THIRD PARTY MARKETING ORGANIZATION

Humana Guardrails for Medicare Communications and Marketing Materials and Activities

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 compliance guidelines 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 required to review and adhere to all applicable state and federal laws, rules, regulations, and policies.

In addition, Medicare Advantage organizations (MA organizations), like Humana, are responsible for ensuring that our first tier, downstream or related entities (FDRs), and TPMOS adhere to all terms and conditions of our contracts with CMS, including compliance with all applicable Medicare laws and regulations, when acting on our behalf. This includes, but is not limited to, the requirements that all marketing materials be submitted to CMS prior to use and that MA organizations are accountable and responsible for communication and marketing materials and activities directed at Medicare beneficiaries, even when used or conducted by a TPMO.

TPMOs are responsible for compliance with CMS's Final Rule CMS-4190-F2; 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, CMS memos, CMS interim sub-regulatory guidance, Humana policies and procedures, and any other applicable state or federal laws, rules or regulations. Not only must the content of the 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.

Table of Contents

I. Marketing vs. Communications

Communications

- Communications means activities and use of materials created or administered by the MA organization or any downstream entity to provide information to current and prospective enrollees. Marketing is a subset of communications.

Marketing

- Marketing is a subset of communications. Marketing means communications materials and activities that meet both the following standards for intent and content:

  1) Intended, as determined below, to do any of the following:

  - Draw a beneficiary's attention to a MA plan or plans.
  - Influence a beneficiary's decision- making process when making a MA plan selection.
  - Influence a beneficiary's decision to stay enrolled in a plan (that is, retention-based marketing).

  2) Include or address content regarding any of the following:

  - The plan's benefits, benefits structure, premiums, or cost sharing.
  - Measuring or ranking standards (for example, Star Ratings or plan comparisons).
  - Rewards and incentives as defined under § 422.134(a).

- Marketing includes those materials and activities that do not mention a specific plan by name (as well as instances where such materials are made on behalf of multiple MA organizations). These materials, previously referred to

as “generic marketing materials”, must be treated the same as branded marketing materials and must comply with CMS guidance.

- **Examples of “generic marketing materials” that should be submitted to Humana for review include:**
    - **Television advertisements that direct beneficiaries to call a lead aggregator or sales agency to enroll in plan benefits like plans with $0 premiums, dental coverage, free glasses, etc.**
    - **Direct mail postcards that direct beneficiaries to complete a business reply card or call a lead aggregator or sales agency for a review of important benefits that the beneficiary qualifies for like prescription drug coverage.**
- In evaluating the intent of an activity or material, CMS will consider objective information including, but not limited to, the audience of the activity or material, other information communicated by the activity or material, timing, and other context of the activity or material and is not limited to the MA organization stated intent.
- TPMOs are responsible for directly submitting all multi-plan marketing materials (i.e. materials made and used on behalf of multiple MA organizations) to CMS via the HPMS Marketing Module. Please refer to the HPMS Marketing Module User Guide.
- TPMOs are required to submit all marketing materials referencing Humana’s brand name, logo, plans or providers for review and approval to Humana, prior to use and filing with CMS. Please contact your account executive with any questions regarding Humana’s review process.
- Refer to Humana’s Generic Marketing Quick Start Guide for Generic submissions.
- TPMOs must submit social media posts (e.g., Facebook, Twitter, YouTube) that meet the definition of marketing to Humana for review
- Lead sources or forms must also be submitted to Humana for review before used to collect leads.

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 marketing that contains 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.
- When submitting generic marketing, use Humana’s Generic submission spreadsheet
- 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 changes

- If Humana logo is used, 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 2023 Medicare Disclaimer Quick Reference Guide from Humana in this link.

II. Third Party Marketing Organizations ("TPMOs")

CMS has enhanced multiple sections of the CFR to specifically address TPMOs and their oversight. These new requirements can be broken down into three categories: 1) Definition 2) Disclaimer 3) Oversight

Definition: CMS specifically defines Third Party Marketing Organizations in the regulation at §§ 422.2260 and 423.2260 to remove any ambiguity associated with MA plans/Part D sponsors responsibilities for TPMO activities associated with the selling of MA and Part D plans:

- *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 now requires the following disclaimer on materials for MA plans/Part D products (§§ 422.2267(e) and 423.2267(e)): "We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options."

