THIRD PARTY MARKETING ORGANIZATION

Humana Guardrails for Medicare Communications and Marketing Materials and Activities

Last Update: June 5, 2023

The purpose of this document is to provide guardrails to Field Marketing Organizations (FMOs), Managing General Agencies (MGAs), and Strategic Alliance agency partners, or other organizations and individuals who are compensated to perform lead generation, marketing, sales, and enrollment related functions (collectively "Third Party Marketing Organizations" or "TPMOs"). These guardrails apply to all communications and marketing materials and activities used by TPMOs in relation to Humana Medicare Products.

These guardrails are not inclusive of all applicable laws and regulations for TPMOs and do not constitute and must not be construed as legal advice. Humana does not represent that compliance with these guardrails will ensure that any communication or marketing material or activity will comply with any applicable laws, rules or regulations. Instead, these guardrails are intended to help TPMOs meet the standards to which Humana holds itself to help our members receive the human care that our brand is built around.

TPMOs are responsible for compliance with 42 CFR § 422.2260 - § 422.2274 & 42 CFR § 423.2260 - 42 CFR §423.2276, Chapter 2 of the Medicare Managed Care Manual, Chapter 3 of the Medicare Prescription Drug Benefit Manual, the Center for Medicare and Medicaid Services ("CMS") memos, CMS interim sub-regulatory guidance, Humana policies and procedures, and any other applicable state and federal laws, rules or regulations. Not only must the content of a material meet all applicable requirements, but also how and when the material is used must comply. All communications or marketing materials must include required CMS disclaimers.

On April 12, 2023, CMS released the Contract Year 2024 Policy and Technical Changes to Medicare Advantage and Prescription Drug Final Rule (CMS-4201-F) making various regulatory changes and additions to the sales and marketing provisions, effective September 30, 2023. Humana strongly encourages all TPMOs to read through the regulations and CMS commentary within the Final Rule and not solely rely on Humana for compliance and operational requirements. A copy of the Final Rule may be found at here. CMS may release updated sub-regulatory guidance within the Medicare Communication and Marketing Guidelines to supplement the Final Rule provisions in the coming months which may result in updates to the requirements for communications and marketing materials and activities. If applicable rules, regulations, or requirements are updated or revised, TPMOs are expected to adhere to those new or revised rules, regulations, or requirements and the updates or revisions take precedence over these guardrails.

Table of Contents

Marketing

CMS regulations include, but are not limited to, ensuring that the materials do not mislead, confuse, or provide materially inaccurate information to current or potential enrollees. TPMOs are responsible for ensuring that **all** materials, whether communications or marketing, meet these requirements. This applies to materials the TPMO and its downlines purchase from other downstream entities or create themselves.

On May 10, 2023, CMS issued a memorandum to clarify and expand the definition of marketing to "include content that mentions any type of benefit covered by the plan and is intended to draw a beneficiary's attention to plan or plans, influence a beneficiary's decision-making process when selecting a plan, or influence a beneficiary's decision to stay enrolled in a plan (that is, retention-based marketing)." CMS further clarified, "content that beneficiaries can receive benefits such as dental, vision, cost-savings, and/or hearing services is sufficient information about plan benefits, benefits structure, or cost sharing to meet the content standard in the definition of marketing in §§ 422.2260 and 423.2260. Further, the use of these statements in advertisements and activities directed to Medicare beneficiaries clearly meets the intent standard. ***Therefore, beginning July 10, 2023, any material or activity that is distributed via any means (e.g., mailing, television, social media, etc.) that mentions any benefit will be considered marketing and must be submitted into HPMS."***

If you are unsure if a piece is marketing versus communication, please email the piece to SalesIntegirtyReview@humana.com. A sampling of materials determined to be communications by a TPMO may be requested by Humana periodically for auditing purposes to ensure compliance.

Materials Review and Filing Instructions

- TPMOs are responsible for directly submitting all multi-plan marketing materials (i.e., materials made and used on behalf of multiple Medicare Advantage and Part D organizations) to CMS via the HPMS Marketing Module after carrier review.
- CMS has made modifications to the media types in the HPMS Marketing Module. Please use the following categories for all future submissions. CMS advised that it is not necessary to resubmit previously submitted materials.
    - The "television" media type will be expanded to include online videos. It will now show in HPMS as "Television/Online Videos.". This includes YouTube or other social media videos. These filings are subject to a 45-day review for approval.
    - An additional category has been added for "Press Releases/Service Area Expansions" (TPMO FYI, only)
    - Please refer to the HPMS Marketing Module User Guide for additional details.
- Prior to use and filing with CMS, TPMOs are required to submit all marketing, any telephonic scripts and select communications (such as Television Commercials, online videos, Permission to Contact forms - print or electronic, and provider-related communications) to Humana for review and approval prior to filing or use.
    - Submit for review and approval to your Humana Account Executive (AE):
        - All telephonic lead, transfer, sales, and enrollment scripts
        - Enrollment forms
        - All plan comparison websites

