carrier online enrollment tool)
- SOAs are valid for up to 12 months following the date of the beneficiary's signature date (DNC policies supersede this 12-month PTC)
- SOAs must contain the following:
    - Product type to be discussed
    - Date of appointment
    - Beneficiary and agent contact information
    - Statement that there is no obligation to enroll, and that current or future Medicare enrollment status will not be impacted by speaking with the agent, and automatic enrollment will not occur
    - If the SOA is completed verbally on the inbound call, it must be recorded
- Agents/agencies may not market any health care related product during the a marketing appointment beyond what was agreed upon with the beneficiary in the SOA
- May not market additional health related lines of business not identified prior to the marketing appointment without obtaining a separate SOA identifying the additional lines of business to be discussed
- May not engage in cross selling of non-health products during a Medicare sales/marketing appointment, such as ordinary life, final expense, or annuities
- Activities permitted at a personal appointment:
    - Provide marketing materials
    - Distribute and accept plan applications
    - Conduct marketing presentations; and/or
    - Review the individual needs of the beneficiary including but not limited to, health care needs and history, commonly used medications, and financial concerns
- Activities "**not**" permitted at personal marketing appointments:
    - Market any health care related product beyond the scope agreed upon by the beneficiary, and documented by the agent/agency, prior to the appointment
    - Market additional health related products not identified prior to the appointment, without a separate Scope of Appointment identifying the additional health related products to be discussed
    - Market any non-related product

Terminology/Language used in Communications and Marketing Materials

Agents/agencies are prohibited from distributing communications and marketing materials that are materially inaccurate, misleading, or otherwise make representations or engage in activities that could mislead or confuse beneficiaries or misrepresent the MA organization. CMS is particularly concerned with and prohibits national advertisements that promote MA plan benefits and cost savings, which are only available in limited-service areas or for limited groups of enrollees, use words or imagery that may

confuse beneficiaries or cause them to believe the advertisement is coming directly from the government, and sales tactics designed to rush or push beneficiaries into enrolling into a plan.

Use of Medicare Name or Card Image

Official government materials/government endorsement

- Agents/agencies are prohibited from using the Medicare name, CMS logo, and products or information issued by the Federal Government, including the Medicare card, in a misleading way in both communication and marketing materials
- The Medicare ID card image may only be used with authorization from CMS prior to the use of the image. This requirement applies to both communications and marketing. Evidence of authorization will be required at time of material review.
- May not make claims that an MA plan(s) are recommended or endorsed by the Center of Medicare & Medicaid Services (CMS), or the Department of Health & Human Services (DHHS).
- Materials must not look like official government notifications or confuse or mislead consumers into thinking the material is from CMS or a government agency.
- Examples of the type of imagery and terminology that should be avoided include the overuse of American flag imagery, patriotic themed colors (red, white, and blue), symbols, logos or images that are made to resemble official government logos, and other terminology or images such as fonts, colors, barcodes, perforated envelopes, and "official" phrases that are associated with government documents.
    - Ensure it is clear to the consumer in a "**prominent**" and "**visible**" location that the advertisement is a solicitation to sell insurance and is coming from a licensed health insurance agency, and not from CMS or a government agency. It is "**not**" sufficient to include a disclaimer in the footer of the material. Disclaimers and taglines must be prominently placed in a font size (12 minimum) and color that is easily noticed, and clearly explain that an entity or website is "**not**" affiliated with, endorsed by, or otherwise somehow related to the federal government, CMS, HHS, or Medicare
    - Agents/agencies name (sender) and whom the consumer will reach if they respond (i.e., "a licensed sales/insurance agent") must be clearly and prominently visible and legible to consumers
    - Direct mail solicitations, the agency name or logo must be prominently included on every mailing to current an prospective enrollees (either on or visible from the front of the envelope, or on the mailing itself when no envelope accompanies the piece).
        - <agent/agency name> an insurance agency with no government affiliation
        - <agent/agency logo> directly below <agent/agency logo> A Health Insurance Agency or Non-Government Entity

Describing Medicare

- "**All**" descriptions of Original Medicare coverage must be accurate and clear to the average consumer/beneficiary
- When comparing Original Medicare to Medicare Products or Medicare Supplement Insurance plans, materials should be more specific than just using the term "Medicare"

Plans and Benefits Availability

Agents/agencies may "**not**" advertise benefits that are "**not**" available to a beneficiary in the service area(s) where the marketing appears, unless the advertisement is in local media that serves area(s) where the benefits are available and reaching beneficiaries who reside in other service areas are unavoidable.