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.

When this is the only reference to 1-800-MEDICARE, must also include the hours of operation, like this: "We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer

in your area. Please contact Medicare.gov or 1–800–MEDICARE (TTY users should call 1-877-486-2048) 24 hours a day/7 days a week to get information on all of your options."

Oversight: CMS outlined clear plan oversight requirements associated with TPMOs, in addition to what is already required under §§ 422.504(i) and 423.505(i) if the TPMO is a first tier, downstream or related entity (FDR). This indicates the increased expectation and scrutiny regarding oversight and monitoring within this space. All TPMOs must develop and/or enhance its oversight and monitoring program to include the following:

- Ensuring the TPMO adheres to any requirements that apply to Humana
- Develop process for proactively providing how and from where it (or its FDR) obtains leads or enrollments
- Disclose to Humana any subcontracted relationships used for marketing, lead generation, and enrollment
- Record **all calls** with beneficiaries in their entirety, including the enrollment.
- TPMOs report to Humana any staff disciplinary actions associated with Medicare beneficiary interaction on a monthly basis
- Violations by TPMOs of requirements that apply to Humana must be reported to Humana, in addition to disciplinary actions.

*Note: The above list is a guide and minimum expectations from CMS regarding TPMO oversight. This list is not exhaustive. However, it clearly indicates the expectation that CMS has in this space for plans and TPMOs to have better oversight and monitoring of their downlines, FDRS and lead generators to ensure all parties are compliant.

III. 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.

- Lead Sources must abide by all of the Communication and Marketing Material requirements noted in these guardrails along with the above referenced TPMO oversight requirements.
- Ensure that the TPMO, when conducting lead generating activities, either directly or indirectly for an MA organization, must, when applicable:

  (i) 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.

  (ii) Disclose to the beneficiary that he or she is being transferred to a licensed 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.
- TPMOs may not 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.
- TPMOs may not target potential enrollees based on income levels, unless it is a dual eligible special needs plan or comparable plan as determined by the Secretary.
- TPMOs may not target potential enrollees based on health status, unless it is a special needs plan or comparable plan.
- Additionally, web-based communications must be Section 508 compliant (generally—able to be read by a screen reader or other screen reader technology) so the member experience is comparable for those who may be vision or hearing impaired.
- TPMOs are required to provide information to beneficiaries in accessible/alternate formats (for example, Large Print, Braille), upon request and thereafter, as outlined in Section 504 of the Rehabilitation Act of 1973 (and subsequent revisions).
- TPMOs must ask all beneficiaries whether they need to converse in an alternate language and accessible format, but beneficiary must not be required to answer the question. All beneficiaries must have an equal opportunity to enroll in Medicare Products, pay premium bills, and communicate with the plan, whether or not the beneficiary requests accessible or alternate formats or languages.

Anti-Discrimination Notice

- Humana complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion.
- TPMOs materials that are Humana-specific or branded, or that exclusively reference Humana Medicare plans, must include the 1557 anti-discrimination notice. TPMOs can obtain these notices from their Humana account executive. The following are not significant publications/communications under Section 1557 and do not require the 1557 language: Radio or television ads, ID cards, appointment/business cards, banner/banner-like ads, envelopes or outdoor advertising such as billboard ads.
- TPMOs materials that are CMS required materials must utilize **both** the 1557 and Multi-Language Insert. Examples of required materials used by TPMOs are the Pre-Enrollment Checklist, Star Ratings Document, and Summary of Benefits. (see § 422.2267 Required materials and content for a complete list of required materials) Humana has created a combined 1557/MLI document to be used for required materials (previously referred to as the long form). TPMOs can contact their account executive to obtain a copy of this notice. Websites may create a page that houses an MA organization's full accessibility information and provide a link to that page, or the combined 1557/MLI can appear on the bottom of the screen. Either is acceptable.

Inappropriate Requests for Health Status Information

- TPMOs may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in a Medicare Product on the basis of any factor that is 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
- 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.

