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Innovative Financial Group Marketing and Communication Guide

Innovative Financial Group (IFG) is committed to ensuring our contracted sales agencies and agents and vendors develop compliant marketing and communication materials. The purpose of this document is to provide a guide to IFG's contracted agencies and agents, and other vendors, and any organizations and individuals who are compensated to perform lead generation, marketing, sales, and enrollment related functions ("Third Party Marketing Organization" or "TPMO"). However, this guide is not inclusive of all applicable laws and regulations for Medicare marketing and communication materials do not constitute and must not be construed as legal advice. IFG does not represent that compliance with this guide will ensure that any communication or marketing material or activity will comply with all applicable laws, rules, or regulations. Agencies and agents are responsible for compliance with all applicable laws and regulations, including, but not limited to, the following:

- Final Rule 42 CFR § 422.2260 - § 422.2274 & 42 CFR § 423.2260 - 42 CFR §423.2276
- Chapter 2 of the Medicare Managed Care Manual, Chapter 3 of the Medicare Prescription Drug Benefit Manual
- The Center for Medicare and Medicaid Services ("CMS") memos
- CMS interim sub-regulatory guidance
- IFG policies and procedures
- Any other applicable state and federal laws, rules, or regulations (i.e., FTC, FCC and HIPAA)

The above is not an exhaustive list. It is the responsibility of the agent or agency to ensure all applicable rules and regulations are adhered to for itself, its sales agents, its employees, and any of its downline sales agencies and/or lead vendors. Not only must the content of a material meet all applicable requirements, but also how and when the material is used must comply. If applicable rules, regulations, or requirements are updated or revised, agencies are expected to adhere to those new or revised rules, regulations, or requirements and the updates or revisions take precedence over this guide.

IFG downline Agencies, Vendors and Agents may only use CMS and Carrier approved materials. All communications or marketing materials must include required CMS disclaimers.

Thank you for your continued commitment to compliance! Any questions on any information provided within this guide or with any marketing or communication materials can be directed to IFGMarketingOversight@teamifg.com.

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Marketing and Communication Requirements

CMS regulations require marketing and communication materials to not mislead, confuse, or provide materially inaccurate information to current or potential enrollees. TPMOs are responsible for ensuring that all materials meet these requirements including those the TPMO and its downlines purchase from other downstream entities or create themselves.

CMS defines marketing as communications materials and activities that meet both intent and content.

A material satisfies "intent" if its purpose is to:

- 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).

A material satisfies content if it includes or addresses:

- 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).

Note: CMS memorandum dated May 10, 2023, further clarified content that beneficiaries can receive benefits such as dental, vision, and hearing is sufficient information to meet the content standard. Use of these statements in materials directed to beneficiaries meets the intent standard.

If you are unsure if a piece is marketing versus communication, please email the piece to IFGMarketingOversight@teamifg.com .

Materials Review and Filing Instructions

Marketing and communication materials must be submitted to IFG by completing the following online submission form teamifg.com/marketingcompliance.

- IFG is responsible for directly submitting all multi-plan marketing materials used by IFG downline agencies and agents (i.e., materials made and used on behalf of multiple Medicare Advantage and Part D organizations) to CMS via the Health Plan Management System (HPMS) Marketing Module after carrier review.
    - Marketing materials must be submitted in HPMS for each Plan Year.
    - CMS generally opens HPMS filing for the next plan year in June.
    - Materials filed for the next plan year June-September may not be used until on or after 10/1.

- Agencies and Agents must ensure the proper media type is selected upon submission.

- Prior to use and filing with CMS, IFG is required to submit all marketing, any telephonic scripts and select communications (such as Television Commercials, online videos, Permission to Contact forms - print or electronic, and provider-related communications) that will be used by IFG downline Agencies and Agents to Carriers for review and approval prior to filing or use, this includes, but it not limited to:
    - All telephonic lead, transfer, sales, and enrollment scripts
    - Enrollment forms
    - All plan comparison websites
    - All other materials that meet the definition of Marketing
    - Lead sources or forms, such as print or electronic Permission to Contact (PTC) and Business Reply Cards (BRC)
    - Television commercials and online videos that are Communications.
    - Post-enrollment member communications mentioning a Carrier, or specific benefits even if not marketing.
- Agencies that use or purchase leads from a lead aggregator, must submit **all** lead aggregator lead sources (marketing and communication) or forms (PTCs/BRCs) for review and approval prior to lead collection.
- If these materials contain marketing as defined by CMS, they are subject to CMS filing regulations. IFG will file the materials for the agency in HPMS as required.
- All lead aggregator materials used by agencies, including communications, must also be submitted for review and approval to IFG and several Carriers.
- Agencies and Agents may not alter CMS-approved materials in any way, other than to add personal information like agent name, phone number, email, or event date, when permitted.

