Internal Compliance

NEISHLOSS & FLEMING, LLC
AN INTEGRITY COMPANY

Issue Date: 4/28/2020
Last Revised: 2/1/2023

I. DEFINITIONS

Term	Definition
CMS	Centers for Medicare and Medicaid Services
Carrier	Insurance Company, or Plan Sponsor as defined by CMS
Organization, We, Us, or Our Company	

II. PURPOSE

The purpose of this policy is to ensure our organization implements and maintains an effective Medicare compliance program in order to operate compliantly according to CMS and carrier regulations.

III. POLICY

It is our policy to implement necessary procedures including the Seven Core Elements of an Effective Compliance Program in order to maintain compliant business operations.

IV. PROCEDURE

We have developed and shall maintain an effective compliance program, incorporating the Seven Core Elements of an Effective Compliance Program as a foundation. These Seven Core Elements include:

1. Written Policies and Procedures (including a Code of Conduct)
2. Designation of a Compliance Officer
3. Effective Training and Education
4. Effective Lines of Communication
5. Internal Auditing and Monitoring
6. Well Publicized Disciplinary Standards
7. System for Prompt Response to Issues

Policies & Procedures, Code of Conduct, and Employee Training will be administered within ninety (90) days of hire and annually thereafter, or as needed when amendments are made. All documents related to compliance training and disciplinary actions will be retained for a minimum of ten (10) years. See Policy on Policies and Employee Training policies for further direction on implementation of our compliance program.

Exclusion & Background Screening

NEISHLOSS & FLEMING, LLC
AN INTEGRITY COMPANY

Issue Date: 4/16/2020
Last Revised: 2/1/2023

I. DEFINITIONS

Term	Definition
OIG	Office of the Inspector General
GSA	General Services Administration
SAM	System for Award Management
CMS	Centers for Medicare and Medicaid Services
MA	Medicare Advantage
PDP	Prescription Drug Plan
Carrier	Insurance Company or Plan Sponsor as defined by CMS
Organization, We, Us, or Our Company	

II. PURPOSE

Federal law prohibits entities or individuals found on the OIG, GSA (SAM), and some state exclusions lists from participation in the Federal health care programs, which includes Medicare, Medicaid, and other governmental programs. The purpose of administering these exclusion screenings is to ensure applicable non-agent employees, contractors, and employees of vendors are not excluded from participation in the Federal health care programs.

III. POLICY

Our organization will ensure all non-agent employees and staff are screened against the OIG, GSA, and any State Exclusion Lists (when required) prior to the initial hire and monthly thereafter. We will also take measures to ensure that all contractors and non-agent employees of third-party vendors are screened against these lists as well. Furthermore, criminal background checks will be conducted on all of non-agent employees.

IV. PROCEDURE

Prior-to-Hire Screening

It is the role of our Compliance Officer to ensure the completion of all prior-to-hire OIG, GSA, and State exclusion checks. If a match is found on any of these lists, the Compliance Officer or their delegate will first validate if it is a true or false match. If it is a true match, they must notify the hiring manager immediately that the employee must be removed from all duties related to MA/PDP business and cannot have access to MA/PDP client information.

Each carrier is responsible for checking agents against the OIG, GSA, and State exclusion lists prior to contracting. Our organization does not perform these checks on independently contracted agents.

Human Resources will conduct background checks on all non-agent employees prior-to-hire as part of the employee onboarding process. The background screenings will consist of County, State, and Federal Criminal Records among other searches deemed necessary by Human Resources. If any negative or adverse response is found, it will be evaluated and handled by the appropriate internal parties. In such a case, we reserve the right to alter the employment with said employee as we see fit, up to and including terminating the hiring agreement.

Monthly Screening

The services of ProviderTrust are utilized to conduct monthly OIG, GSA, and State exclusion checks on its non-agent employees. Provider Trust conducts searches against all applicable exclusion lists multiple times per month and provides weekly summary reports to support our monitoring efforts. Reports can also be ran as needed for verification or documentation purposes. If a confirmed match is found, ProviderTrust will provide notification by email and phone. Our Compliance Officer will notify HR and the staff supervisor immediately to inform them that the individual cannot have access to MA/PDP client information and must be removed from all duties related to MA/PDP business. The Compliance Officer will also notify the applicable carrier or carriers of the finding.