"**All**" marketing materials "**must**" include the name of the MA and Part D organization(s) offering the products or plans, benefits, or cost identified in the materials. The name(s) must be included in the following format:

- MA and Part D organization names must be n a 12-point font in print and may "**not**" be in the form of a disclaimer or fine print
- For television, online, or social media, the MA organization or marketing name(s) "**must**" be either read at the same place as the phone number or "**must**" be displayed throughout the entire advertisement in a font size equivalent to the advertised phone number, contact information, or benefits
- For radio and other voice-based advertisements, MA organization or marketing names must be read at the same pace as the advertised phone numbers or other contact information
- "**Customized**" or "**personalized**" should not be used when describing Medicare plans or benefits as plans cannot be customized for an individual's needs
- "**Entitled**" can only be used when discussing Original Medicare because beneficiaries are "**not**" entitled to benefits a la carte or MS/PDP Plans
- Avoid statements like "get the money you/they deserve" and "see what benefits are available to you"
    - Instead use verbiage like, "You may qualify", "may also be available", "if you qualify"
- Avoid any Affordable Care Act references with respect to Medicare Products

Marketing of Savings Not Realized

Agents/agencies may "not" include information in communications and marketing about savings available that are based on a comparison of typical expenses incurred by uninsured individuals, unpaid cost of dully eligible beneficiaries, or other unrealized cost of a Medicare beneficiary.

Examples of Prohibited "Savings" use:

- Advertising that beneficiaries can "***save $9000 or more***" on prescription drugs in a MA or PDP plan
- Advertising that beneficiaries can "***save over $7000***" in health care expenses if they enroll in a MA plan
- Advertising Dual Eligible Special needs Plans that provide a "savings" of over $7000 to the beneficiary

This also includes a disclaimer that the stated "savings" amount is based on the usual and customary price someone without prescription drug or medical insurance would pay is "**not**" sufficient or appropriate as most beneficiaries are not saving the advertised amount because they would never have incurred the referenced out of pocket cost. Any mention of "savings" must be based on specific cost the

Medicare beneficiary could face, such as accurate comparisons of plan copayments for specific services to original Medicare cost sharing for the same services.

Scare and High-Pressure Tactics:

- Avoid using language that creates undue fear or anxiety in beneficiaries, such as "beware of some plans whose copays could bust your budget", etc.
- Avoid words that would cause a false sense of urgency, such as "Act now, or you may lose your benefits!" etc.
- Avoid creating or using material that may incite fear or mislead beneficiaries and prompt them to respond for fear of losing benefits, plan etc.
- Avoid repetitive phrases, certain fonts/colors, and/or punctuation that may communicate a false sense of urgency to a potential enrollee
    - For example, avoid using "**URGENT!**" on a material font that is in all caps, oversized, bolded and colored

Superlatives and Absolute Language

- Agents/agencies may "not" use superlatives in communications and marketing unless sources of documentation or data supporting the superlative is referenced in the material.
    - The supporting documentation or data "**must**" apply to the "**current**" or "**prior**" year contract. Including data older than the prior contract year is only permitted provided the current or prior years data are specifically identified
    - The documentation or data may be referenced through footnotes explaining the basics, noting the source (with enough information for a beneficiary to locate), or providing the actual comparison done to determine the superlative. For example, if a agent/agency states that they offer MA plans with the lowest premiums, the agent/agency must identify the specific MA plan(s) and their premium and the premiums of other plans in the service area, or reference a study, review, or other documentation that supports the superlative and with which the beneficiary can make accurate comparisons between the plans the agent/agency offers and those it does not.
- Examples of absolute or qualified superlative language that requires substantiation are, "***best***", "***greatest***", "***#1***", or "***outstanding***" when describing Medicare Products. Remember if it "**cannot**" be supported, it "**cannot**" be stated
- Do **not** use absolute language such as "**guarantee**" or "**promise**"
- Do **not** compare MA plans to other plans by name unless the comparison is substantiated based o the requirement above
    - Do **not** use negative language or disparaging comments about any plan(s)
- Agents/agencies must "**not**" use "highly rated" unless it is in relation to the CMS Stars Ratings of the plan(s) rated 4 or 5 stars