IFG WILL COMMUNICATE WITH THE AGENCY AND AGENT UPON FINAL APPROVALS RECEIVED TO PROCEED WITH USAGE.

Submission of Identical Pieces by Multiple Agencies:

Agencies submitting a piece that has already received approval from carriers and CMS through a previous upline, will need to be submitted to IFG for filing under IFG with the carrier and CMS. When submitting to IFG, a note explaining that the piece was already approved under [original SMID material id].

Example:
Original submission: MULTIPLAN_[Name of Creative]_M

Additional Submissions by other Agencies:

MULTIPLAN_[Name of Creative]_[Agency Initials]_M

MULTIPLAN_CALL US CREATIVE 1_ABC_M

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

Materials that Mention Providers or Other Entities

- Any communication or marketing material that mentions or involves a provider must be submitted to IFG for review prior to use.
- Provider Office Materials must be filed with CMS in HPMS for approval, with up to a 45-day review/approval window.
- Any communication or marketing material that is co-branded with another entity, or will be mailed to clients of another entity, such as a bank, financial advisory firm, insurance company, credit union, loan agency, non-profit organization, or any other entity, the agency must submit the material for review.
- Provider images should not show a specific provider (should be a stock photo of a provider) and/or clinic, the provider pictured should not be a contracted provider, and associated text and voiceover should describe only clinical, educational information (such as describing preventive services), and should not be promoting the agency or any plans.

Rules of the Road for Review Process

The following are several rules of the road that will help expedite the review process:

- **All** Permission to Contacts (PTCs) must be submitted to IFG prior to collecting leads with the material.
- Lead sources or forms and Television Commercials that may be Communications must also be submitted to IFG for review before used to collect leads.
- Submit the content in a proofread editable Word document format with changes since last review redlined in tracking mode. Images/mock-ups/PDFs/Screen grabs should also be provided for visual references, but all verbiage must be typed into Word. Images or PDFs of images containing text are not acceptable. Editing non-Word format adds significant delays. For websites, the process flow must be described, and screen grabs must be included on the Word document in addition to the verbiage typed in Word. At top of page, list the URL and SMID and summarize change.
- For websites, the flow must be described, and images 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.
- Video or TV ads must be submitted/filed as a word document that contains all on screen and spoken content, a link or video file can be included as supporting documentation.

- If an agency wants to use Carrier logos, a request needs to be made to IFG to obtain approval from the Carrier prior to usage.
- If Carrier logos are used, you must include images of the logo use/placement in context of the rest of the content.
- Plan well in advance - allow time for IFG, Carrier and CMS processing. 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 IFG and Carriers.
- Ensure all applicable disclaimers are included in the editable Word document.
- Marketing and Communications created by Artificial Intelligence (AI) must have human oversight before sending to IFG for review and during the publishing process. AI should not be used to simulate an actual person or celebrity without their express consent. If either the voice and/or on-screen talent has been generated by Artificial Intelligence, disclaimer should indicate:
    - AI-generated Voice and Actor
    - Or AI-simulated actor portrayal

Third Party Marketing Organizations ("TPMOs") Disclaimers

Definition:

CMS specifically defines Third Party Marketing Organizations in the regulation at §§ 422.2260 and 423.2260: Third-party marketing organization (TPMO) means organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA plan or plans to making an enrollment decision). TPMOs may be a first tier, downstream or related entity (FDRs), as defined under § 422.2, but may also be entities that are not FDRs but provide services to an MA plan or an MA plan's FDR.

TPMO Disclaimer

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

If the TPMO sells all MA organizations and/or Part D sponsors in the service area the disclaimer statement: ''Currently we represent [insert number of organizations] organizations which offer [insert

number of plans] products in your area. You can always contact Medicare.gov, 1–800–MEDICARE, or your local State Health Insurance Program (SHIP) for help with plan choices.''

This disclaimer must be:

- Verbally conveyed within the first minute of a sales call.
- Electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication.
- Prominently displayed on Agency's websites and
- Included in any marketing materials, including print materials and television advertisements, developed, used, or distributed by the Agency.

Lead Generation

Lead Forms and Lead Sources

Agents and Agencies are responsible for ensuring all lead sources (including those purchased) used to solicit Medicare Products are compliant. Agents and Agencies 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.

Notes: PTCs are not Scopes of Appointments (SOA). See SOA requirements further below.