Unsolicited Contact

- Never use door-to-door solicitation or approach beneficiaries in common areas.
- Outbound solicitation (cold calling) is strictly prohibited via telephone, text messaging and other forms of electronic direct messaging (e.g., social media platforms).
- Only call individuals who have given their permission for a MA organization or TPMO to contact them about Medicare Products.
- 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.
        - 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

- If a potential enrollee provides a TPMO with permission to be called or otherwise contacted, the contact must be event-specific, and may not be treated as open-ended permission for future contacts.
- In accordance with TCPA guidelines , when requesting contact information from a consumer, TPMOs must, at a minimum, disclose 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

Non Dual Eligible Special Needs Plans

- For MA plans that are not D-SNPs, TPMOs must ensure that their sales agents do not:
    - Claim that the plan has a relationship with the state Medicaid agency, unless the MA plan (or its parent organization) has contracted with the state to coordinate Medicaid services, and the contract is specific to that MA plan (not for a separate D-SNP or MMP); or
    - State or imply a plan is available only to or is designed for beneficiaries who are dually eligible for Medicare and Medicaid, unless it is a dual-eligible special needs plan or comparable plan as determined by the Secretary; or
    - Market a non-dual eligible special needs plan as if it were a dual-eligible special needs plan; or
    - Target marketing efforts primarily to dual eligible individuals, unless the plan is a dual eligible special needs plan or comparable plan as determined by the Secretary.

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 enrollment opportunities including but not limited to:
            - Marketing to newly Medicare eligible beneficiaries (who have not yet made an enrollment decision),
            - 5-star plans marketing the continuous enrollment SEP, and
            - Marketing to dual-eligible and LIS beneficiaries who, in general, may make changes once per calendar quarter during the first nine months of the year.
        - Send marketing materials when a beneficiary makes a proactive request
        - At the beneficiary's request, have one-on-one meetings with a sales agent
        - At the beneficiary's request, 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.
        - Engage in or promote agent activities that intend to target the OEP as an opportunity to make further sales.
        - Call or otherwise contact former enrollees who have selected a new plan during AEP.

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 outside of AEP - Rest of Year (ROY)

- Although TPMOs cannot market for an upcoming plan year prior to October 1, TPMOs are permitted to concurrently market the current year with prospective year starting on October 1, provided materials make it clear what plan year is being discussed.

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.
- 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

- Invitations to educational or sales/marketing events must clearly state “educational” or “sales” on the materials themselves.
- If advertising for both educational and sales/marketing events on the same material, details regarding the time of each event must be specific on the material so it is clear when each event is taking place.

Educational Events

- Educational events must be explicitly advertised and designed to be educational;
- designed to generally inform beneficiaries about Medicare, including Medicare Advantage, Prescription Drug programs, or any other Medicare program.
- If a sales/marketing event directly follows an educational event, the beneficiary must be made aware of the change and given the opportunity to leave prior to the marketing event beginning.
- Activities permitted at educational events:
    - Provide communication materials;
    - Answer beneficiary-initiated questions pertaining to MA plans;
    - Set up future personal marketing appointments;
    - Distribute business cards; and
    - Obtain beneficiary contact information, including Scope of Appointment forms.
- Activities **not** permitted at educational events:
    - Market specific MA/PDP plans or benefits;

- Distribute marketing materials, including plan applications;
- Conduct sales/marketing presentations

Sales/Marketing Events

- Sales/marketing events fall under the definition of marketing.
- Activities permitted at sales/marketing events:
  - Provide marketing materials;
  - 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.

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.

- Prior to the personal marketing appointment beginning, the Sales Partner must obtain and record the Scope of Appointment from the beneficiary.
- 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.

IV. 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 Sales Partner.

Per the memo issued by CMS in October 2021, CMS is particularly concerned with national advertisements promoting MA plan benefits and cost savings, which are only available in limited service areas or for limited groups of enrollees, as well as using words and imagery that may confuse beneficiaries or cause them to believe the advertisement is coming directly from the government. In addition, CMS receives complaints from beneficiaries and caregivers that highlight sales tactics designed to rush or push beneficiaries into enrolling into a plan.