Each carrier is responsible for checking their respective agents against the OIG, GSA, and all applicable State Exclusion Lists on an ongoing, monthly basis, and must notify our Compliance Officer if a confirmed match is found. Our organization does not perform these checks on independently contracted agents.

Documentation

All documentation related to prior-to-hire and monthly screenings will be stored in accordance with CMS and carrier requirements and for a duration of no less than ten (10) years as required.

V. DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy are subject to discipline up to and including termination in accordance with our Sanctions and Disciplinary Action Policy.

Employee Training

NEISHLOSS & FLEMING, LLC
AN INTEGRITY COMPANY

Issue Date: 4/16/2020
Last Revised: 2/1/2023

I. DEFINITIONS

Term	Definition
CMS	Centers for Medicare and Medicaid Services
MA	Medicare Advantage
PDP	Prescription Drug Plan
Carrier	Insurance Company or Plan Sponsor as defined by CMS
HIPAA	Health Insurance Portability and Accountability Act
FWA	Fraud, Waste, and Abuse
Organization, We, Us, or Our Company	

II. PURPOSE

The purpose of this policy is to develop and implement effective training and education programs in order for employees to remain well informed of the applicable rules and regulations governing this industry.

III. POLICY

In order to satisfy CMS and carrier requirements, our organization will administer effective training and education to all non-agent employees who handle or access MA or PDP plan business or client information. Downline independent insurance agents within our hierarchy will satisfy these training requirements through their applicable carriers.

IV. PROCEDURE

We will administer General Medicare Compliance and Medicare Fraud, Waste, and Abuse (FWA) training to all non-agent employees handling or accessing MA/PDP business within the first ninety (90) days of initial hire and annually thereafter in accordance with CMS and carrier requirements.

The training will be administered in a computer-based format via the Learning Management System of our choosing. The General Compliance and FWA training courses will be assigned to all applicable employees and with a requirement to complete the entire training course or document and attest to its completion and understanding.

In addition to General Compliance and FWA trainings, employees are also required to review our Policies & Procedures and Code of Conduct. To document completion, each employee will complete an acknowledgement or attestation of receipt and understanding.

Our workforce also completes numerous other trainings, including privacy and security training as required by HIPAA. Please see our Workforce Training Policy in the HIPAA & Privacy/Security section.

Each Carrier is responsible for providing necessary training and education including General Compliance and Fraud, Waste, and Abuse training, and all applicable product certification courses to its contracted agents. Although we do not provide this training to independently contracted agents, we help facilitate the completion of these trainings by communicating these requirements to downline agents and point them to the applicable carriers to complete the necessary trainings and certifications.

All documentation related to compliance training will be stored in accordance with CMS and carrier requirements and for a duration of no less than ten (10) years as required.

V. DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy are subject to discipline up to and including termination in accordance with our Sanctions and Disciplinary Action Policy.

Agent Compensation Payments

NEISHLOSS & FLEMING, LLC
AN INTEGRITY COMPANY

Issue Date: 4/17/2020
Last Revised: 2/1/2023

I. DEFINITIONS

Term	Definition
CMS	Centers for Medicare and Medicaid Services
MA	Medicare Advantage
PDP	Prescription Drug Plan
Carrier	Insurance Company or Plan Sponsor as defined by CMS
HIPAA	Health Insurance Portability and Accountability Act
Compensation	As defined by CMS, compensation is pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commissions, bonuses, gifts, prizes, awards, and finder's fees.
Agent	Independently contracted (1099) insurance agent (not W-2 employee)
Employed Agent	W-2 employee (not a 1099 contractor)
Organization, We, Us, or Our Company	

II. PURPOSE

To ensure compliant and accurate compensation payments are made in accordance with applicable CMS and carrier regulations.