Agents and Agencies conducting lead generating activities, either directly or indirectly for a carrier, must disclose to the beneficiary that their information will be provided to a licensed agent for future contact. This disclosure must be provided:

- Verbally when communicating with a beneficiary through telephone.
- 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.

Agents and Agencies conducting lead generating activities, must disclose to the beneficiary that he or she is being transferred to a licensed sales agent who can enroll him or her into a new plan.

High Level TCPA Guidance

When requesting contact information from a consumer and prior to placing any calls or sending any messages to that consumer, Agencies 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 [Agency Name]; and
- The consumer provides this consent even if the consumer's number is listed on a Do Not Call registry.

TPMO to TPMO Beneficiary Data Sharing

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.

- TPMOs may share personal beneficiary data with other TPMOs for marketing or enrollment purposes only if they first obtain express written consent from the beneficiary. As a reminder, all leads sources and materials must be submitted for review prior to use. Therefore, please ensure that updated consent language to meet these requirements is submitted for review to IFG prior to use or distribution.
- One-to-One express written consent must be obtained **separately** for each TPMO that receives the data 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.
- TPMOs are restricted from selling or sharing any person’s personal data with another company that meets the definition of a TPMO without prior express written consent. TPMOs can get permission to share a beneficiary’s data with multiple entities if the beneficiary is able to select

each entity separately. In its commentary to the Final Rule, CMS provides the following example: “For example, through a clear and conspicuous disclosure on a website, a TPMO could provide a check box list that allows the beneficiary to choose each TPMO that they want to hear from.” While a check box system is not required, CMS does want beneficiaries to have the ability to pick and choose which TPMOs (if any) will receive their data.

Anti-Discrimination

Agents and Agencies may **not**:

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

**Exception: Enrollees must have a documented diagnosis of applicable chronic medical conditions when applying for enrollment in a Chronic Condition Special Needs Plan (C-SNP).*

Disability

Agents and Agencies must ensure questions and language used in lead forms, plan comparisons, sales, and enrollment processes/scripts, do not directly, or indirectly, request or require this information. All beneficiaries must have an equal opportunity to enroll in Medicare Products, whether the beneficiary requests accessible formats or alternate languages. Agents and Agencies are required to provide information to beneficiaries in alternate languages or accessible/alternate formats (for example, Large Print, Braille), upon request.

Unsolicited Contact

Unsolicited contact is expressly prohibited. Examples of "unsolicited contact" include, but are not limited to:

- Door-to-door solicitation without a prior appointment
- Approaching beneficiaries in common areas (i.e., parking lots, hallways, lobbies)
- Outbound solicitation (cold calling) including:
    - Calls to confirm receipt of mailed information
    - Calls about other business as a means of generating leads for Medicare plans (e.g., bait and switch strategies)
    - Calls via referral
    - Calls to beneficiaries who attend an event (without express written consent)

Permissible beneficiary contact may include the following:

- In-home meetings with a previously scheduled appointment with a specific date and time.
- Outbound calls to beneficiaries who have given their permission for the Agency to contact them about Medicare Products through a completed PTC or BRC.
- Agencies may initiate unsolicited email contact with potential enrollees but must provide an opt-out process on each communication for those who no longer wish to receive emails. Emails must include a working "Unsubscribe" link.
    - Once an individual has utilized the opt-out option, Agencies are responsible for ensuring that the potential enrollee no longer receives emails or other electronic communications from the Sales Partner.

Note: Using text messaging and other forms of electronic direct messaging (e.g., social media platforms) for the purpose of marketing are not permitted.

- Additionally, it must be made clear up-front above the contact information fields that the respondent will be connected with a "licensed insurance agent(s)" or "licensed sales agent(s)."

Prohibition on Open Enrollment Period (OEP) Marketing

Agencies 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, Agencies and their agents may:

- Conduct marketing activities that focus on other Special Enrollment Period opportunities, such as new to Medicare, 5-star plans, marketing to Dual-eligible Special Needs plans.
- At the beneficiary's request, have one-on-one meetings with a sales agent, send marketing materials or provide information on the OEP.
- Agents may include educational information, 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. The content cannot meet the definition of marketing.

During the OEP, Agencies 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.
- Market the OEP as a means for any beneficiary to change plans for any reason.

Prohibition on Marketing New Plans Prior to Oct. 1

- Agents and Agencies must not communicate about or market the following year's Medicare plans prior to October 1st.
- Agents and Agencies must not solicit or accept enrollment applications for a January 1 effective date until October 15 of the preceding calendar year.