Exaggerative Words/Phrases

Do not use words/phrases such as "all", "full", "complete", "comprehensive", "unlimited", to describe health plan benefits

Correct terminology for Reference to Sales Agents

- *Materials "**must"** use terms like "**Licensed Insurance Agent**" or "**Licensed Sales Agent**" to refer to sales agents*
    - For example, CMS prohibits references/titles like, "Medicare Specialist", "Medicare Benefits Coordinator", Medicare Health Plan Specialist", and "Medicare Expert"
    - The use of the word "Medicare", "specialist", "expert", and other similar verbiage is prohibited in agent title designations (please see **Use of Medicare Name or Card Image)**
- If a sales agent's phone number or one that will route to a sales agent is included in a communication or marketing material, it "**must"** clearly indicate before the number that the number will direct callers to a "licensed sales agent" or "licensed insurance agent"
- "Unbiased" should "not" be used in reference to agent's/agencies since sales agent/agencies can only sell those Medicare Products that they are contracted with so there may be an inherent bias in what products are being sold

Use of the term "Senior":

CMS requires marketing resources are allocated to marketing to the disabled Medicare population as well as Medicare beneficiaries aged 65 and older. CMS prohibits stating or implying that plans are only available to seniors rather than all Medicare beneficiaries. Agents/agencies should refrain from utilizing the term "senior" as it may imply that MA/PDP plans are only available to those who are eligible for Medicare due to age (65+). CMS views the use of the term "senior" in some context as potentially discriminatory or a form of cherry picking against those who have Medicare due to a qualifying disability. In some instances, the term "senior" may be permissible, e.g., for Medicare Supplement plans that are only available to those 65 or older. ***The phrases, "people with Medicare" or "Medicare eligible" must be used when referring to eligibility for Medicare Advantage or Prescription Drug plans.***

Use of the word "Free"

With phrases such as, "Free Medicare Plan Comparison", materials need to include "no obligation to enroll" in the same sentence or near the "FREE" reference. If there are space issues, an asterisk may be used to reference language in a legible footnote.

- Do not use the term "free" to describe zero-plan premium, reduction in premiums (including Part B premium reduction plans), reduction in deductibles or cost-sharing, low-income-subsidy (LIS), or cost sharing for individuals with dual eligibility. "No additional cost" may be an alternative when appropriate.
- It is only permissible to use the term "free" with respect to plan benefits when describing mandatory, supplemental, and preventative benefits provided at a zero-dollar cost sharing for all members.

Medicare Supplement

- A Medicare Supplement plan must not be identified as a Medicare Advantage plan
- The difference between a Medicare Advantage and Medicare Supplement should be explained clearly

- Must make it clear that beneficiaries "must" choose either a Medicare Supplement Plan or a Medicare Advantage Plan since beneficiaries cannot enroll in a Medicare Supplement and a Medicare Advantage plan at the same time
- In plan comparisons/shopping websites, Medicare Supplement Plans and Medicare Advantage plans related content should be in separate sections and clearly distinguish from each other.

Customer Service Numbers

Customer Service numbers "**must**" be toll-free numbers

Days/Hours of Operation

Hours and days of operation are required to be prominently displayed at least once when any customer service call center number is included or displayed. The hours of operation must be included at least once on the material that includes the 1-800-MEDICARE telephone number or Medicare TTY

Use of TTY Numbers

A TTY number must appear in conjunction with the customer service number in the same font size and styles as the other phone numbers on all materials except as outlined below. Agents/agencies can use their own TTY numbers or state relay services, so long as the number included is accessible from TTY equipment. TTY customer service numbers must be toll-free.