Third Party Materials/CMS October 2021 Memo Marketing Checklist

In reviewing the memo issued by CMS in October 2021, Humana created a non-exhaustive checklist. . This checklist was developed to focus on issues identified by CMS as concerns generally found in third party materials in the memo issued in October 2021. Therefore, it may be useful for TPMOs to reference when creating marketing materials, keeping in mind that the checklist is non-exhaustive, and the TPMO is responsible for ensuring all materials comply with all applicable laws, regulations and guidance:

a) Promote benefits that are not generally included in most Medicare Advantage plans (e.g., dentures, free eyeglasses) [Not generally included, ex. dentures]

b) Include benefits that are limited to certain enrollees or where the amount varies per enrollee, like Part B Giveback without making it clear that they are limited to some plans in certain areas [Limited/varies by enrollee, ex. Part B giveback]

c) Promote an SSBCI or VBID benefit without making it clear this is only available on certain plans and to qualifying members (Reminder: these materials must comply with additional marketing requirements and may require special filing with CMS). Examples include grocery cards (VBID) and payment of utility bills (SSBCI). [SSBIC/VBID]

d) Promote cost savings that are not typical or limited to certain enrollees, without qualifying with language such as "there may be plans that may help save money" [Cost savings atypical/limited]

e) Promote very specific amounts related to benefits where most MA members would not receive that level of benefits (i.e. “$1500 back in my social security check”) [Specific amount- rare/high]

f) Describe benefits in a misleading way (e.g. “elimination of copays”, "at no extra cost", "$0 plans", piece doesn't clarify that benefits can only be obtained by enrolling in a Medicare Advantage plan) [Misleading description]

g) Imply benefits can be added to existing coverage or tied to a zip code, as opposed to enrolling in a new Medicare Advantage plan available in their area with the described benefits (e.g. "You can get/are entitled to more benefits") [Implies can add/ala carte]

h) Not prominently identify the company/insurance agency. (Small references to the company embedded in disclaimers are not sufficient) [Governmental]

i) Include the U.S. flag or imagery such as government buildings and symbols [Flag]

j) Overuse of red, white and blue as the color scheme with no company identification to clarify not an official government communication. [RWB imagery]

k) Include a company name that is similar to or includes “Medicare” or a name that may confuse consumers into believing the company is or is affiliated with Medicare and the piece does not prominently clarify that the company is a sales agency and not the government or endorsed by the government. [Medicare-like name/government affiliation]

l) Not include disclaimers, or contains hidden or very small disclaimers, including but not limited to, those to clarify the company is a sales agency and not the government or endorsed by the government [Insufficient/Illegible disclaimer]

Note: If disclaimers shown in actual format of piece are too small, not in a legible font/color, or not present long enough for an average viewer to see, read and interpret them, its equivalent to not having them at all.

m) Use scare tactics [Scare tactic]

n) Promote a false sense of urgency to act now, in either words, imagery or tone (e.g. “CALL NOW!” in all bold, capital letters and/or red font) [False urgency]

o) Stress a deadline for enrolling that could be misleading or unduly pressure beneficiaries into calling [Deadline pressure]

p) Imply that beneficiary must call or respond to the sales agency to implement their Medicare plan/benefits [Must call for benefits/plan]

q) Make it unclear whether it is referring to the Medicare Advantage and Prescription Drug Plan Annual Enrollment Period and/or dates of this enrollment period (e.g. During AEP, if referring to the opportunity to enroll must use the "Medicare Advantage and Prescription Drug Plan Annual Enrollment Period" and not "Open Enrollment Period" or specify AEP dates) [Unclear AEP]

r) Not include SEP qualifiers, such as "Turning 65, New to Medicare, Moving or Losing Coverage" and will be used outside of AEP [SEP qualifiers not included]

s) Market the Open Enrollment Period (OEP) or during the OEP (January – March) and does not include Special Enrollment Period qualifiers. (OEP)

t) Otherwise include misleading, confusing, or materially inaccurate information [Misleading/confusing]

Official Government Materials/Government Endorsement: (Checklist Items H, I, J, K, L)

- Do 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, Medicare ID card image, or patriotic themed colors (red, white and blue), symbols, 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.
- 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, including mailers that do not include a specific plan name or plan names, the Sales Partner's name or logo must be 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).If company name is similar to or includes "Medicare" or a name that may confuse consumers into believing the company is, or is affiliated with, Medicare, the piece should prominently clarify that the company is a sales agency and not the government or endorsed by the government, and include a tagline with the logo or as a frozen banner such as one of the following (examples only):
    - A non-government site powered by <agency name>, a health insurance agency.
    - A non-government entity powered by <agency name>, a health insurance sales agency.
    - <Partner name>, an insurance agency not affiliated with the government.
    - <Partner name> advertisement - no government affiliation.
    - <Partner name> ad - no government affiliation.
    - <Partner name> is an insurance agency with no government affiliation.
    - <Partner name> - an insurance agency with no government affiliation.

