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AGENT MEDICARE COMPLIANCE GUIDE

BEST PRACTICES IN MEDICARE COMPLIANCE & MARKETING

2027

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INTRODUCTION

Important: This guide reflects Medicare marketing requirements and guidance applicable to the 2027 plan year. Agents must continue to comply with all Medicare marketing requirements, carrier requirements, and applicable laws and regulations governing the 2026 plan year for the remainder of the 2026 marketing period. Nothing in this guide should be interpreted as authorizing the early implementation of 2027 plan year requirements or practices where such implementation is not permitted.

You are required to comply with CMS's Medicare marketing rules, guidelines, and guidance documents as well as all other laws that apply to your business. This document is designed merely to help you understand the Medicare marketing rules and guidelines and provide you with best practices. This document is not a summary of all Medicare marketing rules and guidelines or any other laws, nor is it intended to replace CMS's marketing rules and guidelines or other laws that may be applicable to your business.

If you have any questions, you should reach out to your organization's Compliance Officer or your upline's Compliance Officer.

TABLE OF CONTENTS

Ready to Sell 5
- Licensed 6
- Appointed 6
- Certified 6

Enrollment Periods 8
- Initial Enrollment Period 9
- Annual Enrollment Period 9
- Open Enrollment Period 9
- Special Enrollment Periods 10

Lead Generation 11
- Third-Party Marketing Organizations 12
- Contact Rules 16
- One-to-One Consent Disclosure Rule 19
- Marketing and Communications 22
  - Communications Definition 22
  - Marketing Definition 22
- CMS Submission of Marketing Materials 24
- Communications 25
  - General Guidance for All Communications 25
  - Prohibited Language in Communications 29
  - Communications Disclaimers 32
- Marketing 36
  - When You Can Engage in Marketing 36
  - Quick Guide to Marketing Periods 40
  - Marketing Requirements 42
  - Required Marketing Disclaimers 44
  - Guidance for Special Supplemental Benefits for the Chronically Ill (SSBCI) 49
- Personal Business Cards 52
- Business Reply Cards (BRC) and Permission to Contact Forms 53
- Sales Calls and Call Recordings 55
- Endorsements and Testimonials 57
- Lead Generation Best Practices 58
- Communications and Marketing Materials Checklist 61
- Carrier Examples That Avoid Prohibited Language 69
- Website Checklist 73

TABLE OF CONTENTS

Event Compliance **76**
Educational Events 77
Sales and Marketing Events 78
Educational vs. Sales Events – Do's and Don'ts 81
How to Report a Sales Event 81

Compliant Sales **82**
Personal Appointments Generally 83
Scope of Appointment 84
Prior to the Appointment 86
During the Appointment 86
Appointment Checklist 88
After the Appointment 90
Virtual Appointments 90
Do's and Don'ts 92
Compliance Metrics 93

Miscellaneous **101**
Nominal Gifts to Beneficiaries 102
Meals and Snacks 103
Activities With Healthcare Providers or in the Healthcare Setting 103

Privacy/Security **107**
Things to Know 108
Examples of Inappropriate Disclosure or Privacy Incidents 109
Tips for Protecting Sensitive Information 109

Compliance Program Obligations **111**
Compliance Program Obligations 112
Tasks to Maintain Compliance 112
Agent Monitoring and Oversight 115

Resources & Contacts **116**

SECTION 1:

READY TO SELL

READY TO SELL

READY TO SELL = LICENSED + APPOINTED + CERTIFIED

LICENSED

"Licensed" means you have an active Insurance License in each state where you market MA/PDP products (licensed in the state where the client resides).

APPOINTED

"Appointed" means being contracted with the applicable Carrier and appointed to sell each applicable product in each applicable state.

CERTIFIED

"Certified" means you have completed each of the required Carrier-specific prerequisite modules (or AHIP equivalents) and the individual product modules for each product you market/sell.

Example: Agent John Smith resides in Nebraska and has clients both there and in Iowa. He wants to present MAPD products from Company XYZ to clients in both states. In order for him to be "Ready to Sell", he would need to:

1. Be actively licensed with the State DOI's of both NE (resident) and IA (non-resident).
2. Be contracted with Company XYZ and appointed to sell that particular MAPD in both NE and IA (have a NE and IA appointment with Company XYZ for the product being presented).
3. Complete the annual AHIP Certification or the Carrier specific prerequisite modules, the product-specific module for the product in question, as well as any other required trainings a Carrier may have.

READY TO SELL
CHECKLIST

TIPS:

- ❑ **Confirm your state licenses are up-to-date**
- ❑ **Verify you are appointed in each state with each carrier**
  - ❑ **Make sure your state appointments are complete and accurate for each carrier**
- ❑ **Verify your product certifications before sales appointments**
- ❑ **Full portfolio certification**
  - ❑ **Certify for all products not just the ones you "plan" on selling, especially PDPs**
- ❑ **Do NOT give out applications to downline agents who aren't "Ready to Sell"**

Call your Compliance Officer, your upline's Compliance Officer, or the carrier if you are unsure about any of your appointments, certifications, or licenses.

SECTION 2:

ENROLLMENT PERIODS

ENROLLMENT PERIODS

INITIAL ENROLLMENT PERIOD

The **Initial Enrollment Period (IEP)** is unique to each individual and is the timeframe when they are first eligible for Medicare, based on age. Also known as Age-In or T-65, this enrollment period is a seven-month window when an individual becomes eligible for Medicare, and thus, may enroll in an MA/MAPD plan. A person's initial enrollment period includes the three months prior to the month of their 65th birthday, the month in which they turn 65, and three months following the month of their 65th birthday.

ANNUAL ENROLLMENT PERIOD

The **Annual Enrollment Period (AEP)** is the timeframe each year where a client can enroll in, change coverage, or drop coverage for a Medicare Advantage or Prescription Drug Plan. The AEP runs from October 15 to December 7 each year. You cannot enroll clients in MA or PDP plans outside of this period unless another enrollment period applies.

You cannot "market" for an upcoming plan year prior to October 1, but keep in mind the actual definition of "marketing," as marketing includes specific content, such as plan benefit information, premium or cost-sharing information, plan comparisons, rankings, etc. You can still conduct lead generation activities that don't include "marketing."

You are permitted to simultaneously market the current and prospective years starting on October 1, provided marketing materials clearly indicate what plan year is being discussed.

Enrollments in the new plan year may not start until October 15, so no applications can be solicited or taken until then.

OPEN ENROLLMENT PERIOD

During the Medicare Advantage **Open Enrollment Period (OEP)** which runs from January 1 to March 31 each year, beneficiaries can switch from one Medicare Advantage plan to another or go back to Original Medicare. A beneficiary who chooses to switch may also make a coordinating change to enroll or disenroll in a Part D plan. However, beneficiaries in Original Medicare may not enroll in a Medicare Advantage Plan.

ENROLLMENT PERIODS

During OEP agents may not knowingly target or send unsolicited marketing materials to any MA or Part D enrollee. “Knowingly” takes into account the intended recipient as well as the content of the message. See the subsection titled “When You Can Engage in Marketing” in Section 3 for more information about what activities are permissible during OEP.

SPECIAL ENROLLMENT PERIODS

In addition to the regular enrollment periods described previously, beneficiaries can make changes in their health or drug plan coverage if they qualify for a **Special Election Period (SEP)**. A beneficiary is eligible for an SEP when certain events happen in their lives, including, but not limited to:

- Being diagnosed with a severe or chronic condition and there’s a Medicare Chronic Condition Special Needs Plan (C-SNP) available that serves people with that condition. For example:
  - Diabetes
  - Cardiovascular disorders
  - Chronic heart failure
  - Lung disease
- Moving into a different county that’s not in their plan’s service area
- Losing their current MA/PDP Plan in their area
- Qualifying for Extra Help with the cost of their prescription drugs
- Losing their retiree health coverage
- Receiving Medicaid assistance

SECTION 3:

LEAD GENERATION

LEAD GENERATION

THIRD-PARTY MARKETING ORGANIZATIONS

THIRD-PARTY MARKETING ORGANIZATIONS

"Third-Party Marketing Organizations" is the umbrella term that CMS uses to mean ALL organizations and individuals, including independent agents and brokers, who are paid to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment.

The chain of enrollment is the steps taken by a beneficiary from becoming aware of an MA or PDP plan or plans to making an enrollment decision.

Third-Party Marketing Organizations are commonly referred to as "TPMOs."

Third-Party Marketing Organizations include all of the following:

- Individual agents and brokers
- Agencies and brokerages
- Uplines in a hierarchy, including field marketing organizations, national marketing organizations, general agencies, etc.
- Lead vendors
- Any other vendors that are paid to perform lead generation, marketing, sales, or enrollment-related functions

What does it mean to be a TPMO?

You have to comply with TPMO requirements in CMS's Medicare marketing and communications rules and guidelines. These requirements are as follows:

- You **MUST** record all sales, marketing, and enrollment related calls with beneficiaries in their entirety.
- You **MUST** use the TPMO Disclaimer as required by CMS.
- You **MUST NOT** share personal beneficiary data collected for marketing or enrollment into a plan with another TPMO (including independent contractor agents) unless prior express written consent is obtained from the beneficiary.

- When you conduct lead generation activities, you **MUST**:
  - Disclose to the beneficiary that he or she is being transferred to a licensed insurance agent who can enroll the beneficiary into a new plan; and
  - Disclose to the beneficiary that their information will be provided to a licensed insurance agent for future contact verbally when communicating via phone, in writing when communicating via mail or paper, and electronically when communicating through email, online chat, or other electronic messaging platform.
- You **MUST** report to the plans all of your subcontractors that provide sales, marketing, lead generation and enrollment services for you.
- You **MUST** report to the plans monthly:
  - Any staff disciplinary actions related to beneficiary interactions; and
  - Any violations of plan requirements related to beneficiary interactions. These are self-identified violations of plan requirements involving your interactions with beneficiaries that the carrier does not already know about.

We have incorporated these into the relevant sections of this Guide.

What does it mean if you have lead vendors?

You are responsible for your lead vendors and any other vendors, contractors, and subcontractors that provide sales, marketing, lead generation, and enrollment-related services for you. These vendors should comply with the same requirements that you do when they generate leads for you. That means that these vendors should not perform tasks that you are prohibited from performing.

You must ensure that your lead vendors comply with the One-to-One Consent Disclosure Rule. This includes ensuring that all leads generated by the vendor for you include prior express written consent from the beneficiary for you to obtain their information. You should require your lead vendors to provide you with documentation of the prior express written consent.

- See the subsection titled One-to-One Consent Disclosure Rule in this Lead Generation Section for more details and requirements for complying with the rule.

LEAD GENERATION

THIRD-PARTY MARKETING ORGANIZATIONS

You should have written contracts with these vendors. Your written contracts should require your lead vendors to do the following:

- Comply with all Medicare marketing rules and CMS guidelines that apply to the activities that the vendor is performing for you.
- Record all sales, marketing, and enrollment calls with beneficiaries in their entirety, including the enrollment process.
- Use the TPMO Disclaimer as required by CMS.
- Provide you with documentation of prior express written consent given by each beneficiary authorizing the lead vendor to share their personal beneficiary data with you.
- When they conduct lead generation activities for you:
  - When receiving inbound calls and then transferring the calls to an agent, they must disclose to the beneficiary that he or she is being transferred to a licensed insurance agent who can enroll the beneficiary into a new plan and obtain consent from the beneficiary to complete the transfer.
  - When they generate leads for you, they must disclose to the beneficiary that their information will be provided to a licensed insurance agent for future contact verbally when communicating via phone, in writing when communicating via mail or paper, and electronically when communicating through email, online chat, or other electronic messaging platform.
- Report to you monthly: (i) any of their subcontractors that provide sales, marketing, and lead generation services; (ii) any internal staff disciplinary actions related to beneficiary interactions; and (iii) any violations of plan requirements related to beneficiary interactions. You should then notify your Compliance Officer or your upline's Compliance Officer of any reports made to you so that the carrier is notified in accordance with the carrier's required channel for notifications.
- Include terms requiring the lead vendor's (i) representation that they complied with the Telephone Consumer Protection Act ("TCPA") and the California Consumer Privacy Act ("CCPA"), and (ii) agreement to indemnify you for damages resulting from noncompliant generation of the leads.

If you have questions about your relationships with vendors or you would like contracting assistance, you may reach out to your Compliance Officer or your upline's Compliance Officer.

This Guide is intended for agents and brokers, so we use the terms agents and brokers throughout this Guide. However, as you read the Guide, if there are tasks that you purchase from a lead vendor, keep in mind that even though the language says "agents and brokers," the same requirements apply to your lead vendor as well.

NOTE: You are responsible to your carriers for your lead vendors. Your lead vendors should comply with the same requirements that you do when they generate leads for you. That means your lead vendors should not perform tasks that you are prohibited from performing.

CONTACT RULES

Agents may only make unsolicited direct contact with potential clients (including individuals that are referred to you) using the following methods:

- Conventional mail and other print media (e.g., advertisements, direct mail)
- Email – provided all emails contain an opt-out function and the TPMO Disclaimer

  NOTE: Advertisements and posts on social media platforms are permissible, but text messaging and direct messaging on social media platforms fall under unsolicited contact and are not permitted.

NOTE: Unsolicited contact is contact that is not asked for or requested by the consumer. Whereas solicited contact means a consumer has given express consent to be contacted by a sales agent for the purpose of receiving information about Medicare insurance plans.

All other unsolicited contact is prohibited when making contact with potential clients (including individuals that are referred to you). Examples of unsolicited contact include:

- Door-to-door solicitation or "Door Knocking" (Remember, even if you have a Business Reply Card or Permission to Contact form with the consumer's address listed, you cannot go to their residence without a pre-scheduled appointment)
- Leaving flyers, leaflets, door hangers, etc. at residences or on cars (Note: this is only permissible if you have a pre-scheduled appointment who is a "no-show")
- Approaching potential enrollees in common areas such as parking lots, lobbies, sidewalks, retail stores, etc.
- Telephonic or electronic solicitation (cold-calling, robocalling, voicemails, etc.)
- Text messaging
- Sending messages on social media platforms

- Calling attendees of a sales or educational event (unless express and documented permission is given)
- Calling to confirm receipt of mailed information
- Calling a "referral" from a current client
- Contacting beneficiaries using information about them (phone number, name, email) that was obtained without a consent for you to contact them

What can you do?

- Call individuals when valid, documented "permission to call/contact" is given (and, when required, Prior Express Written Consent is given)
- Give your contact information to current clients who want to refer a friend/relative (the referred individual needs to contact you directly)
- Call your current clients to promote other Medicare plan types or to discuss plan benefits (e.g., contact your PDP enrollees to promote MA-PD products)
- Call your current clients to discuss/inform them about general plan information, such as Annual Enrollment Period (AEP) dates, plan changes, educational events, etc.
- Call your current clients enrolled in other products that you may sell
- Return phone calls/messages
- Leave information at a residence if your prescheduled appointment becomes a "no-show"
- Email potential enrollees, provided all emails contain an opt-out function and follow other rules for communication and marketing materials

Other Important Information

- BRCs/Permission to Contact (or call) forms are valid for 12 months
  - BRCs/Permission to Contact forms are valid for 12 months from the beneficiary's signature date or the date of the beneficiary's initial request for information.

        - However, any personal beneficiary data collected prior to October 1, 2024, may not be transferred to or shared with another TPMO (including independent agents) on or after October 1, 2024.
    - A beneficiary may give consent to be reminded about the AEP and the opportunity to evaluate (or reevaluate) MA and Part D plan options, if the reminder is made within 12 months.
    - Permission applies only to the topic of that transaction and to the TPMO from which the individual requested to be contacted.
    - Prior Express Written Consent must be given by the beneficiary for a TPMO to share the beneficiary's data with a second TPMO and to be contacted by the second TPMO.

NOTE: See the following Section titled One-to-One Consent Disclosure Rule for definitions of the terms "Prior Express Written Consent" and a full explanation of the rule.

- Bait-and-Switch strategies are also prohibited (e.g., making unsolicited contact about other lines of business as a means of generating leads for Medicare plans)

NOTE: Cold calling under the guise of selling other lines of business, such as Medicare Supplement or final expense, as a means of generating leads for MA or PDP is prohibited.

- Referrals from current clients do not give you "permission to contact" that referral
- You cannot make calls to market plans or products to former enrollees/clients who have disenrolled, or those in the process of disenrolling
- You cannot call attendees of a sales or educational event, unless they have given permission to be contacted (permission must be documented)
- You cannot call potential clients to confirm receipt of mailed information
- Remember that all communications, especially calls and texts, must also comply with all other applicable laws, including the Telephone Consumer Protection Act (TCPA)

ONE-TO-ONE CONSENT DISCLOSURE RULE

The One-to-One Consent Disclosure Rule

Effective October 1, 2024, MAOs and PDP sponsors must ensure that any personal beneficiary data collected by a TPMO for marketing or enrollment may only be shared with another TPMO when prior express written consent (PEWC) is given by the beneficiary to be contacted by the receiving TPMO.