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

- When marketing Medicare Products outside of AEP, only a small percentage of members/prospects will be newly eligible, have recently moved, or have other SEP qualifying conditions. Accordingly, Agents and Agencies must not mislead members/prospects into believing they could change their respective plans outside of AEP.
- During ROY, materials must include language clarifying that a prospect may "apply, choose or enroll" in a plan along with the appropriate SEP qualifiers. This is necessary so as not to violate the prohibition of knowingly targeting or sending unsolicited material outside of AEP as well as misleading and/or confusing beneficiaries.
    - Examples include: "New to Medicare, Turning 65, Losing coverage or Moving".
    - In television commercials, the SEP qualifiers must be both on-screen graphics and the voice over/audio early and periodically throughout. CMS mandates SEP qualifiers be "early and often".
- Avoid the overall implication that people should call to see if they qualify for a SEP. This is misleading and different than encouraging people who qualify for an SEP to call.
- Do not use the word "NEW" in a context that gives the impression that new plans are being released by MA organizations outside of AEP.

Nominal Gifts

- Agencies and Agents 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 and cannot be the provision of a meal. Agencies and Agents must submit any materials or processes that propose offering nominal gifts to beneficiaries to IFG for review prior to implementation, with the retail value of nominal gifts proposed and any related activities.

Gifts may not be any of the following:

- Cash, rebates or gift cards that could be considered a cash equivalent (i.e., VISA, American Express, MasterCard, Amazon, or gift cards to big box stores.)
    - Other types of gift cards may not be used as a nominal gift for beneficiaries but are subject to review.
- Gifts may not be in the form of drug or health benefits (e.g., a free checkup), including optional mandatory supplemental benefits.
- Gifts may not be tied directly or indirectly to the provision of any other covered item or service.

Educational and Sales/Marketing Events

Educational Events

Marketing is prohibited at educational events. Educational events must be designed to generally inform beneficiaries about Medicare, including Medicare Advantage, Prescription Drug Programs, or any other Medicare program. Educational events must only provide generic, factual, non-biased information about different coverage options, and must not be used to persuade beneficiaries to enroll in a particular plan.

The following requirements apply to educational events:

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

Sales/Marketing Events

Sales/marketing events are events that fall under the definition of marketing. Activities permitted at sales/marketing events:

- Provide marketing materials

- Provide refreshments and light snacks to beneficiaries, as long as the items provided could not be reasonably considered a meal and/or that multiple items are not being "bundled" and provided as if a meal
- Distribute and accept plan applications
- Collect Scope of Appointment (SOA) forms for future personal marketing appointments; and
- Conduct marketing presentations.

Activities **not** permitted at sales/marketing events:

- Require sign-in sheets or require attendees to provide contact information as a prerequisite for attending an event
- Conduct health screenings, health surveys or other activities that may be perceived as, or used for, "cherry picking" or targeting a subset of members
- Use information collected for raffles or drawings for any purpose other than that; and/or
- Providing meals to beneficiaries regardless of value.

Requirements for both educational and marketing sales events:

- Invitations to educational events must clearly state "educational" and invitations to sales/marketing events must clearly state "sales" on the materials themselves.
- If advertising for both educational and sales/marketing events on the same material, the educational events must be clearly labeled as educational and details regarding the date, time and location of each event must be specific on the material, so it is clear when and where each event is taking place.
- Sales agents may not schedule sales/marketing events to take place within 12 hours of an educational event at the same location. The same location is defined as the entire building or adjacent buildings.
- Educational information may be presented at a sales/marketing event, but the sales/marketing event must be accurately identified as sales/marketing.

Personal/Individual Marketing Appointments

Personal marketing appointments may take place in-person, over the phone or via a virtual meeting platform. During a personal marketing appointment, a sales agent **may:**

- 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.

During a personal marketing appointment, a sales agent **may not:**

- Market any health care related product beyond the scope agreed upon by the beneficiary, and documented by the Agency, prior to the appointment
- Market additional health related products not identified prior to the appointment without a separate Scope of Appointment identifying the additional health related products to be discussed; and
- Market non-health related products, such as annuities or life insurance.

Scope of Appointment Requirements

Sales agents must obtain a valid Scope of Appointment from a beneficiary at least 48 hours prior to scheduled personal marketing appointment, except in the following situations:

- When a beneficiary requests an appointment within four days of the end of a valid election period including the AEP, OEP, SEP, ICEP or the month, based on eligibility
- When a beneficiary initiates an in-person meeting, such as walking into agent's office, a kiosk, a plan's office, or any other walk-in
- CMS has provided verbal clarification that the 48-hour waiting period does not apply to inbound calls made to a sales agent by a beneficiary but does apply to outbound calls made by sales agents to beneficiaries.

An SOA must be completed for *all* personal marketing appointments, including in the exceptions/scenarios noted above.