For companies that are not insurance agencies and the brand may be seem to be affiliated with the government: In instances where the name that includes Medicare or may confuse consumers into believing the company is, or is affiliated with Medicare, is a brand, such as a lead generating company, and not an insurance agency, these are examples of appropriate taglines:

- No government affiliation
- A non-governmental website

Plans and Benefits Availability (Checklist Items A, B, C, D, E, F, G)

- If plans are not available in all locations, materials must prominently include language to clearly communicate that, such as "Plan availability varies by region and state."
- If describing benefits, the benefits must be available in at least some of the plans the sales agency represents, and available in the market where the material is being used.
    - If benefits are not available on all plans, that material must prominently include language to clearly communicate that, such as explaining, "Not all benefits listed may be available on all plans or in a single plan benefits package."
- Any statements about the availability of plan benefits should be prefaced with "may" or similar terms.
- "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 any Affordable Care Act reference with respect to Medicare Products.

Exaggerative Words/Phrases

- Do not use words/phrases such as "all," "full," "complete," "comprehensive," "unlimited" to describe benefits (these are only examples).

Scare and High-Pressure Tactics: (Checklist Items M, N, O, P)

- 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.

- Acceptable Words and Terms to use only at the end of AEP (last 4 weeks unless otherwise noted) that likely do not create 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 (may only be used 2 weeks before 12/7)

References to Annual Enrollment Period (AEP) (Checklist Items Q, R, S)

- In order to ensure beneficiaries are not misled or confused about Original Medicare open enrollment versus MA/PDP fall open enrollment and the new January – March Open Enrollment Period (OEP), the following terminology is recommended when describing AEP: "*Medicare Advantage & Prescription Drug Plan Annual Enrollment Period*"
- The terminology of "Fall Open Enrollment" can be used if there is limited space, and as long as it is clear in the context of the piece as a whole that a person can enroll in a Medicare Advantage or Prescription Drug Plan beginning October 15-December 7th.
- If there is limited space, and it is clear from the context of a piece that the enrollment period referred to is that in which a person can enroll in a Medicare Advantage and/or Prescription Drug Plan, then the following terminology would be acceptable:
    - Medicare Annual Election Period (AEP)
    - Medicare Annual Enrollment Period (AEP)
    - Use of these terms may require a case-by-case analysis. For example, in the case of a banner ad, the piece as a whole would include the landing page to which the banner ad links, so the abbreviated terminology listed above would be permissible.

Marketing for a 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.
- Materials that discuss a beneficiary's enrollment eligibility need to be clear that the piece is describing eligibility for a Special Election Period, or to "enroll in the plan", and not that the beneficiary is "eligible for more benefits". It is not accurate to use language that suggests that not all Medicare beneficiaries will qualify for the same benefits, unless the material is referring to a Special Needs Plan.
- If creating materials that will be used during OEP or ROY, the following must be prominently included on the materials:
    - Include in the verbiage 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 during the Open Enrollment Period (OEP).

Checklist Item T:

Superlatives and Absolute Language

- Do not use unsubstantiated absolute or qualified superlative language, such as "best", "greatest," "#1" or "outstanding" when describing Medicare Products unless these statements can be validated. If it cannot be supported, it cannot be stated.

- Do not use absolute language such as “guarantee” or “promise” (these are only examples).
- TPMOs may not make unsupported claims. If a statement is made that requires statistical support or documentation, current and accurate sources should be provided. It is best practice that citations are either built into the text or referenced by footnote and include the date and source of the study or research.
- TPMOs must not use “highly rated” unless it is in relation to the CMS Stars Ratings of the plans rated 4 or 5 stars sold by the Sales Partner to avoid confusion. Please see below for details related to Stars Ratings.