Personal beneficiary data is "contact information" such as name, address, and phone number. It can also include any other information given by the beneficiary for the purpose of finding an appropriate MA or PDP plan. This could include health information or other personal information such as age, gender, or disability.

Prior express written consent (PEWC) from the beneficiary to share the data and be contacted for marketing or enrollment purposes must be obtained through a clear and conspicuous disclosure that lists each entity receiving the data and allows the beneficiary to consent or reject the sharing of their data with each individual TPMO.

- The default selection should be the beneficiary chooses not to share their data.
- There should be an affirmative action by the beneficiary to acknowledge (opt-in) that sharing their data with another TPMO is permitted.
- A beneficiary must consent to each TPMO that will receive their data.
- There is no limit to the number of TPMOs with whom a TPMO may share data.
- A variety of approaches may be permissible.

TPMO is interpreted by CMS to mean a legal entity. Therefore:

- Employees within the same TPMO (such as an FMO or an agency) may share personal beneficiary data without PEWC.
- Independent contractors of a TPMO (such as an FMO or an agency) are not within the same legal entity and may not share personal beneficiary data without PEWC.

- Downline entities in a hierarchy that are separate legal entities may not share personal beneficiary data without PEWC.

TPMOs may obtain permission to contact that beneficiary at the same time that they obtain PEWC to share that beneficiary's personal beneficiary data with other TPMOs.

If one TPMO collects a beneficiary's personal beneficiary data with the purpose of eventually marketing or enrolling that beneficiary into an MA or Part D plan, that TPMO must obtain PEWC from the beneficiary to share the personal beneficiary data with a second TPMO.

If personal beneficiary data is collected and sold with the purpose of eventually marketing to the beneficiary or enrolling them into an MA or Part D plan (such as a lead), then the selling TPMO must have PEWC from the beneficiary to share that data with each TPMO in the marketing or enrollment chain.

If a TPMO receives a call from a beneficiary, in order to share any personal beneficiary data with a second TPMO, the TPMO must obtain PEWC, which could be via text or email while on the phone.

Any personal beneficiary data collected prior to October 1, 2024, may not be transferred to or shared with another TPMO on or after October 1, 2024.

Exceptions to the One-to-One Consent Disclosure Rule

- TPMOs can share personal beneficiary data with MAOs and PDP sponsors without PEWC from the beneficiary. (This is because MAOs and PDP sponsors are not TPMOs).
- Phone calls from a beneficiary to a TPMO that are transferred live by the TPMO to an agent or broker that can provide *immediate assistance* to the beneficiary, as long as the beneficiary has verbally agreed or consented to be transferred during the live phone call, is not sharing personal beneficiary data and does not require PEWC. (However, if the TPMO needs to share the beneficiary's personal data with anyone that the beneficiary will not *immediately be speaking with*, they must obtain PEWC from the beneficiary to share their personal data.)

LEAD GENERATION

ONE-TO-ONE CONSENT DISCLOSURE RULE

NOTE: TPMOs must also comply with the TCPA and the Telemarketing Sales Rule (TSR) when making telemarketing calls and texts with auto-dialers or artificial or pre-recorded voicemails.

As an Agent or Broker, Can I....?

Contact a beneficiary using a BRC that I purchased or received that grants permission to my FMO to contact the beneficiary?	Only if you are a W-2 employee of that FMO listed on the BRC.
Contact a beneficiary using a BRC that I purchased or received that grants permission for my agency to contact the beneficiary?	Only if you are a W-2 employee of that agency listed on the BRC.
Contact a beneficiary using a BRC that I purchased or received from another agent within the same agency that grants permission for my agency to contact the beneficiary?	Only if you are a W-2 employee of that agency listed on the BRC.
Contact a beneficiary who submitted their contact information online on a form granting permission for my FMO to contact the beneficiary?	Only if you are a W-2 employee of that FMO listed on the BRC.
Contact a beneficiary who submitted their contact information online on a form granting permission for my agency to contact the beneficiary?	Only if you are W-2 employee of that agency listed on the BRC.
Contact a beneficiary who granted permission to be contacted by a list of entities, and I am employee of one of the listed entities?	Only if the form has documented PEWC from the beneficiary, which means the beneficiary took an affirmative action to select the entity that is your employer.

Questions? If you have questions about the application of the "One-to-One Consent Disclosure Rule," please reach out to your Compliance Officer or your upline's Compliance Officer.

MARKETING AND COMMUNICATIONS

We understand that advertising materials play a critical role in your daily business activities, but it is vital that you ensure your advertising materials are compliant with CMS guidelines. Follow the guidance below when creating your own materials.

Remember: Lead vendors' materials aren't always compliant! You may be responsible to your carriers for your lead vendors' materials, so you should review your lead vendors' materials before you use them to ensure they are compliant.

As you develop advertising materials for Medicare audiences, it's important to know that CMS makes a distinction between "Communications" and "Marketing."

Any material or activity meeting the definition of "marketing" must be pre-approved by all applicable carriers, submitted into the HPMS Marketing Module, Accepted/Approved (depending on the material type) by CMS, and Opted-In to by all applicable carriers.

COMMUNICATIONS DEFINITION

are all activities and materials used to provide information that is targeted to current and prospective enrollees, including their caregivers and other decision makers.

> **NOTE:** Generic mailers and advertising materials you create to promote your business and generate leads fall under the definition of "communication" materials (given they are free of plan information, and do not list benefits, premiums, copays, and cost sharing).

Communications include, but are not limited to, business cards, print advertisements, such as brochures, flyers, letters, and postcards, websites, emails, social media posts, social media messages, online advertisements, billboards, banner ads, radio ads, TV ads, scripts, and presentations.

MARKETING DEFINITION

is a subset of communications and is determined based on both the content and intent of the activity or materials. Marketing includes activities and materials with the intent to:

(i) draw a beneficiary's attention to a specific plan or plans; or (ii) influence a beneficiary's decision-making process when selecting a plan for enrollment or deciding to stay enrolled in a plan (retention-based marketing). Additionally, marketing must have content with information about plan benefits, benefits structure, premiums, or cost sharing; measuring or ranking standards; or rewards or incentives.

Effective July 10, 2023, CMS expanded its interpretation of the definition of "marketing" to include content that mentions **any type of benefit** covered by the plan. Content stating that beneficiaries can receive benefits such as dental, vision, cost-savings, and/or hearing services is sufficient information about benefits or cost-sharing to meet the content standard.

The following are some examples of materials that constitute "marketing." If your advertising materials (or materials you purchase from a lead vendor) include any language similar to the examples below, they should be submitted to the applicable carriers (through your upline) for approval and then filed with CMS in the HPMS Marketing Module:

- "Medicare Advantage Plans may contain additional benefits such as **Dental, Vision, Hearing, and Prescription Drugs**"
- "Medicare Advantage Plans may come with **OTC** and **Transportation benefits**"
- "Some Medicare Advantage Plans may have a **$0 Monthly Plan Premium**"
- "**Copays as low as $0**"
- "You may be eligible to get your **Part B premium paid back**"

Remember, any advertisement that mentions a premium, a benefit, a copay, or getting your Part B paid for (even if in a general fashion) must be pre-approved by all applicable carriers and filed with CMS in the HPMS Marketing Module.

CMS SUBMISSION OF MARKETING MATERIALS

NOTE: All materials that meet the definition of "marketing" must be pre-approved by all applicable carriers, submitted into the HPMS Marketing Module for filing with CMS, and Opted-In to by all applicable carriers.

How do you submit materials for review and approval to CMS?

Prior to submission, ensure your materials are compliant per CMS regulations. If you have any questions about your materials' compliance, reach out to your Compliance Officer or your upline's Compliance Officer. Be sure to take this step at least two months before you want to use the material, particularly if multiple carriers are involved.

If the materials constitute "marketing," these materials must be submitted to CMS. Submissions are typically made to the HPMS Marketing Module by the direct downline agency partners of the carriers (the "top of hierarchy" contracts) but may also be made by other downlines in some circumstances. The submitting upline must have been granted user access to the HPMS Marketing Module. Thus, the second step is to reach out to your immediate upline agency to escalate materials to the proper upline in your hierarchy for submission. You will also need to inform your immediate upline agency of all carriers for whom the material could generate a lead. This is because prior to submission into HPMS, that upline must first submit the material to the applicable carriers for review prior to filing in HPMS. This carrier review could take six to eight weeks.

After carrier review, the upline in your hierarchy will submit the multi-plan material into the HPMS Marketing Module. Depending on the material type, CMS will either review the material prospectively or it will be subject to "file and use" treatment. Following CMS review or the applicable review period, the material must be Accepted or Approved, as applicable.

After a material is Accepted or Approved, the carriers must Opt-In to the material in the HPMS Marketing Module. Applicable carriers should have previously approved the material, which should expedite the Opt-In process. This is important because marketing materials are intended to be used only for carriers that have Opted-In to the material. Use of a marketing material for a carrier that has not approved or opted in could result in the lead being treated as non-compliant.

Please note that even if your materials are generic communications and do not constitute marketing, some carriers require agents to submit communications materials to them for review. You should follow each of your carriers' requirements. If you have any questions or concerns, you should reach out to your Compliance Officer or your upline's Compliance Officer.

COMMUNICATIONS

GENERAL GUIDANCE FOR ALL COMMUNICATIONS

Remember: Communications include ALL materials and activities used to provide information that is targeted to beneficiaries and their caregivers. This includes what you say and what is written.

- You may not be untruthful, provide information that is inaccurate or misleading, or provide misleading information.
- You may not use the Medicare name, CMS logo, and products or information issued by the federal government, including the Medicare card, **in a misleading way**.
  - Interpretations on this will most likely vary from carrier to carrier, so Integrity suggests you take a conservative approach.
- All communications materials should make very clear that you are not affiliated with the government or the federal Medicare program. Integrity recommends the following disclaimer on all communications (and a variation is required in some states):

  "NOT AFFILIATED WITH OR ENDORSED BY THE GOVERNMENT OR FEDERAL MEDICARE PROGRAM."

LEAD GENERATION
COMMUNICATIONS

- All communications with a name or logo that could appear "governmental" should clearly state that the agency/brokerage is a non-governmental entity directly below the name or logo. Integrity recommends the following language in such cases:

  "A Non-Governmental Entity"

- You should not use the word "Medicare" in your business name or your trade name. This is because names with the word "Medicare" risk being used in a misleading manner. Moreover, some states also prohibit the word "Medicare" to be used in an organization's name.
- You should not use the word "Medicare" in your domain name. This is because domain names with the word "Medicare" risk being used in a misleading manner.
- Use of the Medicare card image is only permitted with prior authorization from CMS.
- All communication materials should make clear that you are a licensed insurance agent or licensed agency/brokerage.

Best Practice: Include qualifying language in conjunction with disclaimers and other language on materials that could appear "governmental" or that prominently use the word "Medicare" to make it clear that you are a licensed insurance agent and not affiliated with Medicare or the government.

- All required materials and content, including required disclaimers, must be printed with a font size equivalent to or larger than Times New Roman 12-point font.
  - **Best Practice:** It is recommended and the practice of most carriers to use at least a 12-point font size in all advertising materials.
- On mailers, the agency/broker name and address should appear on the envelope or postcard. Carrier guidance says you must identify the sender.
- All materials that include a phone number for the consumer to call should also include language near the phone number that conveys the consumer will reach an agent by calling the number, such as:

  "By calling this number, you will reach a licensed insurance agent." OR "Call to speak with a licensed insurance agent."

- Any time you first mention a Medicare Plan, you should use the full name or plan type:
  - Medicare Advantage Plan
  - Medicare Supplement Insurance Plan
  - Part D Prescription Drug Plan
- When offering a free promotional giveaway, gift, prize, or drawing or describing a free service (such as a "free Medicare plan comparison"), you must:
  - Include "no obligation to enroll" in the same sentence or in close in proximity to the "free" reference. If there are space issues, an asterisk maybe used to reference language in a footnote.
  - Provide the free item or service offered.
- Any advertisement or invitation to an educational event must advertise the event as "educational."
- Any advertisement or invitation to an educational or a sales/marketing event must include a variation of the following disclaimer:

  "For accommodations of persons with special needs at meetings, call <insert phone and TTY number>."

Remember: Websites and social media posts must comply with these requirements, too.

TPMO Disclaimer

- Websites must prominently display the appropriate TPMO Disclaimer unless the TPMO only sells plans for one MA/PDP organization.
  - If a TPMO does not sell for all MA organizations or PDP sponsors in the service area, the disclaimer consists of the statement:

    "We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options."

- If the TPMO sells for all MA organizations or PDP sponsors in the service area, which is very rare, the disclaimer consists of the statement:

  "Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov or 1-800-MEDICARE for help with plan choices."

- It is not always easy to calculate the number of organizations or the number of plans. A website is viewable by any consumer in any location, so it is not feasible to know the service area of all viewers, must less tailor the number of carriers and plans to their service areas.

  Best Practice: In the absence of additional CMS guidance, you should be able to demonstrate a good faith attempt to comply with this requirement, and you should comply to the extent feasible. A good faith attempt should ensure that beneficiaries are aware of their options and that they may have multiple plans in their service area. An example of a good faith attempt at compliance could be to include number ranges. A good faith attempt to comply should also include having a reasonable process in place for updating the numbers, as they can also change over time.

- **Note:** The TPMO Disclaimer may not be altered. Also, you may not add language to the TPMO Disclaimer itself because that is considered to be altering the disclaimer.

• Emails, online chat, and other electronic means of communications with beneficiaries must include the appropriate TPMO Disclaimer (above) unless the TPMO only sells plans for one MA/PDP organization, which is very rare.

- It is not always easy to calculate the number of organizations or the number of plans, particularly for electronic communications sent to multiple beneficiaries.
- **Best Practice:** In the absence of additional CMS guidance, you should be able to demonstrate a good faith attempt to comply with this requirement, and you should comply to the extent feasible. For example, if you are sending an email to one individual, you should be able to comply by calculating the number of organizations and plans in the individual's service area. This requires knowing the service area.
- **Best Practice:** Add the TPMO Disclaimer to your automatic email signature line.
- **Remember:** The TPMO Disclaimer may not be altered. Also, you may not add language to the TPMO Disclaimer itself because that is considered to be altering the disclaimer.

PROHIBITED LANGUAGE IN COMMUNICATIONS

- DO NOT state that you are approved, endorsed, recommended, or authorized by Medicare, CMS, HHS, or the Secretary of HHS.
- DO NOT use unsubstantiated statements in any communications.
- DO NOT use statements that may be misleading, confusing, or materially inaccurate.
- DO NOT use the word "free" to describe a $0 premium, any type of reduction in premium (including Part B buy-down), reduction in deductibles or cost-sharing, low-income subsidy (LIS), or cost sharing for individuals with dual eligibility. Suggest using "no additional cost" as an alternative.
- DO NOT use the word "free" to describe a benefit unless the exception below applies.

NOTE: It is only permissible to use the term "free" with respect to plan benefits when describing mandatory, supplemental, and preventive benefits provided at a zero-dollar cost sharing for all members.

- DO NOT give the appearance that the material is from the government or a government agency. Avoid the following words or imagery:
  - Bar codes
  - Member numbers, beneficiary numbers, or ID numbers
  - The U.S. flag
  - The shape outline of the U.S.
  - Red, white, and blue color scheme appearing to be associated with the government
  - Images very similar to those seen on government offices
  - Logos that resemble a government logo
- DO NOT use high-pressure or "scare" tactics
  - Avoid using language to create undue fear, anxiety, or confusion in members/prospects, 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," "you may lose your benefits," "urgent," or "rush."
- Avoid repetitive phrases, certain font/colors, and/or punctuation that may communicate a sense of urgency to or scare a potential enrollee. An example may include **"URGENT!"** used on a material (with font that is in all caps, oversized, and red).
- The following phrases can be used at the end of AEP as not creating a false sense of urgency:
  - Don't delay
  - Enroll now
  - Now's the time
  - The time is now
  - Don't miss out
  - Get the answers you need
  - AEP is ending soon (may only be used 2 weeks before 12/7)
  - AEP ends on 12/7

- DO NOT misrepresent your title.
- DO NOT use the word "Medicare" in your title or use any of the following titles:
  - "Medicare Specialist," "Benefit Specialist," or "Medicare Benefits Specialist"
  - "Medicare Expert" or "Benefit Expert"
  - "Medicare Consultant," "Benefits Consultant," or "Insurance Consultant"
  - "Medicare Agent"
  - "Certified Medicare Professional," "Benefits Professional," or "Certified Benefits Professional"
- DO NOT use the word "entitled" when referring to plan benefits. Use "eligible" instead.
  - You can only use "Entitled" in relation to Part A for Federal Medicare Products.
- Use caution when using the word "Senior."
  - You cannot limit your audience to those over 65. Some Medicare beneficiaries are under 65.
  - You cannot state or even imply that plans are only available to "seniors" rather than to all Medicare beneficiaries.