- Submit for review and approval to Humana MarketPoint Sales Integrity team at SalesIntegrityMarketingReview@Humana.com:
    - All other materials that meet the definition of Marketing
    - Lead sources or forms, such as print or electronic Permission to Contact (PTC) and Business Reply Cards (BRC)
    - Television commercials and online videos that are Communications

- Please contact your AE with any questions regarding Humana's review process.
- TPMOs that use or purchase leads from a lead aggregator, must submit **all** lead aggregator lead sources (marketing and communication) or forms (PTCs/BRCs) for review and approval prior to lead collection.
- If these materials contain marketing as defined by CMS, they are subject to CMS filing regulations. The TPMO is accountable for filing in HPMS as required. Per CMS instruction, adjust the original SMID to add an indicator of their company, such as initials before _M. For example: MULTIPLAN_originalSMID_<initials>_M. Then, in the filing comment section, add a note explaining that the piece was already approved under XXX material id.
- All lead aggregator materials used by TPMOs, including communications, must also be submitted for review and approval to Humana.

Submission of Identical Pieces by Multiple TPMOs:

There are instances where the same material needs to be submitted by multiple TPMOs, all which contract with different Medicare Advantage organizations. Currently, HPMS does not accommodate such submissions as each SMID must be unique. To drive clarity, CMS has provided the following guidance:

1. TPMOs submitting a piece that has already received approval from all applicable carriers and CMS, will add an "[TPMO initials]" just before the "_M" for the material id in HPMS so SMID is unique.

   Example:
   Original TPMO submission: MULTIPLAN_[name of piece]_M
   Additional Submissions by Other TPMOs:
   MULTIPLAN_[name of piece]_[TPMO Initials]_M >> MULTIPLAN_[name of piece]_ABC_M

   NOTE: The material on the actual piece should show as MULTIPLAN_[name of piece]_M (the original SMID)

2. Add a note to the comment section explaining that the piece was already approved under [original SMID material id].

Materials that Mention Providers or Other Entities

- Any communication or marketing material that mentions or involves a provider must be submitted to Humana via their AE to for review prior to use. The TPMO must complete the Provider Intake Form" and must include all of the requested information in the provider section of the intake form.
- Any communication or marketing material that is co-branded with another entity, or will be mailed to clients of another entity, such as a bank, financial advisory firm, insurance company, credit union, loan agency, non-profit organization, or any other entity, the TPMO must complete the Other Entity Intake Form along with submitting the material for review.

- Provider images should not show a specific provider (should be a stock photo of a provider) and/or clinic, the provider pictured should not be a contracted provider, and associated text and voiceover should describe only clinical, educational information (such as describing preventive services), and should not be promoting the TPMO or any plans.

Rules of the Road for Review Process

Humana has also developed several rules of the road that will help expedite the Humana internal review process:

- When submitting multiplan (applicable to or referencing multiple carriers) marketing or communications that contain Humana's brand, logo, name, plans or reference to providers, complete all fields in the intake form, including detailed description, changes since last reviewed, dates/year/selling season(s) being used, other carriers in multi-plan materials, etc. Missing information causes delays.
- Lead sources or forms and Television Commercials that may be Communications must also be submitted to Humana for review before used to collect leads.
- Submit the content in a proofread editable Word document format with changes since last review redlined in tracking mode. Images/mock-ups/PDFs/Screen grabs should also be provided for visual references, but all verbiage must be typed into Word. Images or PDFs of images containing text are not acceptable. Editing non-Word format adds significant delays. For websites, the process flow must be described, and screen grabs must be included on the Word document in addition to the verbiage typed in Word. At top of page, list the URL and SMID and summarize change.
- If Humana logo is used, you must include images of the logo use/placement in context of the rest of the content.
- Plan well in advance - allow time for Humana/CMS processing. See Account Executive for details. Expedited requests due to lack of appropriate planning and upstream processes may not be honored.
- Wording cannot be adjusted after filing without being redlined and resubmitted for review and refiled. All post-review/post-filing changes must be approved by Humana.
- Apply Humana Legal and Compliance reviewer's guidance to future related content/marketing.
- Ensure all applicable disclaimers are included in the editable Word document. See Humana's 2024 Medicare Disclaimer Quick Reference Guide.