Use of Qualifying Language

- Do not use declarative phrases like, “You will save thousands of dollars”, “This is the best plan for you”. Instead, use phrases like “you **may** be able to save money” (if accurate).
- Use words such as “eligible” or “you might”, “you may” “you could potentially save”, “should” or “maybe” (if accurate).

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”.
- May refer to sales agent as “advocate” or “expert” only if substantiated, approved by Humana, and used in conjunction with “licensed sales agent” or “licensed insurance agent”.
- “Unbiased” should not be used in reference to the Sales Partner 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.

Comparisons to Other Plans

- Do not compare Humana plans to other plans by name (unless substantiated by a study or statistical data) and such comparisons are factually based.
- Comparison cannot be misleading or confusing to beneficiaries.
- Do not use pejorative language or disparaging comments about other plans.

Use of the term “Senior”

- Refrain from using 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"

- When a Sales Partner describes services like, "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.

Words to avoid in ROY marketing

- Using the word NEW in a context that gives the impression that new plans are being released by MA organizations.

"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".

"Low" vs. "Affordable"

- Avoid using the word "low" to describe the benefit/premium, unless it is either $0 or is lower than 50% across competitors' plans; it is recommended to use the word "affordable" (if accurate).

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".
- It is preferable to describe Original Medicare as "Medicare Part A and Part B" on documents that also contain reference to Medicare Supplement because some states that regulate Medicare Supplement object to the term "Original Medicare." CMS has no objection to the term "Original Medicare", so if the document is not related to Medicare Supplement marketing, the term "Original Medicare" is acceptable.

Medicare Supplement

- A Medicare Supplement plan must not be identified as a Medicare Advantage plan.
- Never imply that a Medicare Advantage plan operates as a supplement to Medicare.
- The differences between a Medicare Advantage and Medicare Supplement should be explained clearly.

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:
        - Outdoor advertising (ODA) or banner/banner-like ads
        - Radio advertisements and radio sponsorships (e.g., sponsoring an hour of public radio)

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 Sales Partner uses a previous post (whether or not associated with or originated by the MA organization or the Sales Partner) it is considered an endorsement or testimonial.
- The speaker must identify the product or company being endorsed by name.
- 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 that the time the testimonial was created. Testimonial must identify the name of the Medicare Product in which the member was enrolled.
- Ensure member 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 Sales Partner, or its plans or products, this 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.
- Endorsements must reflect the honest opinions, findings, beliefs, or experience of the endorser.
- Endorsements that imply they are made by actual consumers of the Sales Partner or MA Organization should utilize actual consumers in both the audio and video or clearly and conspicuously disclose that the people are not actual consumers.
- Any claims about results, products, or services made in an endorsement or testimonial must be substantiated by reputable sources.

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 (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.

V. Script Requirements

Humana has developed Humana Inbound Multiplan Sales and Enrollment Script PY2023FINAL6.21.22 that partners may use as reference when creating their own scripts.

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.

A. 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. CMS reiterated in recent guidance that their requirements are designed to ensure that an individual conducting marketing activities (that is selling) and enrolling individuals into a plan are licensed and certified. Non-licensed representatives may take demographic information, and then transfer to a licensed sales agent for selling portion, if compliant with applicable state law.

B. All Scripts - Introduction: In the introduction of all scripts, the sales agent **must**:

- Advise, "I am a licensed sales/insurance agent", and state their first and last name. All scripts need to include the Sales Partner's agency name in the introduction so the beneficiary knows whom they called or who called them.
- Clarify that the Sales Partner is a health insurance agency, and not affiliated with the government.
- Per the Final Rule, published May 9, 2022, within the first minute of the sales call agent must verbally state this disclaimer ''We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1–800–MEDICARE (24 hours a day/7 days a week) to get information on all of your options."
    - Recommend adding this in the introduction with a note advising agents must read this within the first minute of the call, such as (**Agent note:** CMS requires this must be read in the first minute of the call.)
    - CMS does not require the disclaimer for those Third Party Marketing Organizations who truly offer every option in a given service area.