- DO NOT use declarative statements.
  - Declarative statements include phrases like, “You will save thousands of dollars,” or “this is the best plan for you,” etc. These statements are not true for all individuals.
  - Instead, use qualifying language such as: “you may be able to save money” (if accurate), “eligible,” “you might,” “you may,” “you could potentially save,” “should,” or “maybe” (if these are accurate).
- Avoid the use of any language that might imply a consumer must call, reply, or contact the agent/agency to implement or qualify for benefits.
  - Negative example: “Call Now to find out what benefits you are missing out on!” or “Fill out the information below to receive benefits you are entitled to!”
  - Positive Example: “To learn more about Medicare Advantage Plans available in your area, call to speak with a licensed sales agent.” or “Fill out the information below to have a licensed insurance agent contact you regarding Medicare Advantage Plans available in your area.”
- DO NOT use exaggerative words/phrases, such as “all,” “full,” “complete,” “comprehensive,” or “unlimited,” to describe benefits (these are only examples).
- DO NOT use the following:
  - “Customized” or “personalized” when describing Medicare plans or benefit as plans cannot be customized for an individual’s needs.
  - “Unbiased” in connection with provided services, given that agents and agencies are restricted to contracted Medicare insurance products, which may create perceived or actual limitations in product neutrality.

Remember: Websites and social media posts must comply with these requirements, too.

COMMUNICATIONS DISCLAIMERS

Although not required, you should use the following disclaimers on all communications (except business cards):

- "NOT AFFILIATED WITH OR ENDORSED BY THE GOVERNMENT OR FEDERAL MEDICARE PROGRAM."
- Next to phone numbers, a variation of the following:
  - "BY CALLING THIS NUMBER, YOU WILL REACH A LICENSED INSURANCE AGENT." OR "CALL TO SPEAK WITH A LICENSED INSURANCE AGENT."

The following disclaimers are required on all communications when applicable:

DISCLAIMER	EXAMPLE OR REQUIRED TEXT	APPLICABLE DOCUMENTS OR NOTES
Accommodations	**Example Text:** "For accommodations of persons with special needs at meetings call <insert phone and TTY number>."	Required on advertisements or invitations for all events, including both educational events and sales/marketing events. The disclaimer must convey accommodations for persons with special needs is available and provide a telephone number and TTY number. The language may be in a disclaimer form or within the material.
Promotional Give-Aways, Prizes, Free Gifts, or Drawings	**Example Text:** "Eligible for a free drawing, gift, or prizes with no obligation to enroll." **Example Text:** "Free gift without obligation to enroll."	Required when offering promotional giveaways such as drawings, prizes, or free gifts. Must convey that there is no obligation to enroll in a plan.

DISCLAIMER	EXAMPLE OR REQUIRED TEXT	APPLICABLE DOCUMENTS OR NOTES
Mailing Statements on Envelopes	**Required Text** if mailing on behalf of one plan: "Important [Insert Plan Name] information." **Required Text** if mailing on behalf of multiple plans: "Important Plan information." **Required Text** if mailing health and wellness information: "Health and wellness or prevention information."	Required on envelopes when mailing information about the enrollee's current plan to current members. Required on envelopes when mailing health and wellness information to current members: "Health and wellness or prevention information."
Certain Communications Developed by a TPMO	**Required Text:** "We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options."	Required on TPMO websites. Required on emails, online chat, and other electronic means of communications with beneficiaries.
TPMO Lead Generation (call transfers to licensed agent)	**Example Text:** "You are now being transferred to a licensed insurance agent who can enroll you in a new plan."	Required on all calls and call scripts by TPMOs, when transferring the call to a licensed agent, the individual speaking to the beneficiary must clearly state the call is being transferred to a licensed agent.

LEAD GENERATION
COMMUNICATIONS

DISCLAIMER	EXAMPLE OR REQUIRED TEXT	APPLICABLE DOCUMENTS OR NOTES
TPMO Lead Generation (obtaining Permission to Contact and remaining in compliance with the One-to-One Consent Disclosure Rule)	**Example Text:** "Your information will be provided to <insert agent name>, a licensed insurance agent. You may be contacted by phone or email by <insert agent name>, a licensed insurance agent, regarding your Medicare options including Medicare Supplement Insurance, Medicare Advantage, and Prescription Drug Plans." **Example Text:** "By providing the information [above], I grant permission for <insert agent name>, a licensed insurance agent, to receive my information and call or email me regarding my Medicare options including Medicare Supplement Insurance, Medicare Advantage, and Prescription Drug Plans."	Required by TPMOs conducting lead generation activities. TPMOs must inform the Medicare beneficiary that their information will be provided to a licensed agent for future contact. Required to be done verbally, electronically, or in writing, depending on how the TPMO is interacting with the Medicare beneficiary. TPMOs are also required to obtain PEWC prior to sharing personal beneficiary data obtained for the purposes of marketing or enrollment in a plan to another TPMO.
Provider Co-Branded Material	**Example Text:** "Other <Pharmacies/ Physicians/ Providers> are available in our network."	Required whenever co-branding relationships with network providers are mentioned, unless (for MA and cost plans, including MA-PD plans only) the co-branding is with a provider network or health system that represents 90% or more of the network as a whole. Required to convey, as applicable, that other pharmacies, physicians, or providers are available in the plan's network.

DISCLAIMER	EXAMPLE OR REQUIRED TEXT	APPLICABLE DOCUMENTS OR NOTES
Out-of-Network Non-Contracted Provider	**Required Text:** "Out-of-network/ non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services."	Required whenever materials reference out-of-network/non-contracted providers. Does not apply to standalone PDP plans.
NCQA SNP Approval Statement	**Example Text:** "Based on a Model of Care review, [Insert Plan Name] has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through [insert last contract year of NCQA approval]."	Required on all documents that reference NCQA SNP approval. Required to be used by SNPs who have received NCQA approval. Required to convey that the MA organization has been approved by the NCQA to operate as a SNP, the last contract year of NCQA approval, and that approval is based on a review of plan's Model of Care. It may not include numeric SNP approval scores.
Medicare Supplement Insurance Disclaimers	**Example Text:** "The purpose of this communication is the solicitation of insurance."	Requirements for disclaimers vary by state and by carrier. It is a best practice to state that the purpose of the communication is the solicitation of insurance if the material mentions Medicare Supplement Insurance or Medicare Supplement Insurance will be solicited.

MARKETING

WHEN YOU CAN ENGAGE IN MARKETING

When you can market current and/or prospective plan year plans can be confusing. Here are some tips to keep you compliant:

- **DO NOT** begin marketing for the prospective plan year offerings until October 1.
  - **Remember:** Marketing is defined as meeting both the intent and content standards. This means that to be marketing, it must contain information about plan benefits, benefits structure, premiums, or cost sharing; measuring or ranking standards; or rewards and incentives.
- **DO NOT** begin marketing for the prospective plan year offerings *under the pretext of plan business* until October 1.
- You **MAY** market for the prospective plan year and the current plan year simultaneously beginning October 1 as long as the materials clearly indicate the plan year.
- **DO** market to beneficiaries aging in to Medicare who have not yet made an enrollment decision.
- **DO** market 5-Star plans to beneficiaries in the service area of the plan through November 30 (and after November 30 if the plan has received a 5-Star ranking for the next plan year).
- See Section 2 Enrollment Periods for a description of the Medicare Enrollment Periods.

MARKETING PRIOR TO OCTOBER 1

Prior to October 1, Agents MAY:

- Contact existing members to schedule a plan review.
  - However, you may not engage in any marketing of prospective plan year plans prior to October 1, even with existing members. Marketing includes sharing information about prospective plan year plan benefits, plan benefit structure, premiums, and cost-sharing.

- Engage in communications activities.
- Distribute communications materials.
- Hold informal and formal educational events.
- Hold sales and marketing informal and formal sales events for the current plan year that are approved by CMS and the carrier(s).
- Market current plan year plans to Age-Ins in their IEP who have not yet made an enrollment decision.
- Market current plan year plans to individuals eligible for an SEP.
- Market current plan year 5-Star plans.

Prior to October 1, Agents may NOT:

- Market plans for the prospective plan year.
- Conduct "marketing" (as the term is defined by CMS) activities for the upcoming plan year. To be clear, agents may not "market" upcoming plan year benefits prior to October 1.
- Solicit or accept enrollment applications for a January 1 effective date prior to the start of the Annual Election Period (AEP), which is October 15.

MARKETING DURING PRE-AEP

You may not market plans for the prospective plan year until October 1. However, the Annual Enrollment Period does not begin until October 15. This time period between October 1 and October 14 is sometimes referred to as "Pre-AEP." Knowing what you can and can't do during this period (Oct. 1 – Oct. 14) can be very confusing.

During Pre-AEP (October 1 – October 14), Agents MAY:

- Distribute communications materials.
- Hold educational events.

- Continue to market current plan year plans to individuals eligible for enrollment in a current plan year product. This includes age-ins in their IEP and individuals eligible for an SEP.
- Continue to market current plan year 5-Star plans.
- Conduct marketing activities and distribute marketing materials for the prospective plan year.
- Hold informal and formal sales/marketing events for the prospective plan year that are approved by CMS and the carrier(s).
- Schedule and hold personal marketing appointments for the prospective plan year, but you cannot receive, accept, or solicit enrollment application forms.

During Pre-AEP (October 1 – October 14), Agents may NOT:

- Receive, accept, or solicit enrollment application forms.
- Pressure or urge a client or prospective client to fill out an application.
- Write your name or writing number on any application.

Remember that any enrollment form received before Oct. 15 with any indication of agent involvement (i.e., agent name or writing #) will be investigated by the respective carrier.

MARKETING DURING OEP

During OEP agents may not knowingly target or send unsolicited marketing materials to any MA or Part D enrollee. “Knowingly” takes into account the intended recipient as well as the content of the message.

- Messaging specifically calling out the OEP would be “knowingly targeting.”
- If you are aware that an individual already made an AEP enrollment decision, sending unsolicited marketing materials to that individual (even if OEP is not mentioned), would be “knowingly targeting.”

During OEP, Agents MAY:

- Conduct marketing activities based on other enrollment opportunities (as long as the content does not address or include any references to OEP), such as:
  - Marketing to age-ins (who have not yet made an enrollment decision),
  - Marketing for 5-star plans, and
  - Marketing to beneficiaries who have moved, are losing coverage, are leaving an employer plan, or to those that have certain severe or disabling chronic conditions.
- Provide marketing materials when a beneficiary makes a proactive request.
- Have one-on-one meetings at the beneficiary's request.
- Include educational information on their websites about Medicare election periods, which may reference OEP, provided the information is presented in a broader educational context and does not include marketing.

During OEP, Agents may NOT:

- "Knowingly target" or send unsolicited marketing materials to any MA or PDP enrollee.
  - Messaging specifically calling out the OEP would be "knowingly targeting."
  - Sending unsolicited marketing materials to an individual that you are aware already made an AEP enrollment decision would be "knowingly targeting."
- Use marketing messages aimed at generating interest or leads (unless it is for other enrollment opportunities as described above). For example, a generic marketing line of "not happy with your plan, change now" would be prohibited.
- Conduct activities or send unsolicited materials advertising the ability or opportunity to make an additional enrollment change or referencing the OEP. For example, "It's Open Enrollment Period. Call today!" would be prohibited.
- Specifically target individuals who are in the OEP because they made a choice during the AEP by purchasing mailing lists or other means of identification.
- Call or otherwise contact former enrollees who have selected a new plan during the AEP.
- Engage in or promote agent or broker activities that intend to target the OEP as an opportunity for further sales.

LEAD GENERATION
MARKETING

MARKETING TIP: OEP is a great time to shift to Age-In or other SEP activities. We also suggest using this time to reach out to your clients who enrolled in a plan during AEP to check in to confirm they know how to use their benefits or ask if they have any questions. Doing so will go a long way with customer retention and satisfaction, will help reduce member complaints, and can spark a request for permissible marketing information.

QUICK GUIDE TO MARKETING PERIODS

GENERAL GUIDANCE
Communications materials and activities may be conducted year-round. Marketing materials and activities are only permitted for specified enrollment periods and only to individuals eligible to enroll during those enrollment periods. In order for material not to be considered "marketing," it must not contain: • Plan Premium or Cost-Sharing Information • Plan Benefit or Benefit Structure Information (may not reference any benefit) • Star Ratings Information • Rankings, Measurements, or Comparisons to Other Plans • Rewards or Incentives
Marketing During AEP (10/15 – 12/7) • Marketing for the upcoming plan year cannot begin prior to October 1. • Enrollment for the upcoming plan year cannot begin prior to October 15. • Marketing to beneficiaries generally is permitted for the upcoming plan year. • Marketing simultaneously for current plan year (IEP, SEP, etc.) is permitted as well as long as the marketing materials clearly indicate the applicable plan year.

LEAD GENERATION

MARKETING

GENERAL GUIDANCE
Marketing During OEP (1/1 – 3/31) • Messages aimed at generating interest or leads during the OEP are generally prohibited unless targeting allowable segments (i.e., IEP, SEPs, 5-Star plans). **Additional OEP Guidance:** • Marketing messages aimed at generating interest or leads during the OEP are generally prohibited. For example, a generic marketing line of "not happy with your plan, change now" would be considered inappropriate marketing. • Any lead/advertising piece that meets the definition of "marketing" sent or displayed during OEP must clearly show who it is targeting. Remember, only certain marketing is allowed during OEP. You can target Age-ins, market 5-Star plans, or market other SEPs. • Do not use an advertising piece that targets a permissible population such as Age-Ins and another population that is not eligible for enrollment.
Rest of Year Marketing (4/1-9/30) • AEP cannot be marketed • OEP cannot be marketed • IEP & SEP can be marketed • Communications are allowed, including general communications that promote a business as well as educational information. • It's strongly recommended that marketing materials be written in a way that the reviewer can easily identify them as IEP or SEP.

MARKETING REQUIREMENTS

When conducting marketing activities and creating, using, or distributing marketing materials, you are required to follow many requirements. Here are some requirements and tips for staying compliant.

- **DON'T FORGET** to first obtain carrier approval and then complete required HPMS filing for all marketing materials.
- **DO NOT** market any products, plans, benefits, or costs, unless the company names of the entities offering the referenced products, plans, benefits, or costs are identified in the marketing material.
  - This means that you should include the carrier names of all carriers offering the referenced products in all marketing materials.
  - Carrier names **MUST** appear as follows in marketing materials:
    - In print marketing, the names must be in 12-point font and may not be in the form of a disclaimer or fine print.
    - In TV, online, or social media marketing, the names must either be read at the same pace as the phone number OR must be displayed throughout the entire ad in a font size equivalent to the advertised phone number, contact information, or benefits.
    - In radio or voice-based advertising, the names must be read at the same pace as the advertised phone numbers or other contact information.
  - You must also obtain approval from each carrier listed to include their name.
- **DO NOT** advertise savings available to potential enrollees that are based on unrealized costs of a Medicare beneficiary, including a comparison of typical expenses borne by uninsured individuals or unpaid costs of dually eligible individuals.
  - There is no exception to this prohibition, even if the advertisement includes a prominent disclaimer.
- **DO NOT** market benefits in a service area where those benefits are not available unless marketing in the particular service area is unavoidable because of the use of local or regional media that covers the service area.
  - In effect, this means that you cannot advertise MA benefits in national media. MA plans are not available in some areas of the country, and the exception only applies to local media.

- Local media includes a newspaper ad in a metro area which is distributed to beneficiaries that live within the metro area, but the beneficiaries do not live within the service area of the plan for which the benefits are being marketed.

- **DO NOT** market any non-health-related product during any marketing activity or presentation, including appointments. This is considered cross-selling and is prohibited.
- Any advertisement or invitation to a sales/marketing event inviting beneficiaries to a group session to possibly enroll should include the following disclaimer:

  "For accommodations of persons with special needs at sales meetings, call <toll-free number> (TTY 711), <days and hours of operation>."

- You **MUST** record all sales, marketing, and enrollment related calls with beneficiaries in their entirety. See the subsection titled "Sales Calls and Call Recordings."
- Marketing materials **MUST** include the appropriate version of the TPMO Disclaimer unless you only sell plans for one MA/PDP organization.
  - **Best Practice:** It is not always feasible to calculate the accurate numbers of carriers and plans that you offer in a service area. In the absence of additional CMS guidance, you should be able to demonstrate a good faith attempt to comply with this requirement, and you should comply to the extent feasible. A good faith attempt should ensure that beneficiaries are aware of their options and that they may have multiple plans in their service area. An example of a good faith attempt at compliance could be to include number ranges. A good faith attempt to comply should also include having a reasonable process in place for updating the numbers, as they can also change over time.
  - **Note:** The TPMO Disclaimer may not be altered. Also, you may not add language to the TPMO Disclaimer itself because that is considered to be altering the disclaimer.
- You **MUST** state the applicable TPMO Disclaimer prior to the discussion of any benefits during sales calls.
  - Not all calls are "sales" calls. Educational calls to set an appointment are not sales calls.
  - If you are making an outbound "sales" call (or a call that could become a sales call), if you have the beneficiary's service area prior to the call, you should calculate the number of carriers and plans before you make that outbound call.