III. POLICY

The respective carrier or carriers generally pay agent compensation. Our organization will only pay agent commission directly to agents when required to do so. Since CMS and the federal government regulate compensation payments for MA and PDP products, we will adhere to these regulations when making compensation payments to downline agents.

IV. PROCEDURE

Explanation

"Compensation," as defined by CMS in sections 422.2274 and 423.2274 of the Federal Code of Regulations, includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commissions, bonuses, gifts, prizes, awards, and finder's fees. "Compensation" does not include the payment of fees to comply with State appointment laws, training, certification, and testing costs; reimbursement for mileage to, and from, appointments with beneficiaries; or reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials.

For 2010 and subsequent years, the compensation amount paid to an agent or broker for enrollment of a Medicare beneficiary into an MA plan is:

A. For an initial enrollment, the prior year's initial compensation adjusted by the change in MA rates that CMS announces each year.

B. For renewals, an amount equal to 50 percent of the initial compensation in (A).

Also, for enrollment of a Medicare beneficiary into a PDP is:

A. For an initial enrollment, the prior year's initial compensation adjusted by the change in Part D rates that CMS announces each year.

B. For renewals, an amount equal to 50 percent of the initial compensation in (A).

Agents must also be actively Licensed, Appointed, and Certified in order to be compensated for federally regulated Medicare products.

In a 6-year compensation cycle, the broker and/or agent is paid a renewal compensation for each of the next 5 years the enrollee remains in the plan in an amount equal to 50 percent of the initial year compensation amount which creates a 6-year compensation cycle. The cycle begins when the beneficiary initially enrolls in the MA, MA-PD, or PDP plan. Compensation is regulated through year six and ends thereafter.

In a 10-year compensation cycle, the broker and/or agent is paid a renewal compensation for each of the next 9 years the enrollee remains in the plan in an amount equal to 50 percent of the initial year compensation amount which creates a 10-year compensation cycle. The cycle begins when the beneficiary initially enrolls in the MA, MA-PD, or PDP plan. Compensation is regulated through year ten and ends thereafter.

Compensation must be recovered when:

- A beneficiary disenrolls from a plan within the first three (3) months of enrollment (rapid disenrollment); or
- Any other time a beneficiary is not enrolled in a plan, but the Plan sponsor paid compensation for that time period.

CMS expects Plan sponsors to retroactively pay or recoup funds based on retroactive beneficiary changes for the current and previous calendar years.

Process

In the instance where our organization must pay out compensation related to the sale of MA or PDP products, a contract and commission schedule is provided to the applicable agent. Such contracts will list how the commission cycle runs and define parameters for payments. We follow the compensation structure recommended by the respective carrier to ensure accurate and compliant payments. The commission schedule lists the company and the product type and specifies the initial and renewal compensation amounts.

Documentation

All documentation related to MA and PDP compensation payments will be stored in accordance with CMS and carrier requirements and for a duration of no less than ten (10) years as required.

V. DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy are subject to discipline up to and including termination in accordance with our Sanctions and Disciplinary Action Policy.

V. DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy are subject to discipline up to and including termination in accordance with our Sanctions and Disciplinary Action Policy.

Application Submission

NEISHLOSS & FLEMING, LLC
AN INTEGRITY COMPANY

Issue Date: 4/17/2020
Last Revised: 2/1/2023

I. DEFINITIONS

Term	Definition
Applications	For the purpose of this policy, applications are enrollment request forms submitted by agents on behalf of their clients as a request for insurance coverage
CMS	Centers for Medicare and Medicaid Services
Carrier	Insurance Company, or Plan Sponsor as defined by CMS
MA	Medicare Advantage
PDP	Prescription Drug Plan
Organization, We, Us, or Our Company	

II. PURPOSE

The purpose of this policy is to ensure that MA and PDP enrollment forms (i.e. applications) are submitted in accordance with CMS and Carrier requirements and when submitted through our organization are handled compliantly.

III. POLICY

Typically, the agent submits applications for insurance coverage directly to the respective carrier. However, in the event that applications are submitted through our organization, they will be processed and submitted in accordance with CMS and carrier guidelines.