Third Party Marketing Organizations ("TPMOs")

Definition:

CMS specifically defines Third Party Marketing Organizations in the regulation at §§ 422.2260 and 423.2260:

- *Third-party marketing organization (TPMO) means organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA plan or plans to making an enrollment decision). TPMOs may be a first tier, downstream or related entity (FDRs), as defined under § 422.2, but may also be entities that are not FDRs but provide services to an MA plan or an MA plan's FDR.*

Disclaimer:

CMS has updated the TPMO disclaimer to read as follows:

- **If a TPMO does not sell all MA organizations and/or Part D sponsors in the service area the disclaimer 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, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options."

- **If the TPMO sells all MA organizations and/or Part D sponsors in the service area the disclaimer 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, 1–800–MEDICARE, or your local State Health Insurance Program (SHIP) for help with plan choices.''

This disclaimer must be:

(ii) Verbally conveyed within the first minute of a sales call.

(iii) Electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication.

(iv) Prominently displayed on TPMO websites and

(v) Included in any marketing materials, including print materials and television advertisements, developed, used, or distributed by the TPMO.

Lead Generation

Lead Forms and Lead Sources

TPMOs are responsible for compliance oversight including ensuring all lead sources used to solicit Medicare Products are compliant with CMS guidelines, Humana policies and procedures, and all other state or federal laws, rules and regulations. TPMOs must also ensure the process of obtaining the lead and the outreach is compliant.

Lead sources must abide by all CMS' sales, communication, and marketing requirements. For example:

- Cannot require age, date of birth, health status questions on lead forms and websites used to generate MA/PDP leads
- Ensure prospect is clearly informed before completing the form that it will result in call(s) from licensed sales agent(s)
- Business Reply Cards (BRC) and Permission to Contact (PTCs) expire after 12 months following the beneficiary's signature date

TPMOs conducting lead generating activities, either directly or indirectly for Humana must disclose to the beneficiary that his or her information will be provided to a licensed agent for future contact. This disclosure must be provided as follows:

(A) Verbally when communicating with a beneficiary through telephone.

(B) In writing when communicating with a beneficiary through mail or other paper.

(C) Electronically when communicating with a beneficiary through email, online chat, or other electronic messaging platform.

TPMOs conducting lead generating activities, either directly or indirectly for Humana must disclose to the beneficiary that he or she is being transferred to a licensed sales agent who can enroll him or her into a new plan.

Anti-Discrimination

TPMOs may **not**:

- Discriminate based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, or geographic location
- Engage in any discriminatory activity such as targeting potential enrollees from higher income areas, stating, or implying that plans are only available to seniors rather than to all Medicare beneficiaries, or stating or implying that plans are only available to Medicaid beneficiaries unless the plan is a Dual Eligible Special Needs Plan (D-SNP) or Medicare Medicaid Plan
- Target potential enrollees based on income levels unless it is a dual eligible special needs plan or comparable plan as determined by the Secretary
- Target potential enrollees based on health status unless it is a special needs plan or comparable plan

- Deny, limit, or condition the enrollment into a Medicare Product based on any factor related to health status, including, but not limited to, the following:
    - Medical condition(s), including both mental and physical
    - Claims experience
    - Receipt of health care
    - Medical history
    - Genetic information
    - Evidence of insurability, including conditions arising out of acts of domestic violence

Disability

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

All beneficiaries must have an equal opportunity to enroll in Medicare Products, whether the beneficiary requests accessible formats or alternate languages. TPMOs are required to provide information to beneficiaries in alternate languages or accessible/alternate formats (for example, Large Print, Braille), upon the beneficiary's request.

TPMO materials that are Humana-specific or branded, or that exclusively reference Humana Medicare plans, must include the anti-discrimination notice. TPMOs can obtain these notices from their Humana account executive. The following are materials do not require the anti-discrimination notice: Radio or television ads, ID cards, appointment/business cards, banner/banner-like ads, envelopes, or outdoor advertising such as billboard ads.