        - **Best Practice:** Include the beneficiary's address in your lead generation forms so that you have this information readily available when you make the sales call.
        - **Best Practice:** Ask for the beneficiary's address when scheduling an appointment so that you have the information to calculate the number of plans and carriers when you make the sales call.
    - You may not immediately know the service area of inbound caller.
        - **Best Practice:** Treat all calls as sales calls during the last 4 days of the Annual Enrollment Period and the Open Enrollment Period and immediately determine the individual's service area at the beginning of the call. Make a good faith attempt to then state the TPMO Disclaimer prior to the discussion of any benefits with the numbers of carriers and plans offered as accurately as possible.

- Marketing materials **MUST** include all of the required content and disclaimers, as applicable, that are set forth in the chart below.

REQUIRED MARKETING DISCLAIMERS

Marketing materials should include the following disclaimer: "This is a solicitation for insurance."

Marketing materials must include all of the disclaimers that are required to be on communications. See the subsection titled "Communications Disclaimers" for a list of all required communications disclaimers.

Marketing materials must also include the following additional disclaimers when applicable to the material:

DISCLAIMER	EXAMPLE OR REQUIRED TEXT	APPLICABLE DOCUMENTS OR NOTES
Federal Contracting Statement (marketing materials)	**Example Text** (Carrier Specific): "[Carrier's legal or marketing name] is a [plan type] with a Medicare contract. Enrollment in [carrier's legal or marketing name] depends on contract renewal." **Example Text** (Generic): "Plans are insured or covered by a Medicare Advantage organization with a Medicare contract and/or a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare." **Example Text** (Agencies): "[Partner/Agency] represents Medicare Advantage [HMO, PPO, and PFFS] organizations that have a Medicare contract. Enrollment depends on the plan's contract renewal." **Example Text** (Lead Vendors): "Participating sales agencies represent Medicare Advantage [HMO, PPO, and PFFS] organizations that are contracted with Medicare. Enrollment depends on the plan's contract renewal."	Required on ALL marketing materials except banners and banner-like ads, outdoor advertisements, text messages, social media, and envelopes. The disclaimer must include the legal or marketing name of the organization, the type of plan, a statement that the plan has a contract with Medicare, and a statement that enrollment depends on contract renewal.

DISCLAIMER	EXAMPLE OR REQUIRED TEXT	APPLICABLE DOCUMENTS OR NOTES
Materials Developed by a TPMO (marketing materials)	**Required Text:** "We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options."	Required on all TPMO marketing materials, including all print materials, TV ads, that are used, created, or distributed by a TPMO and that meet the definition of "marketing." Must also be provided verbally prior to the discussion of any benefits.

DISCLAIMER	EXAMPLE OR REQUIRED TEXT	APPLICABLE DOCUMENTS OR NOTES
NEW Special Supplemental Benefits for the Chronically Ill (SSBCI)	**Example Text:** "The benefits mentioned are part of the special supplemental program for chronically ill members with one of the following disorders: [diabetes mellitus, chronic heart failure, chronic lung disorders, cardiovascular disorders, or chronic and disabling mental health conditions].* This is not a complete list of qualifying conditions. Having a qualifying condition alone does not mean you will receive the benefit(s). Other eligibility and coverage requirements may apply." *If 1 type of SSBCI is mentioned, list all conditions if there are 5 or fewer, but list the top 5 conditions if there are more than 5 and convey that there are other eligible conditions not listed. If more than 1 type of SSBCI is mentioned, list all conditions if there are 5 or fewer and, if relevant, state that they may not apply to all types of SSBCI mentioned. List the top 5 conditions if there are more than 5 and convey that there are other eligible conditions not listed. **Individual carriers may require specific SSBCI disclaimer language.**	Required on any communications whenever SSBCI benefits are mentioned. Required to list the relevant conditions that the enrollee must have to be eligible for the benefit(s) listed. See * in the Required Text column. Required to convey that even if an enrollee has a listed chronic condition, an enrollee may not receive the benefit listed because other eligibility and coverage criteria apply. For TV, radio, or other voice-based ads, the disclaimer must be read at the same pace as, or be displayed in the same font size as, the advertised phone number or other contact information. For outdoor ads, the disclaimer must be displayed in the same font size as the phone number or other contact information.

DISCLAIMER	EXAMPLE OR REQUIRED TEXT	APPLICABLE DOCUMENTS OR NOTES
Accommodations (marketing events)	**Example Text:** "For accommodations of persons with special needs at sales meetings, call <toll-free number> (TTY 711), <days and hours of operation>."	Required on any advertisement or invitation for a marketing event. Required to convey that accommodations are available for persons with special needs and required to contain the TTY and phone number.
Star Ratings (marketing)	**Example Text:** "Every year, Medicare evaluates plans based on a 5-star rating system."	Required on any marketing material that references Star Ratings. The disclaimer must convey that plans are evaluated yearly by Medicare and that the ratings are based on a 5-year rating system.
Part B Giveback (marketing)	**Example Text:** "The Part Giveback Benefit pays part or all of your Part B premium and the amount may change based on the amount you pay for Part B."	Required on any marketing material that mentions the Part B Giveback benefit.
Benefits (marketing materials)**	**Example Text:** "Not all plans offer all of these benefits. Benefits may vary by carrier and location. Limitations, exclusions, copays, deductibles, and coinsurance may apply."	Required if marketing material contains plan benefits (i.e., dental, vision, hearing, OTC, transportation, fitness, etc.)*

****NOTE:** You may no longer market benefits in a service area where those benefits are not available unless the local media exception applies. You must also list all carriers that offer the benefits you list or reference. Including this disclaimer does not relieve you of the obligation to comply with these requirements. See the subsection titled "Marketing Requirements."

GUIDANCE FOR SPECIAL SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL (SSBCI)

SSBCI are supplemental benefits offered to certain Medicare Advantage members that have a reasonable expectation of improving or maintaining the health or overall function of the enrollee. These benefits are in addition to the benefits that traditional Medicare covers and can include benefits that are not primarily health related, such as meal delivery, non-medical transportation, and other services.

Eligibility Criteria

To qualify for SSBCI benefits, a Medicare Advantage enrollee must meet all three of the following criteria:

- The individual must live with one or more complex chronic condition(s) that is life threatening or significantly limits their overall health or ability to function,
- Has a high risk of hospitalization or other adverse health outcomes, and
- The individual requires support with the coordination of their medical care.

Items and Serves Excluded from SSBCI

Examples of items or services that may not be offered as part of SSBCI include all of the following:

- Procedures that are solely cosmetic in nature and do not extend upon Traditional Medicare coverage
- Hospital indemnity insurance
- Funeral planning and expenses
- Life insurance
- Alcohol
- Tobacco

- Cannabis products
- Broad membership programs inclusive of multiple unrelated services and discounts
- Non-healthy food

SSBCI disclaimer

An SSBCI disclaimer is required on any communications whenever SSBCI benefits are mentioned.

The disclaimer must list the relevant conditions that the enrollee must have to be eligible for the benefit(s) listed.

The disclaimer must convey that even if an enrollee has a listed chronic condition, an enrollee may not receive the benefit listed because other eligibility and coverage criteria may apply.

For TV, radio, or other voice-based ads, the disclaimer must be read at the same pace as, or be displayed in the same font size as, the advertised phone number or other contact information.

For outdoor ads, the disclaimer must be displayed in the same font size as the phone number or other contact information.

Example disclaimer text:

"The benefits mentioned are part of the special supplemental program for chronically ill members with one of the following disorders: [diabetes mellitus, chronic heart failure, chronic lung disorders, cardiovascular disorders, or chronic and disabling mental health conditions].* This is not a complete list of qualifying conditions. Having a qualifying condition alone does not mean you will receive the benefit(s). Other eligibility and coverage requirements may apply."

***Disclaimer Quick Reference**

NUMBER OF SSBCI BENEFITS MENTIONED IN THE MATERIAL	NUMBER OF QUALIFYING CONDITIONS FOR THE REFERENCED BENEFIT	HOW TO REFERENCE THE QUALIFYING CONDITIONS IN THE DISCLAIMER
One	Five or fewer	List all of the qualifying conditions
	More than five	List the top five conditions and convey that there are other eligible conditions not listed
Two or more	Five or fewer	List all of the qualifying conditions
	More than five	List the top five conditions and convey that there are other eligible conditions not listedw

IMPORTANT NOTE: Individual carriers may require specific disclaimer language.

PERSONAL BUSINESS CARDS

Things to Remember:

- Business cards are a communication material. You must comply with all of the requirements applicable to communications. Remember that this includes avoiding colors, imagery, or language that may appear governmental.
- **DO** use the title "Licensed Insurance Agent" or "Licensed Sales Agent."
- **DO NOT** use the word "Medicare" in your title (e.g., Medicare Specialist, Medicare Advisor, Medicare Agent, Medicare Insurance Agent, etc.).
- **DO NOT** approach individuals in public places to hand out your business card.
- **DO NOT** go door-to-door and leave your business card.
- **YOU MAY** distribute business cards at educational events.
- **DO NOT** list benefits on business cards (because that makes it marketing).

BUSINESS REPLY CARDS (BRC) AND PERMISSION TO CONTACT FORMS

A BRC (Business Reply Card) is designed and intended to be used as a direct mail material for the purpose of gathering permission to contact. A BRC is generally mailed to potential clients in hopes they will return the BRC giving permission to be contacted. Agents can also display and receive Permission to Contact forms at sales and educational events, or place them on a website, online advertisement, or social media platform (electronic BRCs).

Things to Remember:

- BRCs/Permission to Contact (PTC) forms are communications materials (unless they contain marketing content, in which case, see the bullet point below). You must comply with all of the requirements applicable to communications. Remember that this includes avoiding colors, imagery, bar codes, or language that may appear governmental. It also includes avoiding any scare tactics or language that creates a false sense of urgency.
- BRCs/Permission to Contact forms are marketing if they contain marketing content. If BRCs/Permission to Contact forms constitute marketing, then they must meet the requirements for marketing (and contain all requisite content and disclaimers), be approved by the applicable carriers, and be submitted into the HPMS Marketing Module.
- BRCs must include a statement informing the consumer that a licensed agent may call them as a result of returning or submitting the BRC/Permission to Contact form.
- If the TPMO collecting the BRC will be sharing, transferring, or selling the BRC to another TPMO, then the BRC must include PEWC to share the beneficiary's data with and be contacted by the second TPMO.
    - **Example if the Named Agent is Collecting the BRC:** By providing the information above, I grant permission for <insert agent name>, a licensed insurance agent, to call or email me regarding my Medicare options including Medicare Supplement Insurance, Medicare Advantage, and Prescription Drug Plans.

- **Example if the TPMO is Transferring the BRC to the Named Agent:** Your information will be provided to <insert agent name>, a licensed insurance agent. You may be contacted by phone or email by <insert agent name>, a licensed insurance agent regarding your Medicare options including Medicare Supplement, Medicare Advantage, and Prescription Drug Plans.

- Remember that you must also comply with the Telephone Consumer Protection Act (TCPA) and the Telemarketing Sales Rule (TSR). This includes "prior express written consent" if you are using an auto-dialer, ringless or pre-recorded voicemail, or similar technology.
- BRCs/Permission to Contact forms are valid for 12 months from the beneficiary's signature date or the date of the beneficiary's initial request for information.
  - A beneficiary may give consent to reminded about the AEP and the opportunity to evaluate (or reevaluate) MA and Part D plan options, if the reminder is made within 12 months.
  - Personal beneficiary data that was collected prior to October 1, 2024, may not be shared or transferred with another TPMO on or after October 1, 2024, without PEWC.
- You **MAY** provide and receive BRCs at educational and sales events to be completed at the option of the attendee.
- You should **NOT** ask for a consumer's date of birth.
- You should **NOT** request spousal information. Permission to contact may only be granted by the individual and is not conferred on another without being a legally authorized representative.
- BRCs/ Permission to Contact forms should be retained for documentation purposes and available upon request for the remainder of the selling year plus 10 additional years.
- **BE AWARE** that some carriers require submission of all BRC/ Permission to Contact forms prior to use (regardless of whether they meet the definition of "marketing" or not).

SALES CALLS AND CALL RECORDINGS

- You **MUST** record all sales, marketing, and enrollment related calls with beneficiaries in their entirety. This includes inbound and outbound calls.
  - The audio portion of calls via web-based technology must be recorded if the calls are marketing, sales, or enrollment calls. This includes Zoom calls or other web-based technology platforms.
  - "Sales" calls are those in which any plan or plan information (including cost-sharing, premiums, or benefits) will be discussed.
  - Calls that are not sales, marketing, or enrollment related calls are not required to be recorded. This would include calls that merely set an appointment.
  - However, carriers like to have a recording of the initial contact call. Therefore, as a best practice, you should record outbound calls made in response to a BRC or other PTC form, even it is to set an appointment.
- You **MUST** retain all call recordings for 10 years and be able to provide them to carriers or to CMS upon request.
- You **MUST** state the applicable TPMO Disclaimer during sales calls prior to the discussion of any benefits. You should record the statement of the TPMO Disclaimer.
  - Note that this requirement only applies to sales calls. As described above, "sales" calls are those in which any plan or plan information (including cost-sharing, premiums, or benefits) will be discussed.
  - If a prospective client calls in response to a marketing piece that already bears the TPMO Disclaimer, the TPMO Disclaimer is still required to be provided verbally during the sales call prior to the discussion of any benefits.
  - **Best Practice:** You should determine the beneficiary's service area prior to the call or at the beginning of the call (if it is not known prior to the call), so that you can determine the accurate number of plans and carriers that you sell in their service area for the TPMO Disclaimer, so you can read the TPMO Disclaimer during the sales call prior to the discussion of any benefits.
  - **Best Practice:** You should treat all calls as sales calls within the last 4 days of the Annual Enrollment Period and the Open Enrollment Period. This means recording all calls, determining the beneficiary's service area at the beginning of the call, and stating the TPMO Disclaimer prior to the discussion of any benefits.

LEAD GENERATION

SALES CALLS AND CALL RECORDINGS

- Many states require that the consumer be notified that a call is being recorded. As a best practice, you should notify the consumer at the outset of inbound and outbound calls that the call is being recorded. Sample language to add to your call scripts for outbound call greetings is, "Hello, this is [Agent Name], calling on a recorded line..." You should record the beneficiary's consent to record so you have proof of consent.
- You **MUST** end the call if a beneficiary refuses to permit you to record the call.
- **BE AWARE** that carriers may mandate that agents and brokers follow an approved script for sales, marketing, and enrollment related calls.
- Integrity makes call recording technology available for its partners and downlines for free through IntegrityCONNECT.

ENDORSEMENTS AND TESTIMONIALS

Product endorsements and testimonials are permitted but must adhere to the following requirements:

- You should receive permission when using client endorsements or testimonials.
- You should refrain from using full names that would individually identify the person providing the testimonial.
- The speaker must identify the plan's product or company by name.
- If a beneficiary is providing the testimonial, the beneficiary must have been an enrollee at the time the endorsement or testimonial was created. Additionally, you may only continue to use the endorsement or testimonial if you have good reason to believe that the beneficiary is still actively enrolled in the plan.
- If an individual is paid or has been paid to endorse or promote you, the advertisement must clearly state this (e.g., "paid endorsement").
- If an individual, such as an actor, is paid to portray a real or fictitious situation, the advertisement must clearly state it is a "Paid Actor Portrayal."
- The claims made in the endorsement or testimonial must be able to be substantiated.

NOTE: Reuse of an individual's content or comment from social media sites that promotes a product is considered an endorsement/testimonial and must adhere to the guidance in this section.

LEAD GENERATION BEST PRACTICES

With 10,000 people aging into Medicare every day, there's never been a greater opportunity to reach and serve this demographic. And remember, the people turning 65 today are in the Boomer generation. These are smart, vibrant consumers who are roaring into Medicare like none other. Think Bill Gates. Whoopi Goldberg. Billie Idol. Get ready to build your business by following some of these best practices in Medicare marketing.

Below are some tips and best practices to help you better reach your intended audience and drive sales.

- It all starts and ends with the trust your clients have in YOU, so be sure to build and stay true to your personal brand. If something doesn't feel authentic to you, don't do it or say it. Always act with integrity and let your personality shine through.
- Position yourself as a valuable resource that your clients will feel comfortable going to with any questions — and especially when they're ready to make an enrollment decision.
- Create your own library of content and offer to be a presenter at educational events. Whether it's Medicare basics or a health and wellness topic — providers, faith-based organizations, and local senior centers are often eager to fill up their community calendars, and agents are permitted to provide business reply cards at these events.
- If you don't already, you should have a year-round strategy for reaching people who are turning 65. Although prospects can only enroll during their 7-month Initial Enrollment Period, a nurturing, educational campaign can start any time giving you plenty of time to build your relationship and position yourself as their go-to Medicare resource. Simple direct mail or email drips, or a combination of both, that provide progressively more information and an appropriate sense of urgency are a great way to go. Remember, though, that email campaigns must include an opt-out function and the TPMO Disclaimer.
- Direct Mail is still an industry workhorse, but you definitely need to up your digital game. Develop your own content calendar and use social media. Integrity has developed a variety of resources that can help with ideas and tactics to expand your influence.