IV. PROCEDURE

Even though ultimate responsibility for compliance lies with the agent, we will make reasonable efforts to communicate and educate agents in regards to application submission compliance. Our organization utilizes various methods for communication and education including, but not limited to: email blasts, phone conversations, website postings, job aids/guides, and webinars.

If our organization receives an application from an agent, the application is reviewed by administrative staff for accuracy, completeness, and legibility; as well as to ensure all appropriate forms are attached, such as Scope of Appointment, Replacement forms, and Suitability Forms. Each application must be signed by the beneficiary or the person acting as Power of Attorney or Legal Representative for that beneficiary. In the event that information is not accurate, missing, or illegible administrative staff will take immediate action to contact the agent. Application information is verified against agent records to ensure proper licensing, appointment, and certification before we submit the application to the appropriate carrier.

Certain products, such as MA and PDP, are regulated by CMS and therefore have regulations on the timeliness of their submission. For these regulated products, it is required that the **completed** application or enrollment form be submitted by our carriers to CMS within seven calendar days from the signature date. Because of this requirement, carriers have their own timeframe requirements for application submission as well. Most require the **completed** application be submitted to them within forty-eight (48) hours of the application signature date. We prioritize applications received for processing according to these guidelines to ensure submission timeframes are met.

In order to meet timeliness requirements for application submission laid forth by CMS, agents are responsible for submitting applications to the carriers within a timely manner; usually within forty-eight (48) hours of the application signature date, or as specific carrier requirements dictate. If submitting applications to our organization for processing, it is recommended that agents submit them immediately upon receipt whenever possible, in order to avoid timeliness infractions.

All documentation related to MA and PDP business will be stored in accordance with CMS and carrier requirements and for a duration of no less than ten (10) years as required.

V. DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy are subject to discipline up to and including termination in accordance with our Sanctions and Disciplinary Action Policy. Furthermore, corrective actions can include, retraining, suspension of marketing privileges, termination, and/or reporting of misconduct to the carrier and the respective State Departments of Insurance.

NEISHLOSS & FLEMING, LLC
AN INTEGRITY COMPANY

Issue Date: 4/20/2020
Last Revised: 2/1/2023

I. DEFINITIONS

Term	Definition
CMS	Centers for Medicare and Medicaid Services
Carrier	Insurance Company, or Plan Sponsor as defined by CMS
MA	Medicare Advantage
PDP	Prescription Drug Plan
Consumer	"Consumer" for the purpose of this policy refers to any of the following: Prospective or current clients, beneficiaries, policyholders, members.
Compliance Violation Tracker	Mechanism used within our organization to log and track complaints and violations.
Complaint	A complaint is a member reported grievance in relation to the sale of an insurance policy or agent behavior/service.
Violation	A violation is an action/process that is not compliant with CMS or carrier guidelines.
Marketer	Employee of our organization who is responsible for sales, recruiting, communication, and support.
Organization, We, Us, or Our Company	

II. PURPOSE

The purpose of this policy is to ensure member complaints and agent violations are logged and handled according to CMS and carrier requirements and to demonstrate proper oversight of downline agents.

III. POLICY

Our organization will log and process reported complaints and/or violations in accordance with CMS and carrier guidelines.

IV. PROCEDURE

Direct Reports of Consumer Complaints

When we receive a complaint or grievance directly from a consumer, it will be documented on our preferred tracking mechanism (i.e. CRM database, tracking log, etc.). We will then report said complaint or grievance to the appropriate carrier or carriers. Our organization will work with the applicable carrier to ensure the complaint is processed and remediated according to

carrier processes and procedures. Should we receive any inquiries or investigations directly from a State Department of Insurance, we will notify any applicable carrier when required.

Carrier Reported Complaints and Violations

Our organization relies on carrier reports or communications to identify agent infractions. In the event we receive complaints, member grievances, or a notice of investigation from a carrier, we will assist that carrier to ensure the appropriate action is taken. All complaints or notices of investigations will be distributed to the applicable marketer or staff member who is responsible for the agent in question. The marketer or staff member will relay the information to the agent or agent's upline to ensure the agent takes the appropriate action. Communication methods will generally include an email and/or phone call.

