ADVOCATE HEALTH ADVISORS MEDICARE MARKETING POLICY

Mission: Advocate Health Advisors strives to maintain our standing as a compliance leader in the Medicare field by providing top level guidance and implementation to achieve our vision. To do this, Advocate Health abides by and enforces the current CMS Medicare Marketing Guidelines, as well as the individual Carrier Policies that we partner with.

Prohibited Marketing Activities. Producer acknowledges that certain marketing activities are prohibited by Medicare Program Requirements. The following description of prohibited marketing activities is not exhaustive and is subject to change based on CMS instructions or other changes in Medicare Program Requirements. Additionally, Advocate Health reserves the right to prohibit any marketing activities in its discretion and to adopt standards or practices that may be more rigorous than Medicare Program Requirements. Producer agrees that it shall not (i) conduct door-to-door solicitations and other instances of unsolicited contacts that may occur outside of advertised sales events, (ii) provide or subsidize meals for a Potential Member at any event or meeting at which plan benefits are being discussed and/or plan materials are being distributed, (iii) offer gifts to Potential Members unless such gifts are of nominal value (as defined by the Marketing Guidelines) and are provided whether or not the recipient enrolls in a plan, (iv) distribute marketing materials or collect Carrier applications at educational events, (v) conduct sales activities in healthcare settings except in common areas, or (vi) market non-health care related products (e.g. annuities or life insurance) during any Medicare related sales activity or presentation.

Benefits may not be displayed on any marketing materials, mentioned in radio, television, or other digital ads without carrier and CMS approval. Benefits would include, but are not limited to, dental, vision, hearing, healthy food cards, Part B Giveback, gym memberships, or any other benefit offer by any health plan.

Materials, including communication materials, may not include an image of the Medicare card or other government-issued cards without permission from the issuer. Permission for using the Medicare card must come from CMS and other cards from the governmental entity that issued them (example: Medicaid state must issue permission to use the Medicaid card image.)

Marketing Through Unsolicited Contacts. Medicare Program Requirements restrict marketing Medicare Plans through unsolicited contacts including approaching Potential Members in public areas and telemarketing. Producer shall comply with all Medicare Program Requirements regarding unsolicited contacts and conduct any permitted telemarketing activities in compliance with Laws, including "**do not call**" requirements of Governmental Authorities. All outbound call scripts referencing a Carrier must be approved by Carrier in writing prior to use by Producer or its Representatives.

Scope of Appointment. A Scope of Appointment (SOA) is required to be submitted to the carrier with any MA, MAPD or PDP enrollment form or online/telephonic enrollment. All enrollment forms and SOA forms must be retained by the agent for a minimum of ten years.

70.4.3 – Scope of Appointment 42 CFR 422.2262, 422.2268(g) and (h), 423.2262, 423.2268 (g) and (h)

When conducting marketing activities, in-person or telephonically, a Plan/Part D Sponsor may not market any health care related product during a marketing appointment beyond the scope that the beneficiary agreed to before the meeting. The Plan/Part D Sponsor must document the scope of the appointment prior to the appointment. Distinct lines of plan business include MA, PDP and Cost Plan products. If a Plan/Part D Sponsor would like to discuss additional products during the appointment in which the beneficiary indicated interest, but did not agree to discuss in advance, the Plan/Part D Sponsor must document a second scope of appointment (SOA) for the additional product type to continue the appointment.

SOA documentation is subject to the following requirements:

- The documentation may be in writing, in the form of a signed agreement by the beneficiary, or a recorded oral agreement. Any technology (e.g., conference calls, fax machines, designated recording line, pre-paid envelopes, and email) can be used to document the scope of appointment.
- Date of appointment
- Beneficiary contact information (e.g., name, address, telephone number)
- Written or verbal documentation of beneficiary or appointed/authorized representative agreement
- The product type(s) (e.g., MA, PDP, MMP) the beneficiary has agreed to discuss during the scheduled appointment
- Agent information (e.g., name and contact information)
- A statement clarifying that:
  - beneficiaries are not obligated to enroll in a plan
  - current or future Medicare enrollment status will not be impacted
  - that the beneficiary is not automatically enrolled in the plan(s) discussed 41 A beneficiary may sign an SOA at a marketing/sales event for a future appointment. Marketing/sales events, as defined in section 70.5, do not require documentation of beneficiary agreement.
- Effective September 30, 2023, new CMS regulations re-establish the requirement of a 48-hour waiting period.
  - Call centers may document the SOA on an inbound call and proceed;
  - Outbound calls are subject to the 48-hour waiting period;
  - Field agent appointments are subject to the 48-hour waiting period;
    - Walk-ins are not subject to the 48-hour waiting period but must be documented;
    - If it is the last four days of an enrollment period, the 48-hour timeframe can be waived to allow the beneficiary to enroll.