SOAs must adhere to the following:

- Completed SOA forms must be retained for 10 years and submitted to Carriers (by mail for paper forms, recorded for telephonic, or through Enrollment Hub) with all enrollment applications.
- SOAs are valid for up to 12 months following the date of the beneficiary's signature date.
- SOAs must contain the following:
    - Product types to be discussed
    - Date of appointment
    - Beneficiary and agent contact information
    - Statement that there is no obligation to enroll, and that current or future Medicare enrollment status will not be impacted by speaking with the agent, and automatic enrollment will not occur.
- If the SOA is completed verbally on the inbound call, it must be recorded.

Misleading and Confusing Communication and Marketing Materials

Agencies 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 Agency. CMS is particularly concerned with and prohibits national advertisements that promote MA plan benefits and cost savings, which are only available in limited-service areas or for limited groups of enrollees, use words and imagery that may confuse beneficiaries or cause them to believe the advertisement is coming directly from the government, and sales tactics designed to rush or push beneficiaries into enrolling into a plan. Examples of these tactics that should be avoided include the following:

- Claims that an MAO, its plans or an Agency is endorsed by CMS, DHHS, etc.
- Materials that look official or governmental (i.e., tax notice formats, barcodes, perforated envelopes, official phrases, etc.)
- Use of American flag imagery, patriotic themed colors (red, white, and blue), symbols, logos or images that are made to resemble official government logos, and other terminology.

To help avoid misleading or confusing beneficiaries, Agencies must include a non-governmental tagline and other information as follows:

- A prominently placed disclaimer/tagline that clearly explains that an entity or website is not affiliated with, endorsed by, or otherwise somehow related to the federal government, CMS, HHS, or Medicare.
- The Agencies' name (who the solicitation is coming from) and whom the beneficiary will reach if they respond (i.e., "a licensed sales/insurance agent") must be clearly and prominently visible and legible to consumers.
- For direct mail solicitations, the Agency name or logo must be prominently placed on every mailing (either on or visible from the front of the envelope, or on the mailing itself when no envelope accompanies the piece).
- If "Medicare" is in the name of the Agency, a tagline such as the one below should appear directly below the name. For example, - an insurance agency with no government affiliation.

Reminder: CMS may still find these efforts insufficient and find the material or the Agency name to be misleading. Agencies and Agents should also refer to state regulations to ensure use of "Medicare" in the name is not otherwise prohibited.

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

Agencies and Agents are prohibited from using the Medicare name, CMS logo, and products or information issued by the Federal Government, including the Medicare card, in a misleading way in both communication and marketing materials. The Medicare ID card image may only be used with authorization from CMS prior to the use of the image. This requirement applies to both communications and marketing. To obtain CMS approval for the use of a Medicare card image the following steps must be followed:

1. Send an email to the marketing mailbox at Marketing@cms.hhs.gov with an attached copy of the material that has the Medicare ID card image on it. An email must be sent for both Marketing and Communication material.

2. Receive either an approval or disapproval from the marketing mailbox.
3. For marketing materials, the actual marketing piece and the email permitting the use of the Medicare card image should be zipped and uploaded into the marketing module using the SMID of the marketing piece.
    - Regional Office (RO) marketing reviewers will verify that Medicare card images used on marketing materials have been approved prior to approval in HPMS. If the Central Office (CO) email approval has not been uploaded with the marketing material, reviewers will disapprove the piece and require it to be resubmitted with the email approval.
    - A disclaimer must be placed in the vicinity of the Medicare card image that indicates that the Agency is not affiliated or endorsed by CMS, HHS, the Federal Government, etc.

    Evidence of CMS approval must be submitted at the time of IFG's requested review.

Describing Medicare

When describing Original Medicare, ensure it is accurate. When comparing Original Medicare to Medicare Advantage Products or Medicare Supplement Insurance plans, materials should be more specific than just using the term "Medicare". **Original Medicare cannot and should not be disparaged.**

Plans and Benefits Availability and Including Carrier Names

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

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

- MA and Part D organization names must be in 12-point font in print and may not be in the form of a disclaimer or fine print.
- For television, online, or social media, the MA organization or marketing name(s) must be either read at the same pace as the phone number or must be displayed throughout the entire advertisement in a font size equivalent to the advertised phone number, contact information, or benefits.
- For radio or other voice-based advertisements, MA organization or marketing names must be read at the same pace as the advertised phone numbers or other contact information.

Additional reminders:

- "Customized" or "personalized" should not be used when describing Medicare plans or benefits.