Exceptions

- In television ads the TTY number may be a different font size/style than the other phone numbers to limit possible confusion
- Outdoor advertising (ODA) or banner/banner-like ads "**do not**" require TTY
- Radio advertisements and radio sponsorship (e.g., sponsoring an hour of public radio) "**do not**" require TTY

Product Endorsements and Testimonials

- According to the Federal Trade Commission, endorsements and testimonials are treated identically and any advertising message that consumers are likely to believe reflects the opinions, beliefs, findings, or experience of a party other than the advertiser
- When using social media, if an agent/agency uses a consumer's previous post it is considered an endorsement or testimonial
- Any testimonials that beneficiaries would believe are actual customers of the agent/agency or Medicare products they are endorsing "**must**" use actual customers who have used the product or service they are endorsing in both the audio and video or clearly and prominently disclose that the individuals are not actual consumers
- If the testimonial claims to be from a member of a Medicare Product, the beneficiary "**must**" have been enrolled in that product at the time the testimonial was created. Testimonials "**must**" identify the name of the Medicare Product in which the member was enrolled
- Ensure any member or consumer has given "**documented**" consent for quote or photograph, if applicable, to be used in the medium, such as on a website

- If an individual is paid to endorse or promote agent/agency, or Medicare plans or products, it "**must**" be clearly stated (e.g., paid endorsement)
- If an individual, such as an actor, is paid to portray a real life or fictitious situation, the ad "**must**" clearly state it is a "Paid Actor Portrayal"
- Any endorsement or testimonial that is made by a health care provider (even if another individual quotes the provider) "**must**" be discussed with and reviewed prior to use. Agent/agencies may "**not**" pay or compensate provider for testimonial in any way
- Any claim made in an endorsement or testimonial "**must**" be substantiated
- An endorsement or testimonial "**cannot**" use negative testimonials about other Plans/Part D Sponsors
- An endorsement "**must**" reflect the honest opinions, findings, beliefs, or experience of the endorser

Star Ratings

- If reference to an individual Star Rating measure(s) for a particular plan is made, then material must also include references to the overall Star Ratings for that plan. Do "**not**" use individual underlying category, domain, or measure rating to imply overall higher Star Ratings for a plan or MA organization or the plans that are offered by agent/agency
- Materials "**must**" be clear that the rating is out of 5 stars and clearly identify the Star Ratings contract year
- Star Ratings "**must**" only be marked in the service area(s) for which the Star Rating is applicable, unless using Star Ratings to convey overall MA organization performance and "**must**" do so in a way that is not confusing or misleading.
    - For example, "Plan X has achieved 4.5 stars in <service area>, <service area>, <service area>
- For materials marketing 5-star MA or PDP contracts:
    - Agents/agencies "**must**" not market the 5-star special enrollment period (SEP) after November 30th of each year if the contract did not receive an overall 5 star for the next contract year

Websites

- Websites "**must**" be clear and easy to navigate
- Websites containing **any** marketing content "**must"** be filed with CMS for each new plan year
- When marketing Medicare Advantage plans:
    - If communicating about two plan years (e.g., 2023 and 2024 plans), it "**must"** be clear which plan year the information is referencing
- Websites may "**only**" require users to enter zip code, county, and/or state for access to non-beneficiary specific website content
- Websites may request but "**not**" require, age/date of birth (DOB), gender, or health status information to access non-beneficiary specific plan information. There "**must"** be relevant consumer notifications that this information is "**not"** required, and it must be communicated as "**optional**" to the consumer
- Websites "**must**" keep Medicare Advantage content separate and distinct from other lines of business, including Medicare Supplement plans

- Websites with "Calls to Action" "**must**" accurately reflect the results the user will see/experience in the subsequent step and not confuse beneficiaries.
    - For example, a website should "**not**" indicate that a beneficiary will be able to "find plans" by entering their contact information if the beneficiary will not receive any plan information digitally but will instead receive a call from an agent
- Website must include TTY and day/hours of operation with phone number

Script Requirements

All telephonic sales and enrollments must follow scripting that is reviewed and approved by a MA plan organization and CMS.