Note: Business reply cards are (BRC) separate and independent from a marketing piece, must be submitted in HPMS if benefits and/or costs information is mentioned or the BRC is used as an agreement to be contacted, confirmation of attendance to a sales/marketing event, or request for additional information. Plans/Part D Sponsors should include a statement on the BRC informing the beneficiary that a salesperson may call as a result of their returning a BRC. See section 90.2 for information on the material submission process.

Enrollment Applications. Agents are required to submit all MA, MAPD, and PDP enrollments directly to the carrier, within 24 hours of member signature date. Agents must use the carrier's preferred method to submit enrollment forms – fax, overnight mail, or electronic/telephonic applications. Record of submission must be kept and maintained, i.e. fax confirmation sheet, postage tracking number, or application ID. Agents are required to maintain enrollment records for a minimum of ten years.

Agent Licensure, Certification & Appointment. Advocate Health Advisors shall review and evaluate each Sales Agent's qualifications to provide Marketing Services, including, without limitation, such Sales Agent's qualifications relative to Laws. Agents must have and maintain any and all licenses, permits, certifications or other similar permissions required by law to perform the services and any other activities on behalf of the plan, including such licenses required by the state and government authorities, and such licenses are in full force and effect and unrestricted.
120.3 – Agent/Broker Training and Testing 42 CFR 422.2274(c) and (d), 423.2274(c) and (d) Plans/Part D Sponsors must ensure that all agents/brokers (employed/captive or independent) selling Medicare products are trained and tested annually on Medicare rules, regulations, and on details specific to the plan products that they sell. This means that training and testing must take place prior to the agent/broker selling the product. In addition, agents/brokers must obtain a passing score of at least eighty-five percent (85%) on the test. CMS provides updated guidance annually for agents/brokers training/testing. Plans/Part D Sponsors must ensure that their agents/brokers training/testing programs

are designed and implemented in a way that maintains the integrity of the training and testing and must have the ability to provide this information to CMS upon request.
Agents must also be appointed by the individual Plan Sponsors for whom the Agent will be selling/marketing products. Advocate Health will review each agent and verify licensure and appointment status via the National Insurance Producer Registry (NIPR) website.

Agent Oversight. Agents are responsible for knowing and following the CMS Medicare Marketing Guidelines. It is our responsibility to provide agents with the tools needed to conduct a compliant and comprehensive sales presentation. Advocate Health Advisors will comply with all applicable Laws and any requirements of an applicable government agency. Advocate Health Advisors will cooperate with Plan with respect to Plan's compliance with Laws, government agency requirements, and the requirements of accrediting bodies. Advocate Health shall report to Plan immediately any instances of potential non-compliance or fraud, waste and abuse associated with services, including, without limitation, any instance of non-compliance or fraud, waste or abuse by any Sales Agent and any related decision by Advocate Health Advisors to suspend or terminate a Sales Agent's performance. Advocate Health Advisors shall implement any corrective action reasonable requested by Plan to resolve potential and future instances of non-compliance or fraud, waste, and abuse.

Advocate Health will review and monitor their agent's Section A history to determine if any trending has occurred which signifies a potential for future compliance risk. Disciplinary process will range from corrective action plans, to termination of a Sales Agent's contract or employment with Advocate Health, LLC. We will document all coaching and counseling with a description of action taken, date it was completed, agent's signature or other proof of receipt, and any additional agent-required training.

Branded Marketing Materials. Sales Agents shall use only the Plan's designated marketing materials, including advertising material and application forms that have been provided to the Sales Agents by the Plan. Sales Agents shall return all marketing material to the Plan immediately upon termination. Agents are encouraged to use pre-approved marketing material provided by the Plan.