- To avoid the cost and aggravation of returned mail, work with a best-in-class list vendor, and ensure the mail list is scrubbed against the SSA list of deceased individuals, the national change of address database, the Reassigned Numbers Database (RND), the national Do Not Call (DNC) Registry, any applicable state DNC lists, Integrity's internal DNC list, and any other suppression lists.
- Partner with a reputable print vendor who can recommend print formats and help your mail get noticed — this can be a cost-effective way to boost your response rates and increase your book of business.
- Follow other industry leaders. Like and share their posts.
- Subscribe to industry research to stay abreast of consumer trends.

When it comes to creative, make sure yours gets noticed.

- Photos – Most people see themselves as 10-15 years younger than they really are. Select photos that are a little younger than your target audience but keep them realistic. Most 65- to 70-year-olds aren't jogging along a beach or riding tandem bikes. Photos should convey emotion, be relatable, and take into consideration local flavor and diversity.
- Colors – Be careful using subtle shades as background elements. As people age, their ability to discern lighter shades and certain colors diminishes and a graphic element like a shaded box may look like a blur or may not be seen at all.
- Other images, such as icons, are helpful in creative layouts to help guide readers efficiently through different copy sections to your call to action.
- Reverse Type – It's highly recommended to only use reverse/white type with large fonts, such as headlines and sub heads. Stay away from using reversed type on lightly colored backgrounds (especially yellow) or reversing out smaller type at all. Same with reversing type out of a photo.
- When it comes to direct mail, you want your piece to stand out in the mailbox. Envelopes the size of standard greeting cards or oversized postcards are more noticeable from standard business mail.

- Although CMS guidelines no longer require Times New Roman 12pt font on all marketing materials, due to the vision realities of people as they age, it is still recommended and a best practice to use this minimum font size in marketing materials.
- Stay away from superlatives and absolute statements unless they can be substantiated and you substantiate them.

COMMUNICATIONS AND MARKETING MATERIALS CHECKLIST

SECTION 1 DETERMINE IF THE MATERIAL IS CONSIDERED "MARKETING" OR A "COMMUNICATION"	
Definitions: **Communications** – activities and use of materials created or administered by a Plan or any downstream entity to provide information to current and prospective enrollees. Basically, all activities and materials aimed at prospective and current enrollees, including their caregivers, are considered "communications." **Marketing** – a subset of communications that must meet both **intent** and **content** standards to be defined as "marketing." These require submission to CMS via the HPMS portal. ***Intent*** – material or activities that are intended to: • Draw a beneficiary's attention to a plan or plans, • Influence a beneficiary's decision-making process when making a plan selection, or • Influence a beneficiary's decision to stay enrolled in a plan. ***Content*** – Materials or activities that include or address content regarding: • Plan benefits, benefits structure, premiums, or cost sharing • Measuring or ranking standards (for example, Star Ratings or plan comparisons), or • Rewards and incentives ***Example:*** An agency commercial or mailer states: "Call us to hear about plans that can provide hearing and dental benefits, zero-dollar monthly premiums, and can even lower your Medicare Part B costs." ***Marketing or Communication?*** Marketing. While a specific plan is not mentioned by name, the commercial's **intent** is to draw the beneficiary to a MA plan or plans and the **content** addresses plan premium, cost-sharing, and benefit information for plans being represented and sold by the third party."	
☐ **Yes** ☐ **No**	**1)** Is the material **intended** to draw attention to a Medicare Advantage Plan or Plans or influence a consumer's decision-making process when making a plan selection? *If yes, it meets the "Intent" requirement for marketing. If no, it is not marketing, as there is no "intent" present.*

☐ **Yes** ☐ **No**	**2)** Does the material meet the **content** requirement for "marketing"? *If any of the below can be checked, it is marketing content.* ☐ Plan benefits listed, even if in a general fashion (e.g., Dental, Vision, Hearing, etc.) ☐ Plan specific benefits are listed (e.g., Hearing Aids, Dentures, etc.) ☐ Plan premiums, even if $0, low cost, or no cost (e.g., Medicare Advantage Plans can have monthly plan premiums as low as $0) ☐ Copays, Coinsurance, Deductibles, Cost-sharing (e.g., $0 Copays) ☐ Part B giveback or buydown ☐ Measuring or ranking standards (e.g., Star Ratings, plan comparisons) ☐ Rewards and incentives
*** If #1 and #2 are answered Yes, then it is "marketing" and needs submitted to HPMS**	
☐ **Communication Only** ☐ **Marketing**	
SECTION 2 ENSURE THE MATERIAL IS ALIGNED WITH CMS AND CARRIER GUIDELINES NOTE: If you answer "no" to any of the questions below, it isn't compliant.	
☐ **Yes** ☐ **No** ☐ **N/A**	**Is all font legible and sized appropriately (including disclaimers)?** Required disclaimers must be 12pt Times New Roman or equivalent.
☐ **Yes** ☐ **No** ☐ **N/A**	**Is Agency/Broker name or logo visible, so it is clear who the sender is?**
☐ **Yes** ☐ **No** ☐ **N/A**	**If the piece is being sent/distributed during OEP (Jan 1 – Mar 31), is it compliant with the guidance below?** • Unsolicited "marketing" material is prohibited during this time unless it specifically targets IEP or an SEP. (e.g., Age-ins, 5-Star plans, etc.) • Messages aimed at generating interest or leads during the OEP are generally prohibited unless the piece specifically calls out the IEP or SEP being targeted. Therefore, if the message is not clear that it is marketing IEP and/or SEP during this time, it is prohibited.
☐ **Yes** ☐ **No** ☐ **N/A**	**Are full plan names used when first mentioned?** Examples: Medicare Advantage Plan, Medicare Supplement Insurance Plan, Prescription Drug Plan

☐ Yes ☐ No ☐ N/A	**If the piece is asking the consumer to call, is it clear that by calling the number they will reach a licensed insurance agent?** *Example Text:* CALLING THE NUMBER ABOVE WILL DIRECT YOU TO A LICENSED INSURANCE AGENT. *Example Text:* CALL NOW TO SPEAK WITH A LICENSED INSURANCE AGENT.
☐ Yes ☐ No ☐ N/A	**Is it clear that the agent is not affiliated with or endorsed by the government of Federal Medicare Program?** *Example Text:* NOT AFFILIATED WITH OR ENDORSED BY THE GOVERNMENT OR FEDERAL MEDICARE PROGRAM.
☐ Yes ☐ No ☐ N/A	**Is the piece free of any prohibited terms or language?** See examples of prohibited language below: • **"Entitled"** – when referencing plan benefits. Can only use "entitled" in reference to Part A. • **"Senior"** – should be careful not to limit your audience only to "seniors" as some Medicare beneficiaries are under 65. • **Unsubstantiated Statements** – "the best", "highest rated", "the most" doctors, "largest" network (without substantiation on the piece itself) • **"Free"** – when referencing plan premiums or benefits, suggested language "no additional cost." • **Exaggerative Phrases** – words/phrases such as "all", "full", "complete", "unlimited" to describe benefits/plans (these are only examples) • **Customized or Personalized** – when describing Medicare plans or benefit as plans cannot be customized for an individual's needs • **High-Pressure Sales tactics (scare tactics)** – language that may cause undue fear, anxiety, or confusion. Examples: "Beware", "Act Now", "Missing out", "You may lose your benefits", "URGENT", etc. • **"Medicare"** – when used in an agent title or in a Company name or domain name in a misleading manner

☐ Yes ☐ No ☐ N/A	**Is the piece free of any language, color schemes, and imagery that could cause the piece to appear governmental?** See examples of prohibited content below: • U.S. flag • Eagle • Red, white, blue color scheme appears governmental • Bar codes • Outline of the U.S. shape • Member numbers or ID numbers
☐ Yes ☐ No ☐ N/A	**If discussing benefits, is it clear to consumers that the piece is advertising a Medicare Plan, and not advertising additional benefits that can be added to current coverage?** For example: **Negative example:** "You may be eligible for additional benefits, call to see if you qualify." **Positive example:** "There may be Medicare Advantage Plans in your area that include additional benefits. Call to speak with a licensed insurance agent to learn more."
☐ Yes ☐ No ☐ N/A	**Is the piece free of any language that might imply a consumer must call, reply, or contact the agent/agency to implement or qualify for benefits?**
	Negative example: "Call Now to find out what benefits you are missing out on!" or "Fill out the information below to receive benefits you are entitled to!" **Positive example:** "To learn more about Medicare Advantage Plans available in your area, call to speak with a licensed sales agent." or "Fill out the information below to have a licensed insurance agent contact you regarding Medicare Advantage Plans available in your area."

LEAD GENERATION

COMMUNICATIONS AND MARKETING MATERIALS CHECKLIST

BRC Lead Pieces / Permission to Contact Forms:	
☐ Yes ☐ No ☐ N/A	**If the piece is a Business Reply Card (BRC) or other PTC form intended to gain permission to contact the consumer, does it contain the necessary permission to contact and PEWC language?** ***Example Text for Independent Agent:*** "By providing the information above, I grant permission for licensed insurance agent, <agent name>, to receive my information and call me regarding my Medicare options including Medicare Supplement Insurance, Medicare Advantage, and Prescription Drug Plans." ***Example Text for W-2 Employed Agent of Agency or FMO:*** "By providing the information above, I grant permission for a licensed insurance agent with <agency/FMO name> to receive my information and call me regarding my Medicare options including Medicare Supplement Insurance, Medicare Advantage, and Prescription Drug Plans." *Remember that you must also comply with the Telephone Consumer Protection Act (TCPA) and Telemarketing Sales Rule (TSR). This may include "prior express written consent" if you are using an auto dialer or similar call technologies.*
☐ Yes ☐ No ☐ N/A	**Does the material align with the following guidance?** **BRC/PTC forms should not ask for Date of Birth.** Select Yes if material meets this requirement.
☐ Yes ☐ No ☐ N/A	**Does the material align with the following guidance?** **BRC lead pieces should not include a place for consent to contact a spouse.** (Note: some carriers do not support the use of a single BRC for multiple consumer consents) Select Yes if material meets this requirement.
☐ Yes ☐ No ☐ N/A	**If Permission to Contact can be linked to Medicare Supplement Insurance products, does the piece include the following disclaimer?** **Example Text:** "This is a solicitation for insurance."
☐ Yes ☐ No ☐ N/A	**Does the piece contain the Agent/Agency name or logo?** For names and logos that could appear "governmental," the name/logo should contain the disclaimer "A Non-Governmental Entity."

☐ **Yes** ☐ **No** ☐ **N/A**	**Is the BRC/ Permission to Contact form still valid?** For BRCs/Permission to Contact forms, requests are valid for 12 months from the beneficiary's signature date or the date of the beneficiary's initial request for information.
Disclaimers:	
☐ **Yes** ☐ **No** ☐ **N/A**	**Federal Contracting Statement:** Required on all "marketing" materials, except those specifically excluded by CMS. **Example Text (Carrier Specific):** "[Carrier's legal or marketing name] is a [plan type] with a Medicare contract. Enrollment in [carrier's legal or marketing name] depends on contract renewal." **Example Text (Generic):** "Plans are insured or covered by a Medicare Advantage organization with a Medicare contract and/or a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare." **Example Text (Agencies):** "[Partner/Agency] represents Medicare Advantage [HMO, PPO, and PFFS] organizations that have a Medicare contract. Enrollment depends on the plan's contract renewal." **Example Text (Lead Vendors):** "Participating sales agencies represent Medicare Advantage [HMO, PPO, and PFFS] organizations that are contracted with Medicare. Enrollment depends on the plan's contract renewal."
☐ **Yes** ☐ **No** ☐ **N/A**	**Is the Third-Party Marketing Disclaimer included when required?** Required on all third-party websites, electronic communications, and on marketing materials. (Note: A different version of the disclaimer is required for TPMOs that truly offer every option in a service area.) ***Required Text:*** "We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options."

☐ Yes ☐ No ☐ N/A	**If plan benefits are marketed, is the following disclaimer included?** ***Example Text:*** "Plans offered through [insert list of carrier names]. Not all plans offer all of these benefits. Availability of benefits and plans varies by carrier and location. Limitations and exclusions may apply." **NOTE:** You may not market benefits in a service area where those benefits are not available unless the local media exception applies. You must also list all carriers that offer the benefits listed.
☐ Yes ☐ No ☐ N/A	**If "Medicare" is mentioned in a name, heading, domain name, etc., does it include a clear and prominent qualifier to make it clear there is no government affiliation?** ***Example Text:*** "<Agency name> is an insurance agency not affiliated with the government" or "Advertisement – no government affiliation" or "A Non-Governmental Entity."
Events:	
☐ Yes ☐ No ☐ N/A	**If the piece is an invitation to an event (educational or sales), is the following disclaimer included?** ***Example Text:*** "For accommodation of persons with special needs at meetings call <insert phone and TTY number>."
☐ Yes ☐ No ☐ N/A	**If the piece is an invitation to or advertisement for an educational event, is the event advertised as "educational?"** ***Example Text:*** "This is an educational event" or "Join us for an educational event."
☐ Yes ☐ No ☐ N/A	**If SSBCI benefit(s) are mentioned, is the following disclaimer included?** ***Example Text:*** "The benefits mentioned are part of the special supplemental program for chronically ill members with one of the following disorders: [diabetes mellitus, chronic heart failure, chronic lung disorders, cardiovascular disorders, or chronic and disabling mental health conditions].* This is not a complete list of qualifying conditions. Having a qualifying condition alone does not mean you will receive the benefit(s). Other eligibility and coverage requirements may apply." *See the Disclaimer Quick Reference table on page 51.

☐ Yes ☐ No ☐ N/A	**If a drawing or prize is advertised with the event, is the following disclaimer included?** ***Example Text:*** "Eligible for a free drawing and prizes with no obligation to enroll in a plan." or "Free drawing without obligation to enroll in a plan."
☐ Yes ☐ No ☐ N/A	**If any marketing materials mentions the Part B giveback, is the following disclaimer included?** ***Example Text:*** "The Part Giveback Benefit pays part or all of your Part B premium and the amount may change based on the amount you pay for Part B."

CARRIER EXAMPLES THAT AVOID PROHIBITED LANGUAGE

ISSUE DESCRIPTION	NEGATIVE EXAMPLE (THESE ARE EXAMPLES OF PHRASES THAT MAY BE MISLEADING AND/OR CONFUSING AND MAY IMPLICATE CMS CONCERNS)	POSITIVE EXAMPLE (THESE ARE EXAMPLES OF HOW SUCH PHRASES CAN BE CORRECTED SO THAT INFORMATION ABOUT THE BENEFITS CAN STILL BE ADVERTISED AND COMMUNICATED IN A WAY THAT IS UNLIKELY TO BE MISLEADING OR CONFUSING)
a) Promoting benefits that are not generally included in most Medicare Advantage plans (e.g., dentures, free eyeglasses).	"And coverage for dental work with extractions, fillings, even dentures, all at no additional cost!"	"And plans may be available in some areas that include coverage for dental work with extractions, fillings, even dentures" NOTE: You may only advertise benefits in service areas where the offered unless the local media exception applies. You must also list all carriers offering the referenced benefits. Requires carrier approval and HPMS filing.
b) Advertising benefits that are limited to certain enrollees or where the amount varies per enrollee, like Part B Giveback.	"Included in your plan up to $144 added back to your Social Security check every month"	"Some plans in certain areas may include the Part B Giveback Benefit, which can allow you to get a partial or full Part B premium reduction." NOTE: You may only advertise benefits in service areas where the offered unless the local media exception applies. You must also list all carriers offering the referenced benefits. Requires carrier approval and HPMS filing.

LEAD GENERATION

CARRIER EXAMPLES THAT AVOID PROHIBITED LANGUAGE

c) Advertising an SSBCI benefit.	"You may qualify for help paying for groceries and utility bills."	"There may be plans in your area that help pay for groceries and utility bills.* *These benefits mentioned may be part of a special supplemental program or chronically ill members with one of the following conditions: [insert list of conditions]. [This is not a complete list qualifying conditions.] Having a qualifying condition alone does not mean you will receive the benefits. Other coverage and eligibility requirements may apply." NOTE: You may only advertise benefits in service areas where the offered unless the local media exception applies. You must also list all carriers offering the referenced benefits. Requires carrier approval and HPMS filing. NOTE: The SSBCI disclaimer is required. The disclaimer must meet the font requirements.
d) Promoting cost savings that are not typical or limited to certain enrollees.	"The agent said I'm eligible to eliminate copays"	"The licensed sales agent said there may be plans available in my area that may help me save money."
e) Promoting very specific amounts related to benefits where most MA members would not receive that level of benefits (i.e., "$1,500 back in my Social Security check").	"Get $1,700 a year back in your pocket"	"You may be able to find a plan in your area with the Part B Giveback benefit, which may allow you to get a partial or full Part B premium reduction." NOTE: You may only advertise benefits in service areas where the offered unless the local media exception applies. You must also list all carriers offering the referenced benefits. You also may not advertise unrealized cost savings. Requires carrier approval and HPMS filing.
f) Describing benefits in a misleading way (e.g., "elimination of copays").	"You may be able to get significant extra benefits, all at no additional cost"	"You may be able to find a plan in your area with extra benefits, and $0 monthly plan premium." NOTE: You may only advertise benefits in service areas where the offered unless the local media exception applies. You must also list all carriers offering the referenced benefits. Requires carrier approval and HPMS filing.