Agent/Agencies Telephonic Sales and Enrollment Scripting Oversight

Agents/agencies are "**required**" to have oversight of any agent/agency in their downlines telephonic sales and enrollment activity. It should include ensuring compliance for telephone sales, that current CMS approved scripting is used, and calls are recorded. Agents/agencies "**must**" ensure "**all**" content from the CMS approved scripting is transferred verbatim to downlines and within any agent portal technology or tool and ensure quality control processes are in place to double check script adherence.

Informational, Sales, Pre-Enrollment, and Enrollment Script Requirements

Agents/agencies "**must**" ensure that any agents/downlines that represent MA organizations are licensed, appointed, and ready-to-sell (RTS) in any state they will conduct business in. Representation/Soliciting includes selling products (including Medicare Advantage plans (MA), Medicare Advantage Prescription Drug Plans (MAPD), Medicare Prescription Drug Plans (PDP), and section 1876 Cost plans) as well as outreach to existing or potential beneficiaries and answering or potentially answering questions from existing or potential beneficiaries.

Licensed/Unlicensed Agents

All scripts must clarify either within a single script or by separating out two distinct scripts, what specifically is being said by licensed sales agents and what is being said by non-licensed representatives.

- Agent's Role: call scripts "**must**" clearly identify at the beginning of the conversation whether the agent is a licensed sales agent or a non-licensed representative.
- Non-licensed representatives may only conduct activities as permitted by state law. State law determines activities that require a licensed agent/broker. Unless required by state law, the following do not require the use of state licensed marketing representatives:
    - Providing truthful & accurate information
    - Fulfilling a request for materials, or
    - Taking demographic information in order to complete an enrollment application
- To ensure beneficiaries are not mislead or confused, licensed agents who are also customer service representatives cannot act simultaneously as both customer service representative and a sales/marketing agent, the agent must clearly state to the beneficiary when their role changes to a marketing/sales role, subject to beneficiary request and agreeance.

Sales and Pre-Enrollment Scripts

- All Call Center agents/agencies are required to use CMS approved sales scripts. Scripts must be reviewed annually and adhere to all CMS guidance.
- Sales/Pre-enrollment scripts are considered marketing and must be submitted to CMS for approval subject to the 45-day approval period

Verbally convey the updated TPMO disclaimer (see **Required Disclaimer & Usage**) within the first minute of the sales call

- Verbally convey the Federal Contracting Statement on all sales/pre=enrollment calls
- Advise that the call is being recorded
- During sales/pre-enrollment calls agents may ask if the beneficiary would like to provide information regarding their age (DOB), gender, Medicare ID number, Part A or Part B effective dates, or any other demographic of health information. If the beneficiary does not wish to disclose any of this information, the agent must continue the and provide plan information to the beneficiary. The agent cannot end the call if the beneficiary does not disclose this information, as this could be seen as discriminatory.
- The only information an agent needs from a beneficiary to provide non-beneficiary specific plan information is zip code, county, and/or state.
- Ensure all Scope of Appointment requirements are met prior to beginning a telephonic marketing appointment. (completed SOA 48 hrs. in advance of personal marketing presentation or prior to personal marketing presentation on in-bound calls)
- Agents must ensure that, prior to an enrollment, CMS required questions and topics regarding needs in a health plan choice are fully discussed. Topics include information regarding primary care providers and specialist (ensuring providers are listed in carrier online provider directory), prescription drug cost and coverage (ensuring current prescriptions are covered with the plans formulary), cost of health care services, monthly plan premiums, benefits, and specific health care needs

Enrollment Scripts

- Enrollment scripts must contain the required elements for completing an enrollment request as described in Chapter 2 of the Managed Care Manual and Chapter 3 of the Prescription Drug benefit Manual and must receive CMS approval prior to use.
- Sales agents must obtain a compliant signature from the beneficiary. A signature is only complaint if the sales agent provides all required disclosures and disclaimers (verbally, or via IVR in a clear understandable fashion) and collects agreement and understanding from the beneficiary (or POA authorized representative)
- All disclosures required on the Model Enrollment Forms Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual must be provided either verbally or in writing to the beneficiary
- For telephonic enrollments, the contents of the Pre-enrollment checklist (PECL) must be reviewed with the prospective enrollee prior to the completion of the enrollment.
    - Beginning September 30, 2023, the PECL is required to include “Effect On Current Coverage”, and agents must ensure they discuss this element, along with all listed elements, with prospective enrollee and answer any questions to the prospective enrollee’s satisfaction, prior to enrollment.