- “Entitled” can only be used when discussing Original Medicare.
- Avoid statements like "get the money they deserve" and “see what benefits are available to you”.
- Avoid any Affordable Care Act reference with respect to Medicare Products.
- Do not market any federal programs in order to obtain MA/MAPD leads (i.e., Medicare Savings Program, Food Stamps, etc.)

Marketing of Savings Not Realized

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

Examples of Prohibited “Savings”:

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

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

Scare and High-Pressure Tactics:

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

Superlatives and Absolute Language

Agencies and Agents may not use superlatives in communications and marketing unless supporting evidence/sources of the superlative is referenced in the material.

- Examples of superlative language that require substantiation are: “best”, “top plans,” “#1” or “outstanding” when describing Medicare Products. Remember if it cannot be supported, it cannot be stated.
- Do not use absolute language such as “every”, “all”, “guarantee” or “promise” or statements that give that impression (e.g., “Keep your doctor” as provider networks are subject to change).
- Do not compare Carrier plans to other plans by name unless the comparison is properly substantiated.
- Do not use pejorative language or disparaging comments about CMS or any plans.
- Agencies and Agents must not use “highly rated” in describing a plan(s) unless it is in relation to the CMS Stars Ratings of the plans rated 4 or 5 stars. Please see below for details related to Stars Ratings.
- Do not use words/phrases such as “all”, “full”, “complete”, “comprehensive”, “unlimited” to describe benefits.

Correct Terminology for Reference to Sales Agents

- Materials may use the terms “Licensed Insurance Agent” or “Licensed Sales Agent” to refer to sales agents.
- If a sales agent’s phone number or one that will route to sales agents is included in a communication or marketing material, it must clearly indicate before the number that the number will direct callers to a “licensed sales agent” or “licensed insurance agent”.
- “Unbiased” should not be used in reference to the Agency or its agents since a sales agency can only sell those Medicare Products that they are contracted with so there may be an inherent bias in what products are being sold.

Use of the Term “Senior”

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

Use of the Word "Free"

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

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

"Partnership" or "Alliance"

Avoid words like "partnership" or "alliance" in reference to the relationship between a Carrier and the Agency/Agent. Acceptable terms would be "teamed up" or "working together".

Medicare Supplement

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

Phone Number/Hours of Operation/TTY Requirements

- Customer service numbers must be toll-free numbers.
- 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.
- 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. Agencies and Agents can use either their own TTY numbers or State relay services, so long as the number included is accessible from TTY equipment. TTY exceptions include:
    - In television ads the TTY number may be a different font size/style than other phone numbers to limit possible confusion
    - Outdoor advertising (ODA) or banner/banner-like ads do not require TTY

- Radio advertisements and radio sponsorships (e.g., sponsoring an hour of public radio) do not require TTY

Product Endorsements and Testimonials

The Federal Trade Commission (FTC) guidelines on endorsements and testimonials may be applicable to advertisements and should be taken into consideration as necessary.

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

Communications and Materials with Provider/Celebrity Spokesperson

Agencies and Agents may use materials that involve a provider spokesperson and/or celebrity personality, in order to promote their agency.

The Agency is responsible for submitting these materials for IFG and Carrier review. The materials will go through the normal review process. The Agency should provide the following information in the submission:

- 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.)

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 MA/PDP plans.
- Include the host promoting or appearing to promote the Sales Partner or the plans offered by the Sales Partner, such as stating, "ABC agency is the best and only represents the best plans." The host may state the Sales Partner's name and number and advise beneficiaries to call the Sales Partner to learn about plans that may be right for them.

Any materials that include a provider **must meet** the following requirements:

- Provider spokesperson should remain objective in any assessments made about possible Medicare Products.
- Any assessments about Medicare Products should be prefaced with "may" or similar terms, such as "These types of plans may be a good fit for..."
- Talking points and language must remain neutral and keep the best interest of the beneficiary in mind.
- Include the following disclaimer on the material, "(Provider name) IS NOT AFFILIATED WITH ANY PLAN OR PART D SPONSOR AND DOES NOT RECOMMEND OR ENDORSE ANY PARTICULAR PLAN OR PRODUCT."
- Associated text and voiceover should describe only clinical, educational information (such as describing preventive services), or any plan or plans.

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

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

- Materials must be clear that the rating is out of 5 stars and clearly identify the Star Ratings contract year.
- Star Ratings must only be marked in the service area(s) for which the Star Rating is applicable, unless using Star Ratings to convey overall MA organization performance (for example, "Plan X

has achieved 4.5 stars in Montgomery, Chester, and Delaware Counties), in which case the Agency must do so in a way that is not confusing or misleading. The Agencies 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

The following requirements and expectations apply to all websites, leveraged by Agencies whether owned and operated or utilized for leads. The Agencies are accountable to ensure compliance to all websites involved in their business operations.