LEAD GENERATION

CARRIER EXAMPLES THAT AVOID PROHIBITED LANGUAGE

g) Using the U.S. flag.	Flags displayed in the ad are very similar to images seen of government offices or the same way they are displayed behind the press secretary during a press conference, implying that the message is coming from a government agency.	Flag imagery may be used only to invoke more of a hometown, Americana sense rather than an official, governmental sense. E.g., a flag flowing from a flagpole in a person's yard rather than multiple flags on a stand in an office-like setting, similar to how they are displayed in govt. buildings.
h) Utilizing a red, white and blue color scheme.	Red, white and blue imagery that dominates piece, is combined with a U.S. flag/Medicare card/company name that could appear to be associated with the government.	Red, white and blue color scheme may be permissible if other risky elements are omitted and arrangement of colors does not follow American flag.
i) Using scare tactics.	"Millions of Americans may not have all available benefits." "Take Action now to get the benefits you are entitled to."	"Depending on your area, you may be able to enroll in a plan with additional benefits." Note: The key is removing language that causes undue anxiety or fear which scares the consumer into calling because they think they are at risk of losing Medicare coverage or not receiving certain benefits. Avoid font that is in all caps, oversized and red.
j) Promoting a false sense of urgency to act now, in either words, imagery or tone.	"Attention: Anyone on Medicare" "URGENT" "Act now, or you may lose your benefits!"	"Medicare Advantage Plan Options for 2027" "Information for Medicare Recipients"
k) Stressing a deadline for enrolling that could be misleading or unduly pressure beneficiaries into calling.	During AEP: "AEP is ending soon" (if used at the beginning of AEP) Outside AEP: Any language that implies the beneficiary is required to meet a deadline when they really are not (i.e., "Attention: Important Medicare Deadline"; "Don't Miss the Deadline")	During AEP: "Enroll Now; AEP Ends on 12/7"; "The Time is Now"Outside AEP: "Learn more about your MA plan options"; "Call to speak with a licensed sales agent to see if you are eligible to enroll"
l) Implying that beneficiary must call the sales agency to implement their Medicare plan/ benefits.	"Call now to find out what benefits you are missing out on!" "Call to receive benefits you are entitled to!"	"To learn more about Medicare Advantage plans available in your area, call to speak with a licensed sales agent."

LEAD GENERATION

CARRIER EXAMPLES THAT AVOID PROHIBITED LANGUAGE

m) Making it unclear whether it is referring to the Medicare Advantage and Prescription Drug Plan Annual Enrollment Period and/or dates of this enrollment period.	"Enrollment open now!"; "Open Enrollment Begins Now" (referencing OEP); "Call before December 7th" (with no explanation of what this is referring to); "Annual Open Enrollment Period" (combining AEP and OEP)	"Medicare Advantage & Prescription Drug Plan Annual Enrollment Period"; "Medicare Annual Election Period"; "Medicare Annual Enrollment Period" Note: AEP may be acceptable if there is limited space and it clear from the context of the piece that the enrollment period referred to is that in which a person can enroll in a Medicare Advantage and/or Prescription Drug Plan.
n) Otherwise including misleading, confusing, or materially inaccurate information.	"Get money added back to your Social Security check!" "See if you're eligible for these benefits at no additional cost!" "Eliminate your copays!" "Call to check your ZIP code."	"Depending on your ZIP code, there may be a Medicare Advantage plan available that includes a Medicare Part B premium giveback which can reduce the amount deducted from your Social Security check each month." "Call to see if there are plans with $0 monthly plan premium available in your area." "Call to learn about plans in your area with affordable co-pays." "Call to see if you are eligible for plans that may include additional benefits like vision, hearing, and transportation." NOTE: You may only advertise benefits in service areas where the offered unless the local media exception applies. You must also list all carriers offering the referenced benefits. You may not advertise unrealized cost savings. Carrier approval and HPMS filing.

WEBSITE CHECKLIST

DETAIL	YES	NO	N/A	COMMENTS
Registration Information				
• Is your URL Registered (if necessary)?				For certain Carriers, websites of contracted agents/agencies must be registered. Regardless if it carries logos, branding, materials, or is meant for agents or consumers.
• Does the URL Open/ work?				
Logo Usage				
• Appropriate Logo usage? Approved by Appropriate Carrier?				
Agent Title				
• Appropriate use of Agent Title?				Cannot mislead consumers into thinking an agent is affiliated with Medicare in any way. Prohibited Titles: Medicare Sales Agent or Senior Advisor. Approved Titles: Sales Agent, Sales Representative, Licensed Sales Agent, Independent Sales Agent, etc.
Contact Page – BRC				
• Appropriate Scope of Products included?				The same content regulations apply to an electronic BRC as to a paper BRC. You may post a generic electronic Business Reply Card (eBRC) on your website; however, the following disclaimer must appear: For Contact by Agents Employed by Your Agency: "By providing the information above, I grant permission for a licensed insurance agent with <agent/agency name>, to call me regarding my Medicare options, including Medicare Supplement Insurance, Medicare Advantage, and Prescription Drug Plans." For Sharing with an Agent Not Employed by Your Agency: "By providing the information above, I grant permission for <insert agent name>, a licensed insurance agent, to receive my information and call me regarding my Medicare options, including Medicare Supplement Insurance, Medicare Advantage, and Prescription Drug Plans." For Sharing with Multiple Agents that are Not Employed by Your Agency: "By checking the boxes below, I grant permission for <insert name of TPMO collecting the data> to share my information with the following individuals and for such individuals to call me regarding my Medicare options, including Medicare Supplement Insurance, Medicare Advantage, and Prescription Drug Plans:" ___ Jane Doe ___ John Smith ___ Tom Agent **Note:** Some carriers require submission of websites if it contains a BRC or Contact form regardless if it meets the definition of "marketing" or not. **Note:** If the BRC mentions Medicare Supplement Insurance, include the disclaimer, "This is a solicitation for insurance."
• Appropriate Method of Contact included?				
• Free from REQUIRING contact information: i.e., phone/email?				
• All individual TPMOs who may receive the data are listed for the beneficiary to grant PEWC with an affirmative action.				
• Free from Date of Birth? (Cannot ask for D.O.B – age or date of Medicare eligibility is ok)				
• Free from Medical or RX History?				

LEAD GENERATION

WEBSITE CHECKLIST

DETAIL	YES	NO	N/A	COMMENTS
Disclaimers				
• Required on all websites				"We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare. gov or 1-800-MEDICARE to get information on all of your options."
• Required on all websites that meet the definition of "marketing"				Plans are insured or covered by a Medicare Advantage organization with a Medicare contract and/or a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.
• Required on all websites that include Plan benefit information				Not all plans offer all of these benefits. Benefits may vary by carrier and location. Limitations, exclusions, copays, deductibles, and coinsurance may apply.
• If Star Ratings are mentioned in marketing materials, you need to convey that plans are evaluated yearly by Medicare and that ratings are based on a 5-star rating system				Every year, Medicare evaluates plans based on a 5-star rating system.
• Suggested to include on all websites so it's clear they aren't affiliated with the government				Not affiliated with or endorsed by the government or Federal Medicare Program. Agent Name or Agency Logo should be prominently displayed, and it is suggested to include a qualifying statement like: "<Agency name> is an insurance agency not affiliated with the government."
Content (In addition to below, all guidelines that apply to other marketing materials also apply to websites)				
• Appropriate use of "Free" ?				May not refer to any benefit, item or service as "free", as the costs are built into the plan. May not use the term "free" unless something truly is free, meaning there is no cost to the plan, Medicare/CMS, or the beneficiary in any way. ACTION: Use "at no additional cost" instead.
• Appropriate use of "Senior"?				CMS considers the term "senior" (when used to describe enrollment eligibility) to be discriminatory toward those beneficiaries eligible for Medicare based on disability. ACTION: Revise "senior" to "Medicare beneficiaries" or "seniors and other Medicare beneficiaries"
• Appropriate use of "Entitled"?				Beneficiaries are not entitled to any Medicare benefits, except Part A (if certain requirements are meant) therefore using the term entitled implies that the beneficiary is not receiving something they should be. This is a misleading/inaccurate statement. ACTION: Change to "eligible"

LEAD GENERATION

WEBSITE CHECKLIST

DETAIL	YES	NO	N/A	COMMENTS
• Appropriate and complete product Terms – Medicare Advantage not MA.				Full titles should be used when first introduced. i.e., Medicare Advantage; Prescription Drug Plan; Medicare Supplement Insurance Plans.
• Free from Benefit/ Premiums/Copays info?				Agent web pages may not contain material, including product descriptions and benefits, unless express permission is given by the appropriate Carrier and the material has been filed in HPMS.
• Free from inappropriate use of CMS/DHHS/ Medicare Symbols or name in URL?				Cannot use names, domain names, logos, symbols, colors, etc. that would mislead a consumer into thinking you are affiliated in any way with Medicare or the government.
• Free from inappropriate Private/Proprietary Materials embedded?				Carrier Proprietary Information is not to be disclosed to anyone outside of the company, including the media, under any circumstances without prior approval from the appropriate Carrier's Compliance/Legal department.
• Free from Inaccurate/ Misleading/ Misrepresentation?				Website content must not: speak disparagingly of Medicare, CMS, or a Carrier; include contracts or appointment forms; include plan materials, enrollment kits, or benefit guides.
• Free from inappropriate posting of events for next AEP Prior to October 1?				Marketing for an upcoming plan year may not occur prior to October 1.
• Are appropriate Nominal Gift Disclaimers in place?				When promoting drawings, prizes, or promise of free gifts include a Nominal Gift disclaimer on all websites stating there's no obligation to enroll in a plan. For example: "Eligible for a free drawing and prizes with no obligation to enroll in a plan." or "Free drawing without obligation to enroll in a plan."

SECTION 4:

EVENT COMPLIANCE

EVENT COMPLIANCE

FIRST OF ALL, LET'S LOOK AT THE TWO TYPES OF EVENTS: **(1) SALES AND MARKETING EVENTS AND (2) EDUCATIONAL EVENTS.**

EDUCATIONAL EVENTS

An **educational event** is an event designed to **inform** or **educate** Medicare beneficiaries about Medicare Advantage, Prescription Drug, or other Medicare programs and does not include marketing activities. Agents may not market specific plans or benefits. Accordingly, agents cannot steer, or attempt to steer, potential enrollees toward a specific plan or limited number of plans.

- Educational events must be advertised as "educational."
- Educational events must be held in a public venue and not in an in-home or one-on-one setting.
- Educational events may be held in a healthcare setting. See subsection "Activities with Healthcare Providers" on page 103 for more information.

WHAT YOU CAN DO AT AN EDUCATIONAL EVENT:

- Educate consumers about Medicare, Medicare Advantage, Prescription Drug, or other Medicare Programs.
- Distribute communications materials.
- Display a banner with your agency name and/or agency logo.
- Distribute your business cards and contact information for beneficiaries to initiate contact.
- Make available and collect permission to contact forms, such as BRCs, for attendees to request contact from the agent.
- Make available Scope of Appointment forms.

- Answer questions asked by consumers (provided the response doesn't go beyond the scope of the question asked).
- Make available materials and items that attract beneficiaries at a booth, kiosk, or table. You may not approach beneficiaries, however.
- Provide meals or snacks (as long as they do not exceed $15 in value). See subsection "Meals and Snacks" on page 103 for more information.
- Offer promotional items as long as they are of nominal value, do not contain marketing, are offered without discrimination to similarly-situated beneficiaries without regard to whether or not the beneficiary enrolls, are not in the form of cash, cash equivalents, or other monetary rebates, and are not for referrals. See subsection "Nominal Gifts" on page 102 for more information. These items can display the agency name, logo, phone number, and/or website.

WHAT YOU CAN'T DO AT AN EDUCATIONAL EVENT:

- Distribute plan-specific materials.
- Distribute plan-specific premium or benefit information.
- Discuss any plans offered.
- Distribute or collect plan applications (enrollment forms).
- Make any sales or marketing presentations.

SALES AND MARKETING EVENTS

A **sales event,** or **marketing event** as they are sometimes called, is an event where all allowable types of marketing activities can occur. Marketing events can be designed to steer, or attempt to steer, potential enrollees toward a plan or a limited set of plans. Agents may educate beneficiaries just like at an educational event, but they can also market specific plans, discuss plan specific benefits, along with other compliant marketing activities.

EVENT COMPLIANCE

- Sales and marketing events **MUST** be reported to each applicable carrier you are representing.
  - Each carrier has its own process, timeframes, and requirements. Make sure you know how/when to report your events.
  - If an event must be cancelled, know each carrier's process, timeframe, and requirements for cancellations. If cancelled within the minimum required timeframe, a representative should still be present to notify potential attendees of the cancellation (and stay at least a half an hour past the scheduled start time).
- Sales and marketing events may be held in the common area of a healthcare setting, such as in a lobby, conference room, or cafeteria of a hospital.
  - In a pharmacy, they must be "outside" of the areas where individuals wait for services from or interact with pharmacists or technicians and/or obtain medications. This is generally at least 15 feet away from the pharmacy counter.

There are two different types of sales and marketing events: **Formal** and **Informal**

- **Formal Sales and Marketing Events** are a more structured event using an audience/presenter type format.
- **Informal Sales and Marketing Events** utilize a less structured format; for example, a table, kiosk, etc. that is staffed by a sales representative where consumers must initiate the conversations.

WHAT YOU CAN DO AT A SALES AND MARKETING EVENT:

- Educate consumers about Medicare, Medicare Advantage, Prescription Drug, or other Medicare Programs.
- Provide marketing materials.
- Conduct marketing presentations.
- Distribute advertisements or invitations to the event that meet applicable compliance requirements.
- Use presentations, handouts, and materials that have been approved by each carrier you are representing.

EVENT COMPLIANCE

- Make available materials and items that attract beneficiaries at an informal sales and marketing event, such as at a booth, kiosk, or table. (You may not approach beneficiaries, however).
- Distribute and accept plan applications.
- Collect Scope of Appointment forms for future personal marketing appointments.
- Provide light snacks or refreshments that do not combine to create a meal (if the total value of all snacks and refreshments is $15 or less per person).
- Offer promotional items as long as they are of nominal value, are offered without discrimination to similarly situated beneficiaries without regard to whether or not the beneficiary enrolls, are not in the form of cash, cash equivalents, or other monetary rebates, and are not for referrals. See subsection "Nominal Gifts" on page 102 for more information. These items can display the agency's or a carrier's name, logo, phone number, and/or website.

WHAT YOU CAN'T DO AT A SALES AND MARKETING EVENT:

- Distribute any advertisements or invitations to the event that contain marketing content that has not been approved by each carrier you are representing. Note that some carriers provide or request to approve the advertisements and invitations.
- Use or distribute any marketing materials, handouts or presentations that have not been approved by each carrier you are representing.
- Require attendees to provide contact information as a prerequisite for attending an event.
- Require attendees to sign in or require sign-in sheets.
- Conduct activities, including health screenings, health surveys, or other activities that are used for or could be viewed as being used to target a subset of members (that is, "cherry-picking").
- Approach beneficiaries at an informal sales and marketing event, such as a booth, kiosk, or table.
- Use information collected for raffles or drawings for any purpose other than the raffles or drawings.

EVENT COMPLIANCE

- Provide meals (even if the total value of each meal is $15 or less per person).
- Provide snacks that, if combined together, could constitute a meal (even if the total value of the combined snacks is $15 or less per person).

EDUCATIONAL VS. SALES EVENTS – DO'S AND DON'TS

DO'S AND DON'TS AT AGENT HOSTED EVENTS		
ACTIVITY	**EDUCATIONAL**	**SALES**
File With CMS (via the applicable Carrier/s)	No*	Required
Distribute/Collect Enrollment Applications	No	Yes
Distribute/Collect SOA Forms for a Later Meeting	Yes	Yes
Provide Business Cards	Yes	Yes
Distribute Marketing Materials	No	Yes
Discuss Plans Offered	No	Yes
Distribute Sales/Plan Materials	No	Yes
Provide giveaways displaying agent contact information	Yes	Yes
Provide cash or cash equivalents as giveaways	No	No
Provide meals of nominal value	Yes	No
Provide snacks of nominal value	Yes	Yes
Offer nominal gifts**	Yes	Yes
Offer gifts that exceed $15 retail value	No	No
Restrict event admission	No	No
Provide educational materials on healthcare topics	Yes	Yes

***Even though educational events are not filed with CMS, some carriers require them to be reported with the carrier. Be aware of carrier-specific filing requirements.**

****The nominal gifts must be offered without discrimination to similarly-situated beneficiaries without regard to whether or not the beneficiary enrolls, may not in the form of cash, cash equivalents, or other monetary rebates, and may not be for referrals.**

HOW TO REPORT A SALES EVENT

This process depends on which carrier you're dealing with, as they each have their own process. For assistance reporting events compliantly, contact your carrier or FMO.