- Sales agents must complete the relevant Medicare Product application in its entirety, asking every question on the application, and read all applicable disclaimers and disclosures clearly and understandable (not in a rushed or hurried fashion), with special attention to the following:
    - Confirm first and last name
    - Capture all application contact information
    - Capture selected payment option
- If beneficiary has questions during the signature portion or appears to be confused or hesitant about enrolling into the plan, the sales agent must "stop" the enrollment process, ensure all questions are answered, and confirm that the member would like to enroll prior to proceeding

Communication Involving Providers

- Be sure to inform beneficiaries of all network providers that are available and ensure beneficiaries always feel completely free to choose any provider in the network
- Provide accurate and objective information to beneficiaries about the availability of all participating providers near their place of residence as part of a general description of a Medicare Product's provider network
- "**ALWAYS**" use carrier specific physician finder lookup online lookup tools to locate participating physicians as it is the most up-to-date and comprehensive list of participating providers. If online tools are down and/or do not list a provider that's known to be in the network call carrier agent support for additional assistance.
    - Agent may:
        - Provide information about a particular provider that is included in online physician lookup tools, such as ratings available, address locations, specialty , and whether they are accepting new patients.
    - Agents may "**not**":
        - Distribute materials describing a provider's service or marketing a provider's practice
        - Provide information about any "**free**" services or cost-sharing waivers offered by a provider unless they are part of the plan's benefits (e.g., complementary transportation)
        - Recommend a provider or share opinion about which provider is best (e.g., do not use superlatives when describing a particular provider)
        - Use aggressive marketing or high-pressure tactics when discussing providers
        - Use superlatives (e.g., "better care", "best care", etc.) when describing providers to beneficiaries
        - Offer or give anything to beneficiaries to persuade them to choose a particular provider
        - Accept anything directly or indirectly, from a provider in exchange for communication about or helping a beneficiary choose a particular provider (e.g., charitable donations, sponsorships, gifts, cash, etc.)
        - Engage with providers in a way that may influence the agent's interactions with a member of prospect regarding their choice of providers, including but not limited to, entering into any arrangements with Providers, or offering, receiving or agreeing to offer or receive anything of value from a Provider or Provider's representative unless the arrangement complies with all applicable laws and regulations, including but not limited to, the Federal Anti-Kickback Statute, and

the agent's actions comply in all respects with the requirements outlined in this documents
- Engage with providers in a way that would influence the provider to steer patients towards any plan or set of plans the agent may offer

Reporting Compliance or Fraud, Waste and Abuse (FWA) Concerns

You are required to prevent, and report suspected or actual non-compliance and/or fraud, waste and abuse (FWA). There are four ways to report suspected or actual compliance and/or FWA issues:

1. Reach out to your manager or upline agency to initiate.

2. Each respective carrier has an anonymous hotline (or email) that may be utilized to report activities (consult the carrier's compliance and FWA reporting guidelines for details)

3. Contact the compliance office for One Life or Heartland Financial Group via phone, or email:

a. Compliance@Onelifeamerica.com or Compliance@HFGagents.com
b. 24hr. Hotline - (816) 655-5067
c. Compliance Department - (816) 478-0120

Submitting Marketing for Review/Approve Process

- https://www.hfgagents.com/online-marketing-submission/
  - *See Review Process Requirements for further details on format after initial submission*

Appendix 1 – Standardized Pre-Enrollment Checklist (422.2267(e)(4), 423.2267(e)(4))

Instructions:
Plans must include the Standardized Pre-Enrollment Checklist with the enrollment form and the SB.

Plans may remove parts or portions of the checklist that are not applicable to a particular plan type or product. When the pre-enrollment checklist is used for multiple products, they may add additional language before or after the disclaimer to clarify or distinguish how a disclaimer applies to different products.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at [insert customer service phone number].

Understanding the Benefits

☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [insert Plan website] or call [insert plan phone number] to view a copy of the EOC.

☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

☐ In addition to your monthly plan premium [plans may delete the monthly plan premium portion for $0 premium plans], you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

> [**Note**: Fully integrated dual SNPs may elect to remove this section or modify it to convey that the Part B premium is already paid. Plans that have a Part B buy-down may alter the language to convey the amount the plan pays and the beneficiary owes.]

☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, [insert year].

☐ [For plans that do not offer out of network coverage] Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

☐ [For PPO, PFFS, and other plans that offer out of network coverage] Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services [HMO-POS may insert "certain covered services"], the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. [If applicable, plans must add the following language] In addition, you will pay a higher co-pay for services received by non-contracted providers.

☐ [For C-SNP plans] This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

☐ [For D-SNP plans] This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. [D-SNPs may provide additional information if they impose restrictions to specific Medicaid eligibility category(ies)]

☐ [For I-SNP plans] This plan is an institutional special needs plan (I-SNP). Your ability to enroll will be based on verification that you, for 90 days or longer, have had or are expected to need the level of services provided in a skilled nursing facility, a nursing facility, an intermediate care facility for individuals with intellectual and developmental disabilities, a psychiatric hospital or unit, a rehabilitation hospital or unit, a long-term care hospital, a swing-bed hospital, or a facility approved by CMS that furnishes similar services.

☐ [For MSAs] MSA Plans combine a high deductible Medicare Advantage Plan and a trust or custodial savings account (as defined and/or approved by the IRS). The plan deposits money from Medicare into the account. You can use this money to pay for your health care costs, but only Medicare-covered expenses count toward your deductible. The amount deposited is usually less than your deductible amount, so you generally have to pay money out of pocket before your coverage begins.

Medicare MSA Plans do not cover prescription drugs. If you join a Medicare MSA Plan, you can also join any separate Medicare Prescription Drug Plan.

There are additional restrictions to join an MSA plan, and enrollment is for a full calendar year unless you meet certain exceptions. Those who disenroll during the calendar year will owe a portion of the account deposit back to the plan. Contact the plan at [insert customer service and TTY] for additional information.

☐ Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts. “If you are ready to enroll, then we will fill out the application and process your signature. Once we complete the signature, I will give you the application number for reference, tell you when to expect materials in the mail and provide you with our Customer Service number for your reference."

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Medicare Health Plan Needs Analysis

Client Name: _____ Date of Birth: _____

General Health & Plan Selection Information

- Do you have Medicare Parts A & B? ☐ Yes ☐ No
- Do you have Medicare Part D? ☐ Yes ☐ No
- Do you qualify for any other assistance? ☐ Medicaid ☐ LIS ☐ SPAP
- Do you have access to your current Medicare card? ☐ Yes ☐ No
- Are you currently enrolled on a Medicare Advantage Plan? ☐ Yes ☐ No
    - If "yes" Carrier _____ Plan _____
- Do you have any other forms of insurance?
- ☐ Group ☐ COBRA ☐ VA ☐ ChampVA ☐ Tri-Care ☐ ACA ☐ Indian Health Services ☐ Med Sup
- Do you have a Primary Care Physician (PCP)?
    - ☐ Yes *Name of Physician*: _____
        - In-Network ☐ Yes ☐ No
    - ☐ No Would you like assistance with selecting an in-network plan provider?
        - *Selected PCP#* _____
- How many different prescriptions are you taking? ☐ 0-3 ☐ 4-6 ☐ 7-10 ☐ 10+ ☐ I don't know
- Would you be willing to switch from a name brand to a generic for a lower out-of-pocket cost?
    - ☐ Yes ☐ No
- What prescription medications are you currently taking?
- _____ ☐ Generic ☐ Brand _____ ☐ Generic ☐ Brand
- _____ ☐ Generic ☐ Brand _____ ☐ Generic ☐ Brand
- _____ ☐ Generic ☐ Brand _____ ☐ Generic ☐ Brand
- _____ ☐ Generic ☐ Brand _____ ☐ Generic ☐ Brand
- _____ ☐ Generic ☐ Brand _____ ☐ Generic ☐ Brand
- Are dental benefits an important factor in your next health plan? ☐ Yes ☐ No
- Do you have a dentist that you visit regularly? ☐ Yes ☐ No ☐ I don't know
    - Name of dentist _____
- Which are important to you: ☐ Preventative ☐ Comprehensive ☐ Both
    - Preventative covers items like cleanings, X-rays, & check-ups
    - Comprehensive covers items like extractions, dentures, bridges, and root canals
- Do you currently use any tobacco products? ☐ Yes ☐ No
    - If "yes" are you interested in smoking cessation benefits? ☐ Yes ☐ No
- Are you active and exercise regularly? ☐ Yes ☐ No
    - If "yes" are fitness memberships and healthy lifestyle benefits important to you?
        - ☐ Yes ☐ No