- When this is the only reference to 1-800-MEDICARE, must also include TTY and the hours of operation, like this: “We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1–800–MEDICARE (TTY users should call 1-877-486-2048) 24 hours a day/7 days a week to get information on all of your options.”

- Advise that the call is being recorded for quality assurance and training purposes. The beneficiary must agree to the recording before the agent can proceed.
- Include a short summary describing the purpose of the script, the name of the agency(ies) who will be utilizing the script and whether the script will be used for inbound or outbound calls.

C. Informational scripts:

- Informational scripts must make it clear when a beneficiary is going to be transferred to a sales/enrollment department. Before making any transfer to a sales/enrollment (i.e., marketing) department, the representative must receive the beneficiary's express and informed consent with a yes/no question.

D. 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 Federal Contracting Statement on all sales/pre-enrollment calls.
- 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.

i. Scope of Appointment: A valid scope of appointment (SOA) must be included in the beginning of the sales/pre-enrollment script with all required elements:
    - 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 conducted verbally, it must be recorded.

- A new SOA is required if, during an appointment, the beneficiary requests information regarding a different plan type than previously agreed upon.
- TPMOs must not allow their agents to engage in cross selling of non-health products during a Medicare Product conversation, such as life or final expense policies.

ii. POA/Decision Maker: Sales/pre-enrollment and enrollment scripts must clearly probe and identify if the beneficiary makes his or her own decisions and whether or not the beneficiary has a Power of Attorney or other person with legal authority to make those decisions on the beneficiary's behalf.

- The agent should ask whether the beneficiary makes his or her own decisions or has someone help the beneficiary make decisions.
- If the beneficiary does not make his or her own decisions, or generally has help in making these types of decisions, the agent should invite them to join the discussion. The agent should ask if the beneficiary has an authorized representative such as Power Of Attorney (POA), health care surrogate, or court appointed guardian or another individual they would like to join the discussion. See linked multi-plan script for language recommendations.
- If someone else is calling on behalf of the beneficiary, the agent should ask if this person is the POA and/or whether he or she has legal authority under state law to make decisions for the beneficiary
- The agent should ask if the POA/authorized representative can produce documentation of authority upon request. The MA organization or CMS may request documentation and it should be available upon request.

iii. Other Coverage/Retirement Benefits: It is crucial the sales agent determine whether a beneficiary has other coverage such as Union, Employer, Individual Major Medical, Employer Group Medicare plan, retirement benefits for healthcare, VA benefits, Tricare/Tricare for Life, and/or CHAMPSVA. If a beneficiary has Union, Employer, VA coverage, or Tricare/ChampVA please encourage the beneficiary to contact their union, employer and/or the VA administration, or Tricare/ChampVA administrator, to discuss if and how a Medicare Advantage plan may impact their current benefits.

- The sales agent must also ask the beneficiary if a family member or spouse is receiving health insurance through a current or former employer or union.
- If the beneficiary has Tricare for Life or Champ VA (for veteran's spouses), the sales agent must explain that Tricare for Life coverage is generally more comprehensive than most other types of coverage available and how enrolling in a plan will affect their Tricare (i.e. how the claims will pay differently, Tricare will become the secondary insurance if an MAPD plan is selected and they may lose some of the benefits TRICARE offers.) Agent should answer any additional questions the beneficiary may have, clarify that enrollment into a MA or MAPD plan is not recommended for Tricare beneficiaries, refer the beneficiary to the administrator of their Tricare benefits for additional questions, and end the call.

iv. Election Periods: TPMOs must ensure that sales agents accurately assess and advise each beneficiary of the applicable election periods that may apply to the beneficiary's circumstances.

- Election period qualifying questions must be included in sales/pre-enrollment and enrollment scripts and online enrollment:
  - If the script language refers the sales agent to review a separate election period qualifying job aid, the Sales Partner must provide the job aid to Humana during the script review and ensure that the job aid has been updated to reflect the most recent CMS Medicare Product Enrollment and Disenrollment Guidance.

v. "NEADS" Analysis Section: TPMOs must ensure that their agents fully analyze what each beneficiary wants from their healthcare coverage in order to help the beneficiary choose the plan that works best for the beneficiary. Never skip or speed through this process. Sales agents should especially focus on "N" which is what coverage does a beneficiary have NOW (see below). Sales agents must conduct a complete and thorough NEADS analysis using the following as a guide:

(N) Now. What is your current coverage for health, RX, dental, and vision? What do you pay for each? Quantify per month and year.