SECTION 5:

COMPLIANT SALES

APPOINTMENTS

PERSONAL APPOINTMENTS GENERALLY

- Personal marketing appointments are those appointments that are tailored to an individual or small group (for example, a married couple).
- Personal marketing appointments are not defined by the location. They may be in-person, telephonic, or via web-based technology.
- You may accept applications to enroll individuals in personal appointments.
- You may market specific products, conduct a marketing presentation, provide marketing materials, distribute and accept plan applications, and review the individual needs of the beneficiary, including but not limited to, health history, healthcare needs, commonly used medications, and financial concerns.
- You may only discuss health-related products at an appointment that were agreed upon and documented in the Scope of Appointment form.
- If you would like to discuss additional health-related products that were not included in the original documented Scope of Appointment form, then you must obtain a separate Scope of Appointment identifying the additional health-related lines of business.
- You may not market any non-health-related products in the same personal appointment (such as final expense, annuities, or life insurance).

SCOPE OF APPOINTMENT

- A Scope of Appointment (SOA) is required prior to ALL personal/individual sales appointments with existing or new/potential members regardless of whether the appointment is in-person, telephonic, via web-based technology, or a walk-in.
- A Scope of Appointment must be obtained prior to a personal marketing appointment.
- SOAs are valid for twelve (12) months following a beneficiary's signature date.
- CMS does not require a specific SOA form. Acceptable forms of SOA Documentation include:
  - A signed hard copy SOA form
  - An electronically signed SOA form
  - A telephonic recording of the SOA (for telephonic appointments only) (must cover all required components)
- The SOA should include the following information on the form or the recording:
  - Product types to be discussed.
  - Execution date.
  - Beneficiary name and contact information.
  - Agent name and contact information.
  - A statement stating that there is no obligation to enroll, current or future Medicare enrollment status will not be impacted, and automatic enrollment will not occur.
- You may only discuss products at an appointment that were agreed upon and documented in the SOA form.
- Know the SOA guidelines for each of your carriers.
- Keep SOAs for at least 10 years and have them available upon request (even if you submit with the application).
- **Best Practice:** Have the client INITIAL beside the products they wish to discuss.

FREQUENTLY ASKED QUESTIONS (FAQS):

1. **If a beneficiary requests to discuss another health-related product during an appointment, what do I need to do?**
   A new SOA form is required if the beneficiary has requested to discuss another product type during the appointment. However, a new appointment is not required. The additional product can be discussed after a new SOA is filled out.

2. **Can an SOA be collected at an Educational Event?**
   Yes. Beginning October 1, 2026, agents may make SOAs available and collect SOAs at educational events for Medicare plans with effective dates in 2027.

3. **Can I set up a future personal marketing appointment at an Educational Event?**
   Yes. Beginning October 1, 2026, agents may set up future marketing appointments at educational events for Medicare plans with effective dates in 2027.

4. **If I'm selling for more than one carrier, can I use a generic SOA?**
   Yes.

5. **Can I market non-health-related products (such as final expense, annuities, or life insurance) at a personal appointment?**
   No. If a client asks you about non-health-related products, you will need to schedule a new appointment (at least 48 hours later if possible).

6. **What should I do if my client brings an unexpected guest with them to a personal appointment meeting?**
   You will need to obtain a new SOA for the guest and provide an explanation in the appropriate field.

COMPLIANT SALES
APPOINTMENTS

PRIOR TO THE APPOINTMENT

- **Make sure you are "Ready to Sell" all products you could conceivably discuss.**
  - Licensed, Appointed & Certified
  - Unqualified sales result in loss of compensation and possible termination
- **Complete a compliant Scope of Appointment form for ALL in attendance prior to the scheduled meeting**
  - Only discuss products agreed upon in the Scope of Appointment.
- **Call your prospect to ask the following questions. (The call should be recorded if it will contain any marketing content or pertinent information affecting the sales/enrollment process, including plan presentations, needs analysis, initial contact, medications, providers, enrollment, etc.)**
  - Does someone have a Power of Attorney for making your healthcare and insurance decisions? If they will be signing your enrollment form, they must be able to attest to having the proper legal authority to make healthcare and insurance decisions on the beneficiary's behalf.
  - Would you like to invite any spouse or partner to the presentation?
  - Is there any additional information that you think I should know?
  - Ask them to bring a list of healthcare providers (e.g., Primary Care Physician, specialists, etc.) and any current prescriptions they would like to verify.

DURING THE APPOINTMENT

- You should review the individual needs of the beneficiary, including but not limited to, healthcare needs, preferred providers, commonly used medications, and budget concerns.
- You may market specific products, conduct a marketing presentation, and provide marketing materials.
- Only use carrier-approved marketing materials.

- You may only discuss health-related products during the appointment that were agreed upon and documented in the Scope of Appointment form.
- If you would like to discuss additional health-related products that were not included in the original documented Scope of Appointment form, then you must obtain a separate Scope of Appointment identifying the additional health-related lines of business.
- You may not market any non-health related products (such as final expense, annuities, or life insurance) during the appointment.
- You may distribute and accept plan applications.
- You must fully discuss a specific list of questions and topics prior to the enrollment process. Topics include information regarding:
  - Primary care providers and specialists (including whether or not the beneficiary's current providers are in the plan's network)
  - Prescription drug coverage and costs (including whether or not the beneficiary's current prescriptions are covered)
  - Costs of the healthcare services
  - Premiums
  - Benefits
  - Specific healthcare needs of the beneficiary
- For telephonic appointments, you must review the contents of the Pre-Enrollment Checklist (PECL) prior to the completion of the enrollment.
  - You should ensure that the beneficiary understands the items in the PECL. You can confirm this understanding by receiving an affirmative answer to whether the prospective enrollee understands the information provided or asking the prospective enrollee if he or she has any questions.

APPOINTMENT CHECKLIST

- ❑ **If meeting over the phone, remember to:**
  - ❑ Use an approved script for all telephonic sales.
  - ❑ Record the call and obtain beneficiary consent to record the call.
  - ❑ State the TPMO disclaimer prior to the discussion of any benefits.
  - ❑ Review the contents of the PECL prior to the completion of the enrollment.
- ❑ **Show up on time**
- ❑ **Clearly introduce yourself and stress that you do not work for Medicare.**
- ❑ **Confirm eligibility**
  - ❑ Medicare A & B (or A or B for a standalone PDP)
  - ❑ Medicaid, LIS, or other coverage
  - ❑ Confirm the service area
- ❑ **Thoroughly review the provider network**
  - ❑ Primary care providers and specialists
  - ❑ Include whether or not current providers are in-network
- ❑ **Confirm provider network and provider access**
  - ❑ Role of PCP / Specialist Referrals (if applicable)
- ❑ **Discuss whether or not current prescription drugs are covered**
- ❑ **Thoroughly review the drug formulary**
- ❑ **Review prescription drug tiers, copays, and restrictions (if applicable)**

COMPLIANT SALES
APPOINTMENTS

- ❑ **Carefully review plan benefits**
- ❑ **Carefully review plan premiums**
- ❑ **Describe Part B premium requirement (must continue to pay)**
- ❑ **Explain out-of-pocket costs (office visits/urgent care/hospital/ER/ambulance)**
- ❑ **Thoroughly review copays and coinsurance**
- ❑ **Review dental, vision, and hearing benefits (if applicable)**
- ❑ **Discuss special needs of the beneficiary (physical therapy, DME, etc.)**
- ❑ **Explain what their new ID card will be used for**
- ❑ **Review the Statements of Understanding (SOU)**
- ❑ **Explain the effective date of plan coverage (including the year)**
- ❑ **Provide the plan's customer service telephone numbers**
- ❑ **Make sure the application is filled out fully and accurately**
- ❑ **Ask Yourself: Is this the best plan for my client?**
- ❑ **Always capture the client's consent to enroll in which you allow the consumer to confirm their intent to enroll**
- ❑ **NEVER help a consumer enroll via a consumer website if you are physically present (only enroll consumers using an approved agent enrollment tool)**
- ❑ **Give the client your contact information and urge them to call you or the carrier with questions or issues — NOT Medicare.**
- ❑ **Submit the applications the same day you receive them.**

AFTER THE APPOINTMENT

- ❑ **Call the beneficiary to follow up**
  - ❑ See if they have any questions about the plan they enrolled in
  - ❑ Make sure they fully understand the plan they chose
  - ❑ Make sure they fully understand the Benefits/Coverages, Copays/Coinsurance, & Provider Network
  - ❑ Make sure your client has your contact info so they can contact YOU for any further questions or information they may need

VIRTUAL APPOINTMENTS

There may be times when an in-person appointment is not feasible or safe and, thus, a virtual appointment is needed. Virtual appointments are allowable and a good option for agents when meeting in person isn't an option. There are many carrier-specific tools and resources available to help you through this process including enrollment tools, electronic scope of appointments, job aids, guides, etc. Just remember, that virtual appointments must follow CMS guidelines just like in-person appointments.

FREQUENTLY ASKED QUESTIONS (FAQS):

1. **Do I need to capture a Scope of Appointment for virtual appointments?**
   Yes, you still need an SOA.
2. **How do I capture a Scope of Appointment for virtual appointments?**
   You can capture SOAs for virtual appointments using the same methods you do for regular in-person appointments. Options include paper, electronic, and voice recording. Carriers may have other options as well and should have various tools available for you to capture SOAs. Contact your applicable carriers for further guidance.

3. **What are best practices for remaining compliant?**
   Follow all CMS regulations just as you would for a normal in-person appointment. Follow the above Appointment Checklist. Check with your carrier representatives or your carrier agent portals as most have guides and job aids available for virtual marketing and selling.

4. **What are some requirements that I need to remember?**
   Since a virtual appointment is over the phone, remember to:

   - Record the entire appointment and obtain the beneficiary's consent to record the appointment.
   - State the TPMO Disclaimer prior to the discussion of any benefits.
   - Use any scripts.
   - Review the contents of the PECL prior to the completion of the enrollment.
   - Record the individual's consent to enroll.

5. **What is the best way to submit enrollments online?**
   We suggest either using a carrier-specific online enrollment tool or using IntegrityCONNECT, which is Integrity's multi-carrier online enrollment tool.

COMPLIANT SALES

DO'S AND DON'TS

DO	DON'T
Clearly identify the products to be discussed, and ONLY discuss those agreed upon in the Scope of Appointment (SOA)	Discriminate in any way
Announce you don't work for Medicare and you could be compensated for this sale	Attempt to enroll someone with a diminished capacity to understand
Quote accurate plan costs	Say that you or the plan is CMS-endorsed or recommended by the federal government
Hold meetings in handicapped-accessible facilities	Use misleading, conflicting, or confusing statements
Communicate to non-English speakers in a way they will understand	Engage in high-pressure sales or scare tactics
Advise the client how to use the formulary	Collect financial information during pre-enrollment activities
Use only approved marketing materials	Imply Medicare is only available to seniors
Offer to complete a prescription drug search to confirm formulary coverage, provide a cost estimate, and identify any restrictions	Require a consumer to provide their prescriptions if they decline the lookup offer
Ensure the client understands all elements of the Pre-Enrollment Checklist (PECL) – including the enrollment's effect on current coverage	Offer monetary or promotional gifts to induce enrollment

COMPLIANCE METRICS

Below are some of the common metrics companies use to measure your overall compliance as it relates to the sales process.

- Cancelled Applications
- Rapid Disenrollments
- Late Applications
- Member Complaints

CANCELED APPLICATIONS

A Cancelled App is defined as a submitted application that is cancelled by the consumer before the application's effective date.

Top Reasons for Cancelled Apps:

- **Inaccurate Provider Network Information**
- **Inaccurate Drug Formulary Information**
- **Inaccurate Cost or Benefit Information**
- **Unsuitable Plan Enrollment**
- **Client Confusion with the Plan**

TIPS FOR REDUCING CANCELLED APPS:

- ❑ Verify the provider network and double-check to ensure the client's provider is still participating in the plan.
- ❑ Make sure all medications the client has are covered by the plan.
- ❑ Explain all costs associated with the plan accurately and thoroughly to make sure the client fully understands all costs involved.
- ❑ Discuss all benefits and make sure the client understands what benefits are covered and what is not covered. E.g., dental, vision, gym memberships, etc.
- ❑ Make sure the plan you are marketing/selling is the best option for the client. If it is, they should have no reason to cancel/switch plans.
- ❑ Take extra time with dual-eligible clients to make sure they fully understand the plan and that the plan is the best fit for their needs.

RAPID DISENROLLMENTS

A Rapid Disenrollment is the voluntary disenrollment of a member from an MA/PDP plan within the first 3 calendar months after their initial enrollment effective date.

Top Reasons for Rapid Disenrollments:

- **Inaccurate Provider Network Information**
- **Inaccurate Benefit/Coverage Info (e.g., copay/coinsurance, dental/vision, etc.)**
- **Incorrect Drug Formulary Information**
- **Unsuitable Plan Enrollment**
- **Inaccurate Plan Description**

TIPS FOR REDUCING RAPID DISENROLLMENTS:

- ❑ Confirm the enrollee's providers are participating.
- ❑ Provide and explain thoroughly (and multiple times, if needed) the plan's benefits and coverages (especially dental/vision benefits), its limitations, and its rules, including copays, coinsurance, provider network, and Part D penalty.
- ❑ Verify enrollee's medication coverage. Can use online search tools available to you or reference www.medicare.gov.
- ❑ Ensure that the chosen plan is the best option for your client and the correct plan is chosen on the enrollment form.
- ❑ Pay particular attention to your Dual SNP clients.
- ❑ Explain enrollee is not joining a Medicare Supplement Insurance plan.
- ❑ Review next steps at the time of enrollment.
- ❑ Urge them to attend member events in their area.
- ❑ Send the member a thank you card.

LATE APPLICATIONS

CMS requires enrollment forms to be submitted to them within seven (7) calendar days from the date the agent "receives" the application. Therefore, carriers have their own timeliness requirements in order to give them ample time to get the enrollment form submitted to CMS within the 7-day timeframe. **Most carriers require that the completed enrollment application be submitted to them within 48 hours of the date the agent receives the application.**

TIPS FOR REDUCING LATE APPLICATIONS:

- ❑ **Submit Applications the SAME DAY you receive them**
- ❑ Submit the entire completed application — no missing pages or information
- ❑ Use an online enrollment method if available for agents — **NOT via a consumer enrollment portal,** as agents cannot be present when consumers enroll through a consumer-facing online portal
- ❑ **Write legibly in black ink** (preferably) so processing isn't delayed
- ❑ Use the correct application (e.g., 2027 application for 2027 product)
- ❑ Use an approved electronic enrollment tool to submit your applications. You should get a confirmation of receipt immediately so you know the enrollment application forms have been submitted and received.
- ❑ If submitting applications directly to a carrier, use the carrier's portal or verify you have the correct fax number or email address (if the email is secure) by calling the carrier's broker support department (if they aren't listed on the application itself).

MEMBER COMPLAINTS

A member complaint occurs when a beneficiary expresses dissatisfaction related to an agent, health plan, enrollment, or other Medicare-related activity. There are two types of complaints: Complaints to Medicare (CTM) or a Complaint to a Carrier (grievance). While it's important to avoid all complaints, it's more important to avoid a CTM. A complaint to a Carrier is less severe than one directly to CMS. Contact us for further guidance, we have job aids specific to the causes listed below.

Top Causes for Member Complaints:

- **Inaccurate Benefit/Coverage Information**
- **Inaccurate Copay/Coinsurance (Cost) Information**
- **Inaccurate Provider Network**
- **Inaccurate Plan Description**
- **Enrollment Without Permission**

TIPS FOR AVOIDING COMPLAINTS:

- ❑ Complete a **thorough needs assessment** with the consumer to understand the consumer's medical, prescription, and other needs.
- ❑ Recommend the best plan suited for the consumer based on those needs.
- ❑ Explain how the consumer's needs are being met by this plan.
- ❑ Review the Summary of Benefits document with the consumer.
    - Ensure all associated costs and limitations are clearly disclosed as each benefit is reviewed.

- For plans with out-of-network coverage (e.g., PPO plans), ensure that both in-network and out-of-network cost sharing is disclosed for each benefit reviewed.
- Inform the consumer that a Medicare Advantage plan may limit the annual out-of-pocket maximum a member pay for in-network medical cost sharing.
- Notify the consumer that there are no limits on the out-of-pocket spending for cost sharing in Medicare Part A and Part B.

❑ Thoroughly explain (multiple times, if needed) plan's **benefits**, coverages, limitations, and rules including copays, coinsurance, provider network, and Part D Penalty.

- Explain the service area, prescription drug formulary, prescription deductible, initial coverage stage copays, and medication tiers.

❑ Thoroughly explain the plan's **premiums,** including the requirement to continue paying the Medicare Part B premium.

❑ Confirm the enrollee's **providers** are participating in the plan.