Unsolicited Contact

- Prohibited activities include door-to-door solicitation, approaching beneficiaries in common areas, outbound solicitation (cold calling), and calls to confirm receipt of mailed information
- Contact is prohibited as unsolicited door-to-door contact unless an appointment at the beneficiary's home at the applicable date and time, was previously scheduled.
- Also prohibited are unsolicited calls about other business as a means of generating leads for Medicare plans (e.g., bait and switch strategies)
- It is only permissible to call beneficiaries who have given their permission for a MA organization or TPMO to contact them about Medicare Products through a completed BRC or PTC form.
- Outbound contact based on referrals is prohibited.
- Outbound contact to beneficiaries who attend an event is prohibited unless the beneficiary gave express, documented permission to be contacted

Email Communications:

- TPMOs may initiate unsolicited email contact with potential enrollees but must provide an opt-out process on each communication for those who no longer wish to receive emails. Emails must include an Unsubscribe link.

- Note: Text messaging and other forms of electronic direct messaging (e.g., social media platforms) would fall under unsolicited contact and are not permitted.

- Once an individual has utilized the opt-out option, TPMOs are responsible for ensuring that the potential enrollee no longer receives emails or other electronic communications from the Sales Partner.

Permission to Contact

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

Prohibition on Open Enrollment Period (OEP) Marketing

TPMOs and their agents are prohibited from knowingly targeting or sending unsolicited marketing materials to any beneficiary during the Open Enrollment Period (OEP) (January 1 to March 31).

During the OEP, TPMOs and their agents may:

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

During the OEP, TPMOs and their agents may **not**:

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

Prohibition on Marketing New Plans Prior to Oct. 1

- TPMOs must not communicate about following year's Medicare plans prior to October 1st of the previous year.

- TPMOs must not solicit or accept enrollment applications for a January 1 effective date until October 15 of the preceding calendar year unless the beneficiary is entitled under another enrollment period.

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

- When marketing Medicare Products outside of AEP to the general public, only a small percentage of members/prospects will be newly eligible, have recently moved, or have other SEP qualifying conditions. Accordingly, TPMOs must not mislead members/prospects into believing they could change their respective plans outside of AEP.
- When marketing plans during ROY, materials must include language clarifying that a prospect may "apply, choose or enroll" in a plan only if they are eligible via an SEP and include necessary qualifiers that speak to those who may be aging in, new to Medicare, losing coverage, or another SEP qualifying event, so as not to violate the prohibition of knowingly targeting or sending unsolicited marketing material outside of AEP. Examples include: "New to Medicare, Turning 65, Losing coverage or Moving". In television commercials, the SEP qualifiers must be displayed in both the on-screen graphics and the voice over/audio early in the commercial and periodically throughout.
- Do not use the word "NEW" in a context that gives the impression that new plans are being released by MA organizations outside of AEP.

Nominal Gifts

- TPMOs may not offer gifts to beneficiaries unless the gifts are nominal value (see inducement guidance published by the Department of Health and Human Services Office of the Inspector General), are offered to similarly situated beneficiaries without regard to whether or not the beneficiary enrolls and are not in the form of cash or other monetary rebates.
- TPMOs must submit any materials or processes that propose offering nominal gifts to beneficiaries to Humana for review prior to implementation, with detail regarding the retail value of nominal gifts proposed and any related activities.
- Gifts may not be any of the following:
    - In the form of cash, rebates or gift cards that could be considered a cash equivalent such as VISA, American Express, MasterCard, Amazon, or gift cards to big box stores. Other types of gift cards may not be used by TPMOs as a nominal gift for Medicare beneficiaries.
    - Drug or health benefits (e.g., a free checkup), including optional mandatory supplemental benefits.
    - Tied directly or indirectly to the provision of any other covered item or service.

Educational and Sales/Marketing Events

Educational Events

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

The following requirements apply to educational events:

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

Sales/Marketing Events

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

- Activities permitted at sales/marketing events:
    - Provide marketing materials
    - Provide refreshments and light snacks to beneficiaries, as long as the items provided could not be reasonably considered a meal and/or that multiple items are not being “bundled” and provided as if a meal
    - Distribute and accept plan applications
    - Collect Scope of Appointment (SOA) forms for future personal marketing appointments; and
    - Conduct marketing presentations.
- Activities **not** permitted at sales/marketing events:
    - Require sign-in sheets or require attendees to provide contact information as a prerequisite for attending an event
    - Conduct health screenings, health surveys or other activities that may be perceived as, or used for, “cherry picking” or targeting a subset of members

    - Use information collected for raffles or drawings for any purpose other than that; and/or
    - Providing meals to beneficiaries regardless of value.
- Invitations to educational events must clearly state “educational” and invitations to sales/marketing events must clearly state “sales” on the materials themselves.
- If advertising for both educational and sales/marketing events on the same material, the educational events must be clearly labeled as educational and details regarding the date, time and location of each event must be specific on the material, so it is clear when and where each event is taking place.
- Beginning September 30, 2023, sales agents may not schedule sales/marketing events to take place within 12 hours of an educational event at the same location. The same location is defined as the entire building or adjacent buildings.
- Educational information may be presented at a sales/marketing event, but the sales/marketing event must be accurately identified as sales/marketing.