(E) Enjoy. What do you enjoy about your current coverage? Any benefits, doctors, hospitals, cost or other feature preferences?

(A) Add / Alter. What would you add or alter to have coverage you'd like even more? What are you hoping to gain by changing your coverage arrangement? Is anything more important to you – like health vs Rx benefits? Any preference for plan types, like HMO or PPO? Is travel or living elsewhere at times part of your lifestyle?

(D) Decision. Will you make your own enrollment decision today?

(S) Summary: I'll summarize my notes for you. Did we get it all? What else should we add to have a complete picture?

- Sales agents must offer to review the network participation status of a member's preferred providers and any medications the beneficiary would like to ensure are covered. See the "Communication about Providers" section of these guardrails for further information about network provider discussions.
- Any questions a sale agent asks a beneficiary about his or her health status or prescription medications and provider usage must be worded as optional and beneficiary responses must not be required.
- If the beneficiary does not wish to disclose information, the sales agent must continue the call and provide general plan information to the beneficiary.

vi. Required Documents: As noted above, these documents will require the combined 1557 and Multi-Language Insert

a. Summary of Benefits and Stars Rating Document: TPMOs must ensure that their sales agents review the Summary of Benefits and Stars Ratings in a clear and audible way.

b. Pre-Enrollment Checklist (PECL)

- The PECL is a standardized communications material that TPMOs must ensure their sales agents provide to beneficiaries with the enrollment form (in any medium), so that the beneficiaries understand important plan benefits and rules.
- TPMOs must ensure that every beneficiary has access to the PECL and all required information (SB, disclaimers, checklist, etc.) prior to making an enrollment decision.
- TPMOs must ensure that sales agents read all of the applicable disclosures included in the PECL or include the required disclosures in one of the ways below:
    - Include the PECL verbatim in the sales and/or enrollment script.
    - Embed the disclosures from the PECL within the script sales and/or enrollment script.
    - Advise the beneficiary that the PECL can be found on the MA organization's website (or another medium) and refer the beneficiary to review the PECL before making any enrollment decisions.
    - If the beneficiary wants to move forward with an enrollment, and cannot access the website (or other medium), then the agent must review the PECL verbally, before moving forward with an enrollment.

Before a sales call may progress to a telephonic enrollment, a licensed sales agent must clearly ask the beneficiary if she or he want to enroll into the Plan discussed using the specific Plan name and type. The beneficiary must provide a definitive "yes" before the sales agent can move to the enrollment script.

D. 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.
- 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.

VI. 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.
- Be factual, exclude personal opinions, and avoid the use of superlatives (e.g., "better care", "best care", etc.) when describing providers to beneficiaries.
- ALWAYS use the carrier specific Physician Finder whenever possible 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 may 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.
    - Schedule meetings with prospective members at a particular provider's office so long as:
      - As applicable, Scope of Appointment (SOA), other MarketPoint policies and all other CMS requirements are followed.
  - Agents **must:**
    - Provide only factual information about services a particular provider offers that are covered by the Humana plan.
      - Always refer beneficiaries to the relevant provider directory and make it clear that other providers are available in the network.
      - Ensure beneficiaries always feel completely free to choose any provider in the network.
  - 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.
    - 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. Under the CMS regulations, the provider should be a neutral party who is offering guidance to patients based solely on what is best for the patient.

Communications and Materials that mention Providers

- Any communication or marketing material that mentions or involves a provider must be submitted to Humana via their AE to go through the regular, branded process (not the generic process) for review prior to use. The TPMO should complete the intake form, and must include all of the requested information in the provider section of the intake form
- If requested by a beneficiary, a Provider may answer questions or discuss the merits of an MA plan or plans, including cost sharing and benefit information (these discussions may occur in areas where care is delivered) but may not market or steer a beneficiary toward a particular Medicare Products. Providers should remain neutral and keep the best interest of the beneficiary in mind during any such discussion.
- 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 Sales Partner or any plans.

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.