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Medicare Health Plan Needs Analysis

- Do you use eyeglasses or contact lenses? ☐ Yes ☐ No
  - Are vision benefits an important factor in your next health plan? ☐ Yes ☐ No
- Do you use hearing aids or other devices to help you hear? ☐ Yes ☐ No
  - Are hearing benefits an important factor in your next health plan? ☐ Yes ☐ No
- Are you interested in other benefits that are "not" covered by Original Medicare?
  - ☐ Food Cards ☐ OTC ☐ Transportation ☐ Part B Premium Reduction (*If Available*)
- Do you have a healthcare power of attorney, or a living will? ☐ Yes ☐ No
  - If "yes" who is your POA _____
- Do you have any other physicians or healthcare providers? ☐ Yes ☐ No
- Cardiologist _____ Pulmonologist _____
- Eye doctor _____ Endocrinologist _____
- Physical therapist _____ Pain Management _____
- OBGYN _____ Dermatologist _____
- Ear, nose, and throat _____ Other (DME) _____

What are the things you like about your current plan? (Check all that apply)

- ☐ Copays ☐ Provider/Network ☐ Inpatient ☐ Outpatient ☐ OTC ☐ D/V/H ☐ Fitness ☐

What is it that you like most about that/those benefit(s): _____

_____

_____

If there were some things, you could change with your current plan what would they be?

_____

_____

Date of appointment _____

Source of business ☐BRC ☐ Phone-In ☐ Social Media ☐ Internet Landing Page ☐Referral ☐ Lead Vendor

SOA dated at least 48hrs in advance ☐ Yes ☐ No

- If "no" reason _____

Products discussed ☐ MA ☐ Part D ☐ Med Sup ☐ Other Health Related Products

Who was in attendance:

- Participant _____ Participant _____
- Participant _____ Participant _____

Additional Member Info

- Email _____ Phone _____
- Zip Code _____ County of Residence _____

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.
(Refer to page 2 for product type descriptions)

- ☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**
- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Dental/Vision/Hearing Products**
- ☐ **Hospital Indemnity Products**
- ☐ **Medicare Supplement (Medigap) Products**

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature:	Signature Date:
If you are the authorized representative, please sign above and print below:	
Representative's Name:	Your Relationship to the Beneficiary:

To be completed by Agent:	
Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	Date Appointment Completed:
[Plan Use Only:]	
Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:	

*Scope of Appointment documentation is subject to CMS record retention requirements *

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

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Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) : A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO): A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan: A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-For-Service (PFFS) Plan: A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

Medicare Point of Service (POS) Plan: A type of Medicare Advantage Plan available in a local or regional area which combines the best feature of an HMO with an out-of-network benefit. Like the HMO, members are required to designate an in-network physician to be the primary health care provider. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Special Needs Plan (SNP): A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

Medicare Medical Savings Account (MSA) Plan: MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan: In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

Medicare Medicaid Plan (MMP): An MMP is a private health plan designed to provide integrated and coordinated Medicare and Medicaid benefits for dual eligible Medicare beneficiaries.

Dental/Vision/Hearing Products

Plans offering additional benefits for consumers who are looking to cover needs for dental, vision or hearing. These plans are not affiliated or connected to Medicare.

Hospital Indemnity Products

Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans are not affiliated or connected to Medicare.

Medicare Supplement (Medigap) Products

Plans offering a supplemental policy to fill "gaps" in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes covers items and services that are not covered by Medicare, such as care outside of the country. These plans are not affiliated or connected to Medicare.