Personal/Individual Marketing Appointments

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

- Sales agents must obtain a valid Scope of Appointment from a beneficiary at least 48 hours prior to scheduled personal marketing appointment or meeting, except in the following situations, where an SOA must be obtained, but the 48-hour waiting period would not be required:
    - When a beneficiary requests an appointment within four days of the end of a valid election period including the AEP, OEP, SEP, ICEP or the month, based on eligibility
    - When a beneficiary initiates an in-person meeting, such as walking into agent’s office, a kiosk, a plan’s office, or any other walk-in
    - CMS has provided verbal clarification and confirmation of information provided in a third party (Citi) report on May 10, 2023, that the 48-hour waiting period does not apply to inbound calls made to a sales agent by a beneficiary but does apply to outbound calls made by sales agents to beneficiaries.
    - Note: An SOA must be completed for all personal marketing appointments, including in the exceptions/scenarios noted above.
- Completed SOA forms must be retained for 10 years and submitted to Humana (by mail for paper forms, recorded for telephonic, or through Enrollment Hub) with all enrollment applications. (See SOA Job Aid in Vantage)
- SOAs are valid for up to 12 months following the date of the beneficiary's signature date.
- SOAs must contain the following:
    - Product types to be discussed
    - Date of appointment
    - Beneficiary and agent contact information
    - Statement that there is no obligation to enroll, and that current or future Medicare enrollment status will not be impacted by speaking with the agent, and automatic enrollment will not occur.
- If the SOA is completed verbally on the inbound call, it must be recorded.

- Sales agents may not market any health care related product during a marketing appointment beyond what was agreed upon with the beneficiary in the SOA.
- Sales agents may not market additional health related lines of business not identified prior to the marketing appointment without obtaining a separate SOA identifying the additional lines of business to be discussed.
- Sales agents may not engage in cross selling of non-health products during a Medicare sales/marketing appointment, such as life or final expense policies.
- Activities permitted at a personal marketing appointment:
    - Provide marketing materials
    - Distribute and accept plan applications
    - Conduct marketing presentations; and/or
    - Review the individual needs of the beneficiary including but not limited to, health care needs and history, commonly used medications, and financial concerns.
- Activities **not** permitted at a personal marketing appointment:
    - Market any health care related product beyond the scope agreed upon by the beneficiary, and documented by the TPMO, prior to the appointment
    - Market additional health related products not identified prior to the appointment without a separate Scope of Appointment identifying the additional health related products to be discussed; and
    - Market non-health related products, such as annuities.

Terminology/Language used in Communication and Marketing Materials

TPMOs are prohibited from distributing communications and marketing materials that are materially inaccurate, misleading, or otherwise make misrepresentations or engage in activities that could mislead or confuse beneficiaries or misrepresent the MA organization or TPMO. CMS is particularly concerned with and prohibits national advertisements that promote MA plan benefits and cost savings, which are only available in limited-service areas or for limited groups of enrollees, use words and imagery that may confuse beneficiaries or cause them to believe the advertisement is coming directly from the government, and sales tactics designed to rush or push beneficiaries into enrolling into a plan.

Use of Medicare Name or Card Image/Official Government Materials/Government Endorsement:

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

        <Partner name> - an insurance agency with no government affiliation.

Describing Medicare

- Ensure all descriptions of Original Medicare coverage are accurate and clear.

- When comparing Original Medicare to Medicare Products or Medicare Supplement Insurance plans, materials should be more specific than just using the term “Medicare”.

Plans and Benefits Availability

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

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

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

Marketing of Savings Not Realized

TPMOs may not include information in communications and marketing about savings available that are based on a comparison of typical expenses incurred by uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a Medicare beneficiary.

Examples of Prohibited “Savings”:

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

Including a disclaimer that the stated “savings” amount is based on the usual and customary price someone without prescription drug or medical insurance would pay is not sufficient or appropriate as most beneficiaries are not saving the advertised amount because they would never have incurred the referenced out of pocket costs. Any mention of “savings” must be based on specific costs that a Medicare beneficiary would or could actually face, such as accurate comparisons of plan copayments for specific services to original Medicare cost sharing for the same services.