- Disclose how in-network and out-of-network differ and research whether the consumer's provider(s) would be in-network or out-of-network.
- Explain that Health Maintenance Organization (HMO), Health Maintenance Organization Point-of-Sale (HMO-POS), and Preferred Provider Organization (PPO) plans have a contracted network of doctors, specialists, hospitals, and pharmacies.
- Ensure that the consumer is aware whether or not the plan requires a Primary Care Physician (PCP) referral for specialist visits.
- Utilize the electronic Plan Provider Directory to verify that providers are in-network.

COMPLIANT SALES

COMPLIANCE METRICS

- ❑ Verify the enrollee's **medication** coverage. Can use online search tools available to you or reference www.medicare.gov. Provide tier level and any restrictions (i.e., prior authorization, quantity limit, step therapy). Also, explain preferred vs. non-preferred pharmacy, if applicable.
  - Be sure to inquire about any assistance they may require or receive for paying medical or prescription costs.
  - If a consumer receives Medicaid or Low-Income Subsidy (LIS) cost-sharing help, do not guarantee a particular copayment or coinsurance cost to the consumer.
- ❑ Thoroughly cover all **COSTS** involved with the plan (copays, deductibles, premium, etc.).
- ❑ Ensure that the chosen plan is the best option for your client.
- ❑ If the beneficiary must qualify or elect a certain benefit, ensure that is clear.
- ❑ Conduct a final review of the enrollment form and confirm all information is complete.
- ❑ Verify the enrollee understands all necessary components of the plan.
- ❑ Thoroughly review the pre-enrollment checklist (PECL), including the effect on the individual's current coverage.
- ❑ Urge clients to contact YOU or the Plan with any questions or issues.
- ❑ **FOLLOW UP** after the appointment to be sure they don't have questions and still understand crucial elements of the plan.

SECTION 6:

MISCELLANEOUS

MISCELLANEOUS

NOMINAL GIFTS TO BENEFICIARIES

Agents may offer nominal gifts ($15 or less, or $75 aggregate, per person, per year) to beneficiaries, provided the gift is not contingent on enrollment and is given without discrimination. Moreover, the following rules apply to nominal gifts:

- DO NOT offer a gift to a client or prospective client for referrals.
- If a nominal gift is a chance to receive one large gift or a communal experience (e.g., a concert, raffle, drawing), the total fair market value must not exceed the nominal per person value based on anticipated attendance. For example, if 10 people are expected to attend an event, the nominal gift may not be worth more than $150 ($15 for each of the 10 anticipated attendees). Anticipated attendance must be based on venue size, response rate, and/or advertisement circulation.
- Nominal gifts are permissible if they are offered to similarly situated beneficiaries without discrimination and without regard to whether the beneficiary enrolls in a plan.
    - YOU MAY gift small gifts like pens, magnets, mini calendars, etc. if the combined retail value is $15 or less and the gifts are offered to similarly situated beneficiaries without discrimination and without regard to whether the beneficiary enrolls in a plan.
- Nominal gifts may not be cash, cash equivalents, or other monetary rebates.
    - DO NOT give cash to a beneficiary, even if it is $15 or less.
    - DO NOT give a check or an item convertible to cash to a beneficiary, even if it is less than $15.
    - DO NOT give a gift card to a retailer or online vendor that sells a wide variety of consumer products to a beneficiary, even if it is $15 or less.
    - DO NOT give a gift card to a that is not restricted to a specific retail chain or a specific item or category of goods, even if it is $15 or less (i.e., a Visa gift card).

MISCELLANEOUS

MEALS AND SNACKS

- **DO NOT** provide or subsidize meals at **sales and marketing events.** Refreshments and light snacks may be provided.
- Refreshments and light snacks **MAY NOT** be combined to equal a meal at sales and marketing events. You should ensure that food and drinks provided could not be reasonably considered a meal and/or that multiple items are not being "bundled" and provided as if a meal.
- Agents and brokers may provide meals at **educational events** and other events that would fall under the definition of communications.
- The total value of the meals provided at educational events **MAY NOT** exceed $15 per person.

ACTIVITIES WITH HEALTHCARE PROVIDERS OR IN THE HEALTHCARE SETTING

Healthcare Provider

This term is used to mean any individual, organization or entity that provides or supplies healthcare items or services. This may include, but is not limited to, pharmacies, hospitals, health systems, physicians (including PCPs), physician organizations or offices, clinics, dental practices, dentists, and DME suppliers. Whenever the term is used, it encompasses the licensed healthcare professionals affiliated with the organization or entity as well as the employees or other staff of the organization or entity (such as receptionists and nursing staff in a clinic).

CMS distinguishes between Healthcare Provider-initiated activities and Plan-initiated activities when activities involve Healthcare Providers or are in the healthcare setting.

MISCELLANEOUS

Healthcare Provider-Initiated Activities

Healthcare Provider-initiated activities are those activities that Healthcare Providers engage in on their own as part of their professional relationships with their patients. They are not done at your request or the request of a Plan.

Healthcare Providers may engage in several specific Healthcare Provider-initiated activities on their own. One such activity is that Healthcare Providers are permitted to refer patients to other sources of information, including to plan representatives. Accordingly, agents who have relationships with Healthcare Providers may have a referral opportunity.

PRACTICE TIP: Offer to be a presenter at an educational event in conjunction with a Healthcare Provider. Healthcare Providers are often looking to fill up their community calendars and agents are permitted to provide business reply cards at educational events.

Plan/Part D Sponsor Initiated Activities

Plan-initiated activities are those activities that you conduct or that are conducted by a Healthcare Provider at your request or at the request of a carrier.

You may conduct sales and marketing activities, including sales presentations, the distribution of marketing materials, and the distribution and collection of Scope of Appointment and enrollment forms in common areas of a healthcare setting. Common areas include, but are not limited to, common entryways, vestibules, waiting rooms, hospital or nursing home cafeterias, and community, recreational, or conference rooms.

Sales and marketing activities cannot take place in restricted areas where care, treatment, or Healthcare Provider interaction occurs, such as exam rooms, hospital patient rooms, and pharmacy counter areas.

Communication materials (materials without any marketing content, which may include but are not limited to, business cards, rack cards, or post cards) may be distributed, displayed, and made available in all areas of the healthcare setting.

MISCELLANEOUS

Healthcare Providers may:

- Make available, distribute, and display communications materials in all areas of the healthcare setting as well.
- Provide or make available marketing materials in common areas.

Healthcare Providers may not:

- Accept or collect Scope of Appointment forms.
- Accept Medicare enrollment applications.
- Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the Healthcare Provider.
- Mail marketing materials.
- Mail affiliation announcements that contain marketing content.
- Offer inducements to persuade patients to enroll in a particular Plan or with a particular carrier.
- Conduct health screenings as a marketing activity.
- Distribute marketing materials or enrollment forms in areas where care, treatment, or Healthcare Provider interaction occurs.
- Offer anything of value to induce enrollees to select the Healthcare Provider.
- Accept compensation for any marketing or enrollment activities.

BEST PRACTICE: Always ensure that you have permission from the applicable Healthcare Provider to engage in any communication or marketing activities or leave behind any materials in a healthcare setting.

MISCELLANEOUS

COMMUNICATIONS ABOUT HEALTHCARE PROVIDERS

Agents must **not**:

- As a general matter, hand out materials promoting a Healthcare Provider's services or advertising the Healthcare Provider's practice.
- Provide information about any free services or cost-sharing waivers offered by a Healthcare Provider unless they are part of a Plan's benefit package (e.g., complimentary transportation).
- Offer or give anything to clients or prospective clients to persuade them to choose a particular Healthcare Provider.
- Engage with Healthcare Providers in a way that would influence the Healthcare Provider to steer patients towards a certain Plan or set of Plans based on the financial interest or other interests of the Healthcare Provider.
- Use any marketing material that mentions a Healthcare Provider unless it has been submitted to the applicable carrier(s) for review prior to use. Agents should know each carrier's requirements for submitting materials for review as they may vary.

BEST PRACTICE: Avoid recommending a particular Healthcare Provider or sharing your opinion about which Healthcare Provider is best and avoid using superlatives when describing a particular Healthcare Provider.

SECTION 7:

PRIVACY/SECURITY

PRIVACY/SECURITY

All employees, contracted workers, and business associates (including agents) have a responsibility to protect the sensitive information of clients/members. Protecting this sensitive information can reduce the risk of identity theft and the negative impact it will have on your clients.

There are two types of sensitive information you need to be aware of and protect:

- **PHI — Protected Health Information**
- **PII — Personally Identifiable Information**

Both can be classified as any "non-public" personal information that can individually identify someone (i.e., SSN, DOB, medical info, etc.). All consumer and member information, including demographics, should be considered protected and confidential.

THINGS TO KNOW

- All employees, contracted workers, and business associates (including agents) are required to report any potential or actual inappropriate or unauthorized disclosures or uses of consumer/ member PHI/PII.
- All privacy or security incidents (even potential incidents that may impact the confidentiality, security, or integrity of the PHI or PII) must be reported to either the:
  - Compliance Department of the affected Carrier/s or
  - Your FMO's Compliance Department:
- You must Encrypt all portable storage devices housing sensitive information, including flash drives, cell phones, laptops, tablets, etc.

Remember that you and your organization are required to implement reasonable administrative, physical, and technical safeguards to protect client information. This includes guidelines for reporting privacy or security incidents involving PHI.

PRIVACY/SECURITY

EXAMPLES OF INAPPROPRIATE DISCLOSURE OR PRIVACY INCIDENTS

- Emails or faxes containing PHI/PII sent to the wrong person/address
- Lost or stolen unencrypted electronic storage devices housing consumer PHI/PII
  - **If fully encrypted this would not be considered a breach of privacy. Ask your IT Lead for more information.*
- Lost or stolen hard copies of consumer PHI/PII
- Discussing member/customer information in public settings

TIPS FOR PROTECTING SENSITIVE INFORMATION

- Use Secure/Encrypted Email and include a Privacy Disclaimer when emailing sensitive info
- Recheck Email Addresses and Fax numbers before sending
- When Faxing use a cover page with the **HIPAA disclaimer**
  - **Acceptable HIPAA Disclaimer language:**

    CONFIDENTIALITY NOTICE: Information accompanying this facsimile is considered to be confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it is addressed. Such recipient shall be liable for using and protecting the information from further disclosure or misuse, consistent with applicable contract and/or law. The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including, but not limited to HIPAA. Individuals who misuse such information may be subject to both civil and criminal penalties. If you believe you received this information in error, please contact the sender immediately.
- Encrypt all portable storage devices housing sensitive information

PRIVACY/SECURITY

- Remember, Password Protecting is NOT the same as Encrypting. Ask your IT lead about acceptable means of encryption.
- Do not leave laptops, tablets, enrollment forms, etc. (anything housing sensitive client information) unattended in a non-secure place (e.g., your car, sales event kiosk/booth, etc.) where they could be stolen or lost
- NEVER connect to a public Wi-Fi (coffee shop, airport, etc.) without using VPN
- Properly dispose of all sensitive information (e.g., shred it)
- Do not discuss sensitive info in public places where others could overhear your conversation
- Don't bring unauthorized guests with you to appointments (e.g., spouse, other agent, friend, etc.)
- **Immediately report any suspected incident to the affected Carriers or your FMO!**

SECTION 8:

COMPLIANCE PROGRAM OBLIGATIONS

COMPLIANCE PROGRAM OBLIGATIONS

COMPLIANCE PROGRAM OBLIGATIONS

CMS requires MA and PDP carriers to have an effective compliance program. An effective compliance program includes seven core elements.

SEVEN CORE ELEMENTS OF AN EFFECTIVE COMPLIANCE PROGRAM

1. Written Policies and Procedures
2. Compliance Officer & Compliance Committee
3. Training & Education
4. Effective Lines of Communication
5. Well-Publicized Disciplinary Standards
6. Routine Monitoring and Identification of Risk
7. System for Prompt Response to Issues (Without Retaliation)

Carriers may push this same requirement down to your agency or your upline in contracts or carriers may require you to implement elements of their compliance program. It is important to comply with the compliance requirements imposed on you by your carriers, your agency, and your uplines.

COMPLIANCE BEGINS WITH ALL OF US.

TASKS TO MAINTAIN COMPLIANCE

1. **Policies & Procedures**

- You will likely be asked to acknowledge and adopt each carrier's Medicare compliance policies and procedures upon hire and on an annual basis.
- You may also be asked by your agency or your upline to acknowledge and adopt their Medicare compliance policies and procedures upon hire and on an annual basis.

- If you have employees, you should ensure that each employee adopts the policies and procedures required by your contracted carriers upon hire and on an annual basis. You should retain documentation of such acknowledgments for a minimum of 10 years.
- Policies and Procedures typically cover specific topics, including but not limited to:
  - Employee Code of Conduct and Policies and Procedures distribution
  - Employee FWA and general compliance training
  - Employee OIG/GSA exclusion screening
  - Reporting compliance concerns and non-retaliation
  - Record retention

2. Code of Conduct

- A Code of Conduct is designed to promote honest, ethical, and lawful conduct.
- You will likely be asked to acknowledge and adopt each carrier's Code of Conduct upon hire and on an annual basis.
- You may also be asked by your agency or your upline to acknowledge and adopt their Code of Conduct upon hire and on an annual basis.
- If you have employees, you should ensure that each employee adopts the code of conduct required by your contracted carriers upon hire and on an annual basis. You should retain documentation of such acknowledgments for a minimum of 10 years.

3. CMS Medicare Parts C & D Fraud, Waste, & Abuse and General Compliance Training

- You may be asked by each of your carriers or by your agency or upline(s) to take CMS's Medicare Parts C & D Fraud, Waste, & Abuse and General Compliance Trainings upon hire and on an annual basis.
- You may also be asked to provide documentation evidencing proof of completion.
- You should maintain proof that you completed such trainings for a minimum of 10 years. This may include maintaining certificates of completion and/or attestation pages.
- If you have employees, you should ensure that each employee completes the CMS trainings and any other trainings required by your contracted carriers upon hire and on

an annual basis. You should retain documentation of such trainings for a minimum of 10 years.

4. OIG and GSA Excluded Parties Lists Screening

- You will likely be screened by each contracted carrier against the OIG LEIE and the GSA Excluded Parties List. You may also be screened against additional state exclusion lists. These screenings will be conducted prior to hire and monthly thereafter.
- Your agency or your upline(s) may conduct their own screenings.
- If you appear on a list as being an excluded individual, you will be removed immediately from all contracts related to federal healthcare programs, such as MA and Part D.
- If you have employees, you should screen each employee against the OIG LEIE, the GSA Excluded Parties List, and any other lists required by your contracted carriers prior to hire and monthly thereafter. If an employee appears on a list as being excluded, you must remove that employee immediately from all contracts related to federal healthcare programs. You should also comply with any carrier reporting requirements. You should maintain proof of pre-hire and monthly screenings for 10 years (e.g., screenshots, print outs, saved PDFs for GSA checks, etc. – should include a Date/Time stamp of when search took place).

5. Report Compliance Concerns to Carriers and Enforce a Non-Retaliation Policy

- You should report compliance concerns to your Compliance Officer or your upline's Compliance Officer and the applicable carrier(s). Follow the carriers' reporting processes.
- If you have employees:
  - Train your Employees on your organization's reporting processes for reporting compliance concerns and suspected or actual violations related to the Medicare program or a carrier.
  - Emphasize that reports must be made to the appropriate carrier.
  - Widely-publicize a no-tolerance policy for retaliation or retribution against any employee who in good faith reports suspected non-compliance or fraud, waste, & abuse (such as through postings and other different methods).

COMPLIANCE PROGRAM OBLIGATIONS

AGENT MONITORING AND OVERSIGHT

CMS states that MA and PDP carriers must provide oversight to ensure that their agents and brokers abide by all applicable state and federal laws, regulations, and requirements.

CMS requires MA and PDP carriers to have a monitoring and oversight program that:

- Monitors agent and broker activities;
- Identifies non-compliance with CMS requirements; and
- Reports non-compliance to CMS.

What does this mean for you?

You are obligated to comply with the Medicare marketing and communications rules and guidelines.

You should be aware that your contracted carriers and your uplines may have monitoring and oversight plans. They may be monitoring and auditing your conduct and compliance with the rules and guidelines. You should be prepared to cooperate with the carriers and your uplines and assist them upon request with implementing their monitoring and oversight plans.

If you have employed agents, you may be contractually obligated by your carriers or your upline(s) to monitor your agent activities. You should conduct required monitoring and be prepared to answer questions from your carriers about your agent oversight and monitoring activities.

RESOURCES & CONTACTS

CMS updates its Medicare marketing rules and guidelines as needed. It's a good practice to stay familiar with the Medicare marketing rules, the Medicare Managed Care Manual, and other CMS guidance.

If you have questions, reach out to your Compliance Officer or your upline's Compliance Officer.

Medicare Advantage Communications and Marketing Rules
Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V

Medicare Prescription Drug Communications and Marketing Rules
Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-V

Medicare Managed Care Manual
Available at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms019326