All complaints and violations, whether received directly from the consumer or from a carrier, are tracked in order to identify risk or trends, and coaching or training opportunities. Coaching or training is provided accordingly to ensure effective oversight. If further action is needed or the issue is especially egregious, the matter will be escalated to the leadership of our sales/marketing department and together with the Compliance Officer a decision will be made in regards to further disciplinary action.

Carrier Compliance Metrics

Carriers have their own specified thresholds for specific compliance metrics to measure agent compliance. These metrics can include application timeliness, rapid disenrollment rate, cancelled applications, member complaints, and PCP auto-assignments. When reports for these metrics are received, our Compliance Officer will review for trends and risk areas. If trends or risk areas are identified, and further action is deemed necessary, the Compliance Officer will notify the appropriate marketers or staff members responsible for the agent in question and coaching or training will be provided. Agents who consistently fail to meet certain compliance standards may face disciplinary action up to and including termination of their contract.

V. DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy are subject to discipline up to and including termination in accordance with our Sanctions and Disciplinary Action Policy. Other actions may include any of the following depending on the severity of the situation: coaching, training, completion of corrective action plans, and/or revocation of some or all of its responsibilities up to and including termination of carrier contract.

CMS Record Retention Requirements

NEISHLOSS & FLEMING, LLC
AN INTEGRITY COMPANY

Issue Date: 4/20/2020
Last Revised: 2/1/2023

I. DEFINITIONS

Term	Definition
MA	Medicare Advantage
PDP	Prescription Drug Plan
HIPAA	Health Insurance Portability and Accountability Act
CRM	Customer Relationship Management system, database
CMS	Centers for Medicare and Medicaid Services
Carrier	Insurance Company, or Plan Sponsor as defined by CMS
Organization, We, Us, or Our Company	

II. PURPOSE

The purpose of this policy is to ensure that record retention requirements are being met in accordance with CMS and carrier requirements.

III. POLICY

Our organization will retain all documents related to the sale of MA and PDP products for a minimum of ten (10) years. Additionally, all such documents, including hard copy and electronic, will be stored securely in accordance with HIPAA regulations. Documents subject to ten-year file retention include:

- Training material and related attestations and test results
- Background checks
- OIG/GSA exclusion database search results (pre-hire and monthly)
- Complaints and disciplinary actions
- Contracting documentation
- Audit records
- Documents related to the marketing or sale of MA and PDP products, including enrollment forms, Scope of Appointment forms, Business Reply Cards, etc.

IV. PROCEDURE

Documents related to the sale of MA and PDP products are generally received in electronic form via secure means. Once received, the documents are processed within the workflow interface of our internal CRM, which is secured using appropriate encryption and firewalls (see “Handling Confidential Information Policy” and “Data Protection Policy). These documents are then attached to the applicable agent or client profile within the CRM for storage and future reference. We will provide carriers with information housed in our systems as requested. This information may include demographic or contracting information of agents.

V. DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy are subject to discipline up to and including termination in accordance with our Sanctions and Disciplinary Action Policy.

Termination Reporting

NEISHLOSS & FLEMING, LLC
AN INTEGRITY COMPANY

Issue Date: 4/20/2020
Last Revised: 2/1/2023

I. DEFINITIONS

Term	Definition
MA	Medicare Advantage
PDP	Prescription Drug Plan
Carrier	Insurance Company, or Plan Sponsor as defined by CMS
CMS	Centers for Medicare and Medicaid Services
"For Cause"	Termination based on a breach, misfeasance, or other inappropriate action of an agent that is in violation of Carrier or CMS policy
Organization, We, Us, or Our Company	

II. PURPOSE

The purpose of this policy is to meet contractual obligations with carriers in regards to reporting "For Cause" terminations.

III. POLICY

In the event a downline agent is terminated "For Cause" by an MA or PDP carrier, the terminated agent will be reported, when required, to other applicable MA or PDP carriers.