Scare and High-Pressure Tactics:

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

Superlatives and Absolute Language

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

Exaggerative Words/Phrases

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

Correct Terminology for Reference to Sales Agents

- Materials may use the terms "Licensed Insurance Agent" or "Licensed Sales Agent" to refer to sales agents.
- If a sales agent's phone number or one that will route to sales agents is included in a communication or marketing material, it must clearly indicate before the number that the number will direct callers to a "licensed sales agent" or "licensed insurance agent".

- "Unbiased" should not be used in reference to the TPMO or its agents since a sales agency can only sell those Medicare Products that they are contracted with so there may be an inherent bias in what products are being sold.

Use of the Term "Senior"

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

Use of the Word "Free"

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

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

"Partnership" or "Alliance"

Avoid words like "partnership" or "alliance" in reference to the relationship between Humana and the TPMO or Humana and a vendor. Acceptable terms would be "teamed up" or "working together".

Medicare Supplement

- A Medicare Supplement plan must not be identified as a Medicare Advantage plan.
- The differences between a Medicare Advantage and Medicare Supplement should be explained clearly.
- Must make it clear that beneficiaries must choose either a Medicare Supplement Plan or a Medicare Advantage Plan since beneficiaries cannot enroll in a Medicare Supplement and Medicare Advantage plan at the same time.
- In plan comparison/shopping websites, Medicare Supplement Plans and Medicare Advantage plans and related content should be in separate sections and clearly be distinguished from each other.

Customer Service Numbers

Customer service numbers must be toll-free numbers.

Days/Hours of Operation

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

Use of TTY Numbers

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

Exceptions:

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

Product Endorsements and Testimonials

- According to the Federal Trade Commission, endorsements and testimonials are treated identically and any advertising message that consumers are likely to believe reflects the opinions, beliefs, findings, or experiences of a party other than the advertiser.
- When using social media, if a TPMO uses a consumer's previous post it is considered an endorsement or testimonial.
- Any testimonials that beneficiaries would believe are actual customers of the TPMOs or Medicare Products they are endorsing must use actual consumers who have used the product or service they are endorsing in both the audio and video or clearly and conspicuously disclose that the individuals are not actual consumers.
- If the testimonial claims to be from a member of a Medicare Product, the beneficiary must have been enrolled in that product at the time the testimonial was created. Testimonials must identify the name of the Medicare Product in which the member was enrolled.
- Ensure any member or consumer has given consent for quote and photograph, if applicable, to be used in the particular medium, such as on a website.
- If an individual is paid to endorse or promote the TPMO, or Medicare plans or products, it must be clearly stated (e.g., "paid endorsement").
- If an individual, such as an actor, is paid to portray a real or fictitious situation, the ad must clearly state it is a "Paid Actor Portrayal."
- Any endorsement or testimonial that is made by a health care provider (even if another individual quotes the provider) must be discussed with and reviewed by Humana prior to use. TPMOs may not pay or compensate provider for testimonial in any way.
- Any claim made in an endorsement or testimonial must be substantiated.
- An endorsement or testimonial cannot use negative testimonials about other Plans/Part D Sponsors.

- An endorsement must reflect the honest opinions, findings, beliefs, or experience of the endorser.

Communications and Materials with Provider/Celebrity Spokesperson

- Humana recognizes that TPMOs may use materials that involve a provider spokesperson and/or celebrity personality, in order to promote their agency.
- The TPMO is responsible for submitting these materials for Humana's review. The materials will go through the normal Humana review process. The Sales Partner should complete the intake form, and must include the following information in the provider section of the intake form:
    - Name of provider/celebrity personality:
    - Are they currently a practicing physician? If not, please list the date that they stopped practicing.
    - Are they contracted with any medical groups?
    - Are they contracted with any MA Organization or Part D Plan sponsors?
    - What is their specialty?
    - If a TV personality, please provide a brief description of their program (is it on TV, internet, etc.)
- Once Humana has reviewed and approved a material that includes a provider spokesperson, the TPMO may move forward with using the approved materials, with all edits and comments incorporated.
- Materials that include (or give the appearance of including) a provider must **not**:
    - Include a contracted provider.
    - Market or steer a beneficiary toward a particular Medicare Product or a set of Medicare Products, such as Humana MA/PDP plans.
    - Include the host promoting or appearing to promote the Sales Partner or the plans offered by the Sales Partner, such as stating, "ABC agency is the best and only represents the best plans." The host may state the Sales Partner's name and number and advise beneficiaries to call the Sales Partner to learn about plans that may be right for them.
- Any materials that include a provider must meet the following requirements:
    - Provider spokesperson should remain objective in any assessments made about possible Medicare Products.
    - Any assessments about Medicare Products should be prefaced with "may" or similar terms, such as "These types of plans may be a good fit for..."
    - Talking points and language must remain neutral and keep the best interest of the beneficiary in mind.
    - Include the following disclaimer on the material, "(Provider name) IS NOT AFFILIATED WITH ANY PLAN OR PART D SPONSOR AND DOES NOT RECOMMEND OR ENDORSE ANY PARTICULAR PLAN OR PRODUCT."
    - Associated text and voiceover should describe only clinical, educational information (such as describing preventive services), or any plan or plans.