- Websites must be clear and easy to navigate.
- Website filing documents should include the site URL and SMID on the document they submit in HPMS.
- Websites containing any marketing content, must be filed with CMS for each new plan year. The entire website should also be filed, not just the pages with marketing content.
- When marketing Medicare Advantage plans and if communicating about two plan years (e.g., 2024 and 2025 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. An example would be a plan comparison or plan shopping websites.
- Websites may request, but not require, age/date of birth (DOB), gender, or health status information to access non-beneficiary specific plan information. It must be clear to the beneficiary that this information is not required, and it must be clearly marked as 'optional'.
- Websites must keep Medicare Advantage content separate and distinct from other lines of business, including Medicare Supplement Insurance plans.
- Websites with 'Calls to Action'- must accurately reflect the result the user will see/experience in the subsequent step and not confuse beneficiaries as to the result.
    - For example, a website should not indicate that a beneficiary will be able to "find plans" by entering their contact information if the beneficiary will not receive any plan information digitally but will instead receive a call from an agent.
- Include TTY and days and hours of operation with phone number.

Script Requirements

All telephonic sales and enrollments must follow scripting that is reviewed and approved by IFG and Carriers and filed with CMS (file and use since July 24, 2023).

Agency Telephonic Sales and Enrollment and Scripting Oversight

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

Informational, Sales, Pre-Enrollment and Enrollment Script Requirements

Agencies 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)
- Outreach to existing or potential beneficiaries
- Answering or potentially answering questions from existing or potential beneficiaries.

Licensed/Unlicensed Agents:

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

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

Sales and Pre-Enrollment Scripts:

All Call Centers and Field Agent/Agency 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 filed with CMS as file and use.
- The TPMO disclaimer must be conveyed within the first minute of the sales call.
- The Federal Contracting Statement must be stated on all sales/pre-enrollment calls.
- Advise that the call is being recorded.
- The only information needed from a beneficiary to provide plan options is zip code, county, and/or state.
    - An agent may ask if the beneficiary would like to provide additional information (i.e., date of birth, gender, Medicare ID number, Part A or Part B effective dates, etc.). The beneficiary can say no. If the beneficiary declines to provide this information the agent **must continue the** call and provide plan options.

- Ensure all Scope of Appointment requirements are met prior to the personal marketing appointment.

Prior to an enrollment, CMS requires certain questions and topics are fully discussed. Required topics include:

- What kind of health plan does the beneficiary wish to enroll in (such as low premium and higher copay (or vice versa)?
- Preferred primary care providers, specialists, pharmacies, hospitals and any other facilities (that is, whether or not the beneficiary's current providers are in the plan's network). If not, explain they will need to pick a new one.
- Prescription drug coverage and costs (including whether or not the beneficiary's current prescriptions are covered).
- Costs of health care services, premiums (plan and Part B), copays, deductibles, benefits, and specific health care needs such as needing durable medical equipment or physical therapy.
- Does the beneficiary require hearing, dental and/or vision coverage? Discuss the costs and limitations on those benefits.
- The right to cancel this enrollment and the specific date through which cancellation may occur.
- Review coverage outside of the United States.
- Explain potential effect enrolling in this plan will have on other current coverage.
- Explain that this is not a hearing/dental/vision "rider" but a full plan.
- Explain that plan operates on a calendar year basis, so benefits may change on January 1 of the following year.
- Explain that Evidence of Coverage provides all of the costs, benefits, and rules for the plan.
- Review how to file a complaint.

When applicable:

- Review PPO or PFFS out-of-network coverage.
- Review the need to qualify for chronic/disabling condition requirement for C-SNPs
- Review the need to have Medicaid to qualify for D-SNP.
- Review the need to remain in institutional skilled nursing facility in order to qualify for I-SNP.
- Review the need to maintain trust/custodial account in order to remain enrolled in MSA.

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 be filed with CMS prior to use. These requirements include the following:

- Sales agents must obtain a compliant signature from the beneficiary. A signature is only compliant if the sales agent provides all required disclosures and disclaimers (i.e., verbally or via

IVR in a clear and understandable fashion) and collects agreement and understanding from the beneficiary (or his or her POA/authorized representative).

- All disclosures required on the Model Enrollment Forms in Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual must be provided either verbally or in writing to the beneficiary.
- For telephonic enrollments, the contents of the Pre-enrollment Checklist (PECL) must be reviewed with the prospective enrollee prior to the completion of the enrollment. The PECL is required to include "Effect on Current Coverage", and agents must ensure they discuss this element, along with all listed elements, with the prospective enrollee and answer any questions to the prospective enrollee's satisfaction, prior to enrollment.
- Add a check box under the "Important Rules" header with the following information:

  "Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use."