IV. PROCEDURE

Upon receiving a "For Cause" termination from an MA or PDP carrier, our organization will determine if that agent holds a contract with any other MA or PDP carriers. If they do, and the carrier or carriers require reporting of "For Cause" terminations, we will take the necessary steps to ensure that said termination is reported to those applicable carriers.

V. DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy are subject to discipline up to and including termination in accordance with our Sanctions and Disciplinary Action Policy.

Vendor Management

NEISHLOSS & FLEMING, LLC
AN INTEGRITY COMPANY

Issue Date: 4/27/2020
Last Revised: 2/1/2023

I. DEFINITIONS

Term	Definition
MA	Medicare Advantage
PDP	Prescription Drug Plan
Carrier	Insurance Company, or Plan Sponsor as defined by CMS
FDR	First-Tier, Downstream, and Related Entities
FWA	Fraud, Waste, and Abuse
OIG	Office of the Inspector General
GSA	General Services Administration
Organization, We, Us, or Our Company	

II. PURPOSE

The purpose of this policy is to ensure proper processes are followed whenever we contract with third-party entities or vendors to handle or process MA or PDP business.

III. POLICY

Our organization shall complete due diligence in selecting third-party vendors, by having them complete a Vendor Security Questionnaire and ensuring they complete certain FDR requirements.

IV. PROCEDURE

Our organization will have third-party entities (contractors and vendors) complete our Vendor Security Questionnaire prior to contracting. Said questionnaire should be reviewed for gaps or risk areas, and IT personnel should be consulted in order to determine if the third-party vendor meets certain standards.

We will ensure that said third-party vendor is aware they are responsible for training their employees on General Compliance and FWA principles and checking their own non-agent staff and entity against the OIG, GSA and any applicable State Exclusion lists (unless other arrangements are made in writing between the vendor and our organization). If the vendor does not complete the required trainings and/or exclusion checks, we will administer the training courses and exclusion checks on the vendor's employees to ensure compliance with these requirements. We will utilize ProviderTrust's VendorProof product to conduct the monthly OIG, GSA, and State exclusion checks by manually entering the vendor's employee names into the database for automated monthly reviews. Documentation for proof of completion must be retained for ten (10) years and be reproducible upon request.

As it pertains to handling and accessing MA/PDP plan business, our organzation will report all third-party entities that operate off-shore to all applicable carriers when required. Off-shore for the purpose of this policy means handling or accessing MA/PDP plan business outside the United States or its territories.

V. DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy are subject to discipline up to and including termination in accordance with our Sanctions and Disciplinary Action Policy.

Agent Oversight

NEISHLOSS & FLEMING, LLC
AN INTEGRITY COMPANY

Issue Date: 4/27/2020
Last Revised: 5/23/2023

I. DEFINITIONS

Term	Definition
MCMG	Medicare Communication and Marketing Guidelines
MA	Medicare Advantage
PDP	Prescription Drug Plan
CMS	Centers for Medicare and Medicaid Services
FDR	First-Tier, Downstream, and Related Entity, as defined by CMS
Carrier	Insurance Company, Plan Sponsor or Part D Sponsor, as defined by CMS
OIG	Office of the Inspector General
GSA	General Services Administration
TCPA	Telephone Consumer Protection Act
TPMO	Third-party marketing organization — organizations and individuals, 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 (the steps taken by a beneficiary from becoming aware of an MA or PDP plan or plans to making an enrollment decision) on behalf of MA or PDP plans. Ex: agents, brokers, agencies, lead generation vendors, etc.
Organization, We, Us, or Our Company	

II. PURPOSE

The purpose of this policy is to ensure that our organization provides sufficient oversight of its downline agents and agencies.

III. POLICY

All agents contracted under our organization must adhere to all CMS regulations, CMS MCMGs, other CMS guidance, TCPA, and carrier guidelines regarding the marketing and selling of all Medicare related products, including MA and PDP. We will take reasonable steps to educate and communicate relevant guidelines to downline agents and agencies in order to help them conduct compliant sales and marketing activities.