Star Ratings - If a Material References Stars Ratings, then the Following Rules Apply

- If reference to an individual Star Rating measure(s) for a particular plan is made, then the material must also include references to the overall Star Rating for that plan. Do not use an individual underlying category, domain, or measure rating to imply overall higher Star Ratings for a plan or MA organization or the plans that a Sales Partner offers.

- Materials must be clear that the rating is out of 5 stars and clearly identify the Star Ratings contract year.
- Star Ratings must only be marked in the service area(s) for which the Star Rating is applicable, unless using Star Ratings to convey overall MA organization performance (for example, ‘‘Plan X has achieved 4.5 stars in Montgomery, Chester, and Delaware Counties), in which case the TPMO must do so in a way that is not confusing or misleading.
- For materials marketing 5 Star MA or PDP contracts:
    - TPMOs must not market the 5-star special enrollment period after November 30 of each year if the contract did not receive an overall 5 star for the next contract year.

Websites

- Websites must be clear and easy to navigate.
- Websites containing any marketing content must be filed with CMS for each new plan year.
- When marketing Medicare Advantage plans:
    - If communicating about two plan years (e.g., 2021 and 2022 plans), it must be clear to which plan year the information is referencing.
- Websites may only require users to enter zip code, county, and/or state for access to non-beneficiary specific website content, and function as such.
- Websites may request, but not require, age/date of birth (DOB), gender, or health status information to access non-beneficiary specific plan information. There must be relevant consumer notification that this information is not required, and it must be communicated as ‘optional’ to the consumer.
- Websites must keep Medicare Advantage content separate and distinct from other lines of business, including Medicare Supplement plans.
- Websites with ‘Calls to Action’- must accurately reflect the result the user will see/experience in the subsequent step and not confuse beneficiaries as to the result. For example, a website should not indicate that a beneficiary will be able to “find plans” by entering their contact information if the beneficiary will not receive any plan information digitally but will instead receive a call from an agent.
- Include TTY and days and hours of operation with phone number.

Script Requirements

All telephonic sales and enrollments must follow scripting that is reviewed and approved by both Humana and CMS. Humana has developed Sales and Enrollment Scripting, which will be shared at a later date, that TPMOs who engage in telephonic sales/enrollments may use as reference when creating their own scripts. Contact your AE with questions.

TPMO Telephonic Sales and Enrollment and Scripting Oversight

Humana and TPMOs are required to have oversight of their agents' and any downlines' telephonic sales and enrollment activity. It should include ensuring compliance for telephonic sales, that current CMS-approved scripting is used, and calls are recorded. TPMOs must ensure all content from the CMS-approved scripting is transferred verbatim to downlines and within any agent portal technology or tool and ensure a quality control process is in place to double check.

Informational, Sales, Pre-Enrollment and Enrollment Script Requirements

TPMOs must ensure that their agents who represent MA organizations are licensed and appointed (if applicable) per state law to sell Medicare Products. Representation includes selling products (including Medicare Advantage plans, Medicare Advantage-Prescription Drug plans, Medicare Prescription Drug plans, and section 1876 Cost plans) as well as outreach to existing or potential beneficiaries and answering or potentially answering questions from existing or potential beneficiaries.