  Version for use with all PDP contracts: **Effect on Current Coverage. If you are currently enrolled in a Medicare Prescription Drug plan, your current Medicare Prescription Drug healthcare coverage will end once your new Medicare Prescription Drug coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Prescription Drug coverage starts. Please contact Tricare for more information.**

- 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.

Agent Communication with Beneficiaries about Providers

During a personal marketing appointment, the topic of providers should be discussed between the sales agent and beneficiary to ensure all of their needs are met. When discussing providers, it is important to remember the following:

- Inform beneficiaries of all network providers that are available and ensure beneficiaries always feel completely free to choose any provider in the network.

- Provide accurate and objective information to beneficiaries about the availability of all participating Providers near their place of residence as part of a general description of a Medicare Product's provider network.
- ALWAYS use the carrier specific Physician Finder to look up provider participation as it is the most up-to-date and comprehensive list of participating providers. If a Carrier's Physician Finder is not available, agents may call Carrier's Agent Support for assistance.
- Agents may:
    - Provide factual information about a particular provider that is included in the Physician Finder.
- 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 Carrier plan benefit (e.g., complementary transportation).
    - Recommend a provider or share opinion about which provider is best (e.g., do not use superlatives when describing a particular provider).
    - Use aggressive marketing or high-pressure tactics when discussing providers.
    - Use superlatives (e.g., "better care", "best care", etc.) when describing providers to beneficiaries.
    - Offer or give anything to beneficiaries to persuade them to choose a particular provider.
    - Accept anything, directly or indirectly, from a provider in exchange for communicating about or helping a beneficiary choose a particular provider (e.g., do not accept promises that provider's patients will choose a Carrier 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 a Carrier plan.

Medicare Supplement Insurance Plan Marketing Guidelines

For Agencies that are engaged in selling of Medicare Supplement Plans, it is the Agency and Agent's responsibility to ensure that they are reflecting plans accurately and in alignment with all state and federal regulations.

- States have varying filing requirements for Medicare Supplement materials which should be followed.
- For all Medicare Supplement member or prospect-facing materials ensure that communication conforms with NAIC Standards for Marketing, as well as any state-specific requirements. General NAIC

marketing requirements include prohibitions on the following acts and practices, as well as references to state unfair trade practices act, which generally prohibit statements that may be misleading, false, or deceptive:

(1) Twisting - Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics - Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising - Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

- The Model NAIC Medicare Supplement, which has been adopted by many states, includes reference to the state's unfair trade practices act, which vary from state to state, but generally prohibit statements in advertisements that may be misleading, false, or deceptive.
- States have different requirements which must be adhered to for materials. For example, some states do not permit advertising of "extra services" available on some Medicare Supplement plans prior to enrollment, therefore these should not be mentioned on materials that will be used in those states. Some states do not permit varying compensation to agents based on the type of policy sold, therefore discussing bonus amounts in materials that are not specific or limited to a certain group of agents or states, is not recommended.
- A Medicare Supplement insurance plan must be identified as "insurance" and must not be identified as a Medicare Advantage plan.
- The differences between a Medicare Advantage and Medicare Supplement should be explained clearly and accurately.
- It must be clear that beneficiaries must choose either a Medicare Supplement Plan or a Medicare Advantage Plan since beneficiaries cannot enroll in a Medicare Supplement and Medicare Advantage plan at the same time.
- In plan comparison/shopping websites, Medicare Supplement Insurance Plans and Medicare Advantage plans and related content should be in separate sections and clearly be distinguished from each other.
- Limit use of the term "Medigap" in materials about Medicare Supplement Insurance Plans.
- Refer to the NAIC Model 660 – Rules Governing Advertisements of Medicare Supplement Insurance for general guidelines. MO660 (naic.org).
- Materials with the intent to promote and solicit the sale of a Medicare Supplement Insurance plan should contain the following disclaimers. For materials utilized in New Hampshire, state regulation requires the italicized text below to be prominently displayed immediately at the top of a piece or on the front of an envelope.
    - PLEASE NOTE: Medicare Supplement insurance is available to those age 65 and older enrolled in Medicare Parts A and B and, in some states, to those under age 65 eligible for Medicare due to disability or End-Stage Renal disease.

- The purpose of this communication is the solicitation of insurance. Contact will be made by an insurance agent/producer or insurance company.
- Medicare Supplement insurance plans are not connected with or endorsed by the U.S. government or the federal Medicare program.