Materials created by agents or brokers that mention plan specific benefits must be submitted by the Plan/Part D Sponsor to CMS. Materials that include an agent's/broker's phone number should clearly indicate that calling the agent/broker number will direct an individual to a licensed insurance agent/broker.

Generic Marketing Materials. Producer may prepare marketing materials for use by Producer, provided that Producer shall not, and shall not allow any Representative to, use any marketing materials that are not first approved by Advocate Health Advisors or the Plan in writing. All generic materials created by Sales Partners must comply with CMS Medicare Marketing Guidance, applicable state and federal laws, Plan policy and procedures, and include all required disclaimers.

If Sales Agents maintain a website for the purpose of obtaining leads, then Sales Agents are required to submit their website to the Plan for approval. Advocate Health Advisors will also review their agent's websites for compliance with CMS Medicare Marketing Guidelines.

Partners will be required to maintain all generic materials and will be subject to a Retrospective Review by Advocate Health Advisors or the Plan upon request.

If any generic material is found to be noncompliant and presents a risk, the Agent will be alerted that they must immediately cease using the piece to solicit Medicare products. If warranted, the Sales Agent may also be placed on a corrective action. In addition to the random selection process, any Sales Agent that is identified as possibly using non-compliant marketing (either through a complaint or other compliance monitoring activities) may be subject to more frequent review or other corrective action.

Educational Events. You may not perform sales activities at educational events, including but not limited to, the distribution of marketing materials or distribution or collection of Medicare Advantage and/or Part D enrollment applications. Additionally, the following disclaimer must be included on all advertising materials at

an educational event: “For educational purposes only.” Materials distributed or made available at an educational event must be free of plan-specific information, (including plan-specific premiums, co-payments, or networks) and any bias toward one plan type over another. An educational event is one that is sponsored by a health insurance plan or by outside entities and are promoted to be educational in nature such as health information fairs, conference expositions, state-or community-sponsored events. Please refer to CMS policy for additional guidance.

You may not:
1. Discuss plan-specific premiums and/or benefits;
2. Distribute plan specific materials;
3. Distribute or display enrollment forms, and sign up sheets must be clearly marked “optional”.
4. Display or distribute any material that is deemed “marketing” under current CMS guidelines
5. You may not conduct an education event and a sales event in the same location within 12 hours of each other. Sales events must be at least 12 hours after the educational event, or held in a different location.

Formal Sales and Marketing Events. Formal marketing/sales events are designed to steer, or attempt to steer, potential customers toward particular products and/or plans. An Agent can discuss plan specific information and is allowed to collect enrollment applications. All materials, terminologies and statements expressed during these events must be compliant with CMS and the Health Plan’s regulatory guidance and all materials used at these events must be approved by the Health Plan and CMS prior to use. Please refer to policy.
Agents must notify the Health Plan of all formal marketing/sales events, including cancellations, within the regulated timeframes, so please ensure you follow CMS policy to meet these requirements.

You may not:
1. Discuss plan options beyond the scope of what was advertised in the event invitation. Non-healthcare related products (i.e., life insurance) cannot be discussed during a formal marketing/sales event.
2. Obtain referrals from event attendees.
3. Require persons responding (RSVP) to an event invitation to provide contact information as a condition for attending the event.
4. Sales presentations open to the public do not require documentation of prior beneficiary agreement to the scope of the presentation (SOA), but event advertising materials must indicate what products will be discussed at that time. **Note:** This applies to Informal Events too. Educational events must be reported to carriers when specifically branded for them, in particular UnitedHealthcare® and Florica Community Care.
5. Discriminate against attendees based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, and genetic information, evidence of insurability or geographic location.
6. Target prospective customers from higher income areas.
7. Conduct formal marketing/sales events in healthcare settings; except in common areas.
8. Conduct health screenings or similar activities that could give the impression of “cherry picking”.
9. Collect personal information in order to enter a raffle or a drawing during a formal marketing/sales event.