Licensed/Unlicensed Agents:

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

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

Sales and Pre-Enrollment Scripts:

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

- Verbally convey the updated TPMO disclaimer (see page 5) within the first minute of the sales call.
- Verbally convey the Federal Contracting Statement on all sales/pre-enrollment calls.
- Advise that the call is being recorded.
- During sales/pre-enrollment calls, agents may ask if the beneficiary would like to provide information regarding their age (date of birth), gender, Medicare ID number, Part A or Part B effective dates, or any other demographic or health information. If the beneficiary does not wish to disclose any of this information, the agent must continue the call and provide plan information to the beneficiary. The agent cannot end the call if the beneficiary does not disclose this information, as this could be seen as discriminatory.
- The only information an agent needs from a beneficiary to provide non-beneficiary specific plan information is zip code, county, and/or state.
- Ensure all Scope of Appointment requirements are met prior to beginning a telephonic personal marketing appointment.
- Agents must ensure that, prior to an enrollment, CMS' required questions and topics regarding beneficiary needs in a health plan choice are fully discussed. Topics include information regarding primary care providers and specialists (that is, whether or not the beneficiary's current providers are in the plan's network), regarding pharmacies (that is, whether or not the beneficiary's current pharmacy is in the plan's network), prescription drug coverage and costs (including whether or not the beneficiary's current prescriptions are covered), costs of health care services, premiums, benefits, and specific health care needs.

Enrollment Scripts:

- Enrollment scripts must contain the required elements for completing an enrollment request as described in Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual and must receive CMS approval prior to use.
- Sales agents must obtain a compliant signature from the beneficiary. A signature is only compliant if the sales agent provides all required disclosures and disclaimers (i.e. verbally or via IVR in a clear and understandable fashion) and collects agreement and understanding from the beneficiary (or his or her POA/authorized representative).
- All disclosures required on the Model Enrollment Forms in Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual must be provided either verbally or in writing to the beneficiary.
- For telephonic enrollments, the contents of the Pre-enrollment Checklist (PECL) must be reviewed with the prospective enrollee prior to the completion of the enrollment. Beginning September 30, 2023, the PECL is required to include "Effect on Current Coverage", and agents must ensure they discuss this element, along with all listed elements, with the prospective enrollee and answer any questions to the prospective enrollee's satisfaction, prior to enrollment.
- Sales agents must complete the relevant Medicare Product application in its entirety, asking every question on the application, and read all applicable disclaimers and disclosures clearly and understandably (not in a rushed or hurried fashion), with special attention to the following: 1) confirm first and last name, 2) capture all application contact information; 3) capture selected payment option.
- If a beneficiary has questions during the signature portion or appears to be confused or hesitant about enrolling into the plan, the sales agent must stop the enrollment process, ensure all questions are answered, and confirm that the member would like to enroll prior to proceeding.

Communication Involving Providers

- Be sure to inform beneficiaries of all network providers that are available and ensure beneficiaries always feel completely free to choose any provider in the network.
- Provide accurate and objective information to beneficiaries about the availability of all participating Providers near their place of residence as part of a general description of a Medicare Product's provider network.
- ALWAYS use the carrier specific Physician Finder to look up provider participation as it is the most up-to-date and comprehensive list of participating providers. Please note, Humana and CarePlus physician finder differ. If Physician Finder is not available, agents may call Agent Support for assistance.
    - Agents may:
        - Provide factual information about a particular provider that is included in the Physician Finder, such as ratings available through the Care Highlights program.
    - Agents must **not**:
        - Distribute materials describing a provider's services or marketing a provider's practice.
        - Provide information about any free services or cost-sharing waivers offered by a provider unless they are part of the Humana plan benefit (e.g., complementary transportation).
        - Recommend a provider or share opinion about which provider is best (e.g., do not use superlatives when describing a particular provider).
        - Use aggressive marketing or high-pressure tactics when discussing providers.
        - Use superlatives (e.g., "better care", "best care", etc.) when describing providers to beneficiaries
        - Offer or give anything to beneficiaries to persuade them to choose a particular provider.
        - Accept anything, directly or indirectly, from a provider in exchange for communicating about or helping a beneficiary choose a particular provider (e.g., do not accept promises that provider's patients will choose Humana plans, charitable donations, sponsorships, gifts, cash, etc.).
        - Engage with providers in a way that may influence the agent's interaction with a member or prospect regarding their choice of a Provider, including but not limited to, entering into any arrangements with Providers, or offering, receiving or agreeing to offer or receive anything of value from a Provider or a Provider's representative unless the arrangement complies with all applicable laws and regulations, including but not limited to, the Federal Anti-kickback Statute, and the agent actions comply in all respects with the requirements noted in this document.
        - Engage with providers in a way that would influence the provider to steer patients toward a certain plan or set of plans or encourage a provider to steer patients towards Humana plans.