You must:
1. Arrive at least 15 minutes prior to the formal marketing/sales events scheduled start time to prepare the room for the event.
2. Bring enough marketing material to ensure each attendee will be given their own copy of materials presented (considering room size and RSVPs and ensuring an ample supply of extra materials are on hand).
3. Verify the marketing material to be used is appropriate for the plan year and the service area; as well the products advertised to be discussed during the event.
4. Verify appropriate Star Rating sheet is included in material provided to attendees.
5. Ensure sign-in sheets, if used, clearly read “optional”.
6. Greet attendees and assure them that providing contact information is not required.

7. Provide business cards and marketing material to each attendee.
8. Begin the event on time, at the start time advertised.
9. Take time at the end of the event to answer questions.
10. Collect a Scope of Appointment document or recording via telephonic line for attendees requesting a follow-up appointment at a future time.
12. Return all calls or emails if requested by an attendee RSVP prior to the event.

Informal Events
Informal marketing/sales events occur in a less structured environment such as at a health fair or booth in a common area. The requirements are similar to those of a formal event.

Prohibition on the Provision of Meals
You may not provide meals or subsidize meals for any prospective enrollee of a Medicare Advantage or Part D plan at any event or meeting at which plan benefits are being discussed and/or plan materials are being distributed. You may provide refreshments and light snacks so 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. The following light snacks could generally be considered acceptable: fruit, raw vegetables, pastries, cookies or other small dessert items, crackers, muffins, cheese, chips, yogurt or nuts.

Required Disclosure
You must provide the following disclosure or a substantially similar disclosure, prior to enrollment or at the time of enrollment, in writing, to a potential customer:
"The person that is discussing plan options with you is either employed by or contracted with <Medicare Health Plan>, and its applicable affiliates offering Medicare Advantage and/or Medicare Part D plans. The person may be compensated based on your enrollment in a plan."

Additional disclosures and disclaimers may be required. Please contact Advocate Health Advisors for assistance.

Prohibition of Payment / Gifts / Incentives to Beneficiaries
You may not provide or offer gifts or payments to a Medicare Advantage and/or Part D customer as an inducement to enroll in a Medicare Advantage and/or Part D Product. You may provide an individual eligible for Medicare Advantage and/or Part D a gift of nominal value, so long as the gift is provided whether or not the individual enrolls in the plan. A nominal value is defined as an item having little or no resale value and which cannot be readily converted into cash. Nominal value gifts are worth less than fifteen dollars ($15.00) based on the fair market value of the item or less, with a maximum aggregate of $75 per person per year. Cash gifts or gifts readily converted into cash are prohibited in any amount, as are charitable contributions in the name of the potential customer. In addition, while you may describe legitimate benefits, you are prohibited from offering or giving rebates, dividends or any other incentives, especially those that in any way compensate for lowered utilization of health services by such eligible individuals. Please refer to the CMS policy for additional guidance, as changes in federal and state laws, rules, regulations, and CMS guidance may occur from time to time. See also Prohibition of provision of meals.

What does CMS classify as a "third-party marketing organization?"
Per 422.2260 and 423.2260, "third party marketing organization" (TPMO) means an organization or individual, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment-related functions as part of the chain of enrollment into a Medicare Advantage or Part D plan.

- May be a first-tier, downstream, or related entity (FDR) or provide applicable services to an FDR as a vendor

Standardized Disclaimers
Effective September 30, 2023 TPMOs must use the following standardized disclaimer on all marketing materials, online, television and radio ads, as well as websites and print material that contain marketing content:

"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."

Or

"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 provided verbally, electronically, or in writing, depending on how the TPMO is interacting with the prospective enrollee
    - If using telephone, must be done withing the first minute of the call
- Must be prominently displayed on websites and marketing materials, including print materials and television advertising
    - Medicare Advantage plans are required to ensure TPMO adherence, and thus will be conducting regular and ad hoc oversight of materials being used as part of our overall compliance oversight

Call Recording Requirement

TPMOs are required to record all sales calls, including those as part of the enrollment process, in their entirety. Call recordings are subject to the same records retention policies agreed to in your contract. Sales calls may include, but are not limited to, appointment setting, preliminary plan reviews, and enrollments. These recordings must be stored in a HIPAA compliant manner for a minimum of ten years. In the event a beneficiary declines to be recorded, the agent must set up a face-to-face meeting and end the call.

Effective September 30, 2023 CMS clarified that only calls within the chain of enrollment must be recorded. Chain of enrollment would include any discussions/comparisons of plan benefits and enrollment of the member. Virtual calls such as Zoom or Teams calls are also subject to the recording requirements for chain of enrollment. These recordings must be stored in a HIPAA compliant manner for a minimum of ten years. In the event a beneficiary declines to be recorded, the agent must set up a face-to-face meeting and end the call.

1. Advocate Health Advisors supports agents by offering a call recording solution for agents to use free of charge. The calls are stored for a minimum of ten years.
2. Agents may also use call recording solutions offered by Carriers or other enrollment platforms such as Sunfire or Connecture.
    a. We do not recommend using a personal cell phone unless there is a recording app or feature that will hold the recording for ten years and is readily retrievable. If this is the solution being used, agents are responsible for ensuring compliance with the recording and record retention requirements.
3. Calls on our recording solution are retrievable by locating the recording and downloading it. Advocate Health also has admin access in order to retrieve the call(s) on the call recording system.
4. Calls monitored by Advocate Health are scored against a scorecard for accuracy and to ensure all elements are covered in the call as required.
5. Calls are identifiable by the agent's NPN and can be retrieved by the agent or admin staff with Advocate Health.
6. We remind agents on a quarterly basis to record any calls that are within the chain of enrollment quarterly.

Compliance oversight of all lead sources:
TPMOs are responsible for compliance oversight including ensuring all lead sources used to solicit Medicare product enrollments are compliant with CMS guidelines, and all other state or federal laws, rules and regulations.

This includes but is not limited to ensuring that the TPMO, when conducting lead generating activities, either directly or indirectly, must:

- Disclose to the beneficiary that his or her information will be provided to a licensed agent for future contact. This must be done -
    - Verbally when communicating with a beneficiary by phone
    - In writing when communicating with a beneficiary through mail or other paper
    - Electronically when communicating with a beneficiary through email, online chat, or other electronic messaging platform
- TPMOs are responsible for compliance oversight including ensuring all lead sources (including those purchased) used to solicit Medicare Advantage Products are compliant. TPMOs must also ensure the process of obtaining the lead and the outreach is compliant. Lead sources must abide by all CMS' requirements, including but not limited to:
    - Cannot require age, date of birth, health status questions, or any other information outside of the necessary contact information, on lead forms and websites used to generate MA/PDP leads.
- Ensure beneficiary is clearly informed before completing the form that it will result in call(s) from licensed sales agent(s) and include all applicable consent language as mandated by the TCPA, FTC, FCC, and HIPAA. This disclosure must be conspicuously placed.
- Business Reply Cards (BRC) and Permission to Contact (PTCs) expire after 12 months following the beneficiary's signature date.
- Must not engage in cold-calling or unsolicited contact when conducting lead generating activities.
- When executing a direct mail campaign, agents must only use compliant, approved marketing or communications materials. Agents should honor any opt-out requests and remove from any future mailings.

TPMO to TPMO Beneficiary Data Sharing

When requesting contact information from a consumer and prior to placing any calls or sending any messages to that consumer, TPMOs must obtain express written consent that is specific to the entity on whose behalf the call is made or message is sent. At a minimum, the opt-in language must be clear and conspicuous, and include that:

- The consumer agrees to receive telephonic sales and marketing calls and text messages using an automated system for the selection or dialing of telephone numbers, automated voice calls, AI generative voice calls, prerecorded messages played when a connection is made, or prerecorded voicemail messages;
- Calls and messages are for marketing purposes;
- Cellular charges may apply;
- Providing permission does not impact the consumer's eligibility to enroll;
- The consumer can change his or her permission preferences at any time by contacting [TPMO Name]; and
- The consumer provides this consent even if the consumer's number is listed on a Do Not Call registry.

Beginning October 1, 2024, personal beneficiary data collected by a TPMO for marketing or enrolling them into a Medicare Advantage or Part D plan may only be shared with another TPMO when prior express written consent is given by the beneficiary. Prior express written consent from the beneficiary to share the data and be contacted for marketing or enrollment purposes must be obtained through a clear and conspicuous disclosure that lists each entity receiving the data and allows the beneficiary to consent or reject to the sharing of their data with each individual TPMO.