IV. PROCEDURE

Downline Agent and Agency Oversight

Our employees communicate directly with their independent agents or those agents' uplines to offer them product knowledge, agent support, answer questions, offer advice on effective and proper selling practices, advice or instruction regarding compliance, or anything else deemed necessary in order for agents to sell and market effectively and compliantly. Any new or pertinent information regarding industry changes, updates to training, education, or any other information will also be communicated as needed.

Our organization also assists carriers in communicating to downline agents and agencies the need to complete FDR requirements on their own non-agent employees. These FDR requirements include:

- Distribution of Policy & Procedures and a Code of Conduct to employees within ninety (90) days of hire and annually thereafter
- Administration of General Compliance and Fraud, Waste, and Abuse Training to employees within ninety (90) days of hire and annually thereafter
- Screening non-agent employees and entities against the OIG List of Excluded Individuals and Entities (LEIE), GSA Excluded Parties Lists System (EPLS), and any applicable State Exclusion lists prior to initial hire and monthly thereafter
- Documentation of completion of these requirements must be retained for a minimum of ten (10) years and made readily available should CMS or a Carrier request it
    - Certain carriers may require the use of tracking logs, screenshots, attestations, etc. to satisfy documentation requirements
        - We also provide oversight by communicating compliance requirements to downline agents. Methods of communications or education can vary and include but are not limited to email blasts, agent portal or company website postings, webinars, and telephone conversations. Furthermore, we will provide or make available the Agent Medicare Compliance Guide to downline agents in order to demonstrate oversight according to their compliance responsibilities under CMS regulations.

In addition, we provide agent oversight by logging and handling reported complaints and/or violations that we receive. Please refer to the Complaints and Violations Policy. We also provide support and assistance to downline agents and agencies who request review of their materials. Please refer to the Compliant Marketing & Sales Practices Policy.

Annual compliance reviews will be conducted, whenever possible, on a random sample of at least three downline agencies in order to demonstrate oversight. Downline agencies, for the purpose of this exercise, are defined as organizations contracted under our organization, where said organization has sub-agents contracted with them and has employees who handle or have access to MA/PDP plan business. Applicable agencies should be identified for completion of the Medicare Compliance Questionnaire and Attestation located on the compliance team shared drive. Once completed, the questionnaire will be reviewed for

compliance gaps. If any are identified, they will be addressed with a representative from the agency in order to derive a remediation plan.

MA and PDP carriers are required to establish and implement an oversight plan that monitors agent and broker activities, identifies non-compliance with CMS requirements, and reports non-compliance to CMS. We will cooperate with the carriers and assist them with their oversight efforts upon request.

TPMO Requirements

Call Recording – All Third-Party Marketing Organizations (TPMOs), which include licensed sales agents, must record all sales, marketing, and enrollment calls with Medicare beneficiaries in their entirety, including the enrollment process and pre- and post-sales calls. This requirement pertains to telephonic, virtual, and online conversations. Only the audio of calls using web-based technology must be recorded. Recordings must be stored in accordance with CMS storage requirements for a duration of no less than 10 years. Please note, face to face (in-person) appointments are not required to be recorded and are exempt from this guidance.

TPMO Disclaimer – The TPMO Disclaimer must be used by all TPMOs that sell on behalf of more than one MA or PDP carrier. The disclaimer must be:

- Verbally conveyed within the first minute of all sales calls
- Electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication (regardless of content)
- Prominently displayed on all TPMO websites, regardless of content and whether the website meets the CMS definition of "marketing"
- Included on all marketing materials, including print materials and television and radio advertising

Lead Generating Activities – Lead generating activities facilitated by a TPMO must include a notice to the beneficiary that their information may be shared with a licensed agent for future contact. The notice must be conveyed verbally, in writing, or electronically depending how the communication with the beneficiary is being completed. Lead generating activities facilitated by a TPMO should also include a notice to the beneficiary that they are being transferred to a licensed agent who can enroll them in a plan.

TPMOs must adhere to any requirements that apply to the applicable MA or PDP carriers in their lead generation, marketing, sales, and enrollment-related activities. TPMOs should be able to make available lead sources for enrollments upon request by MA or PDP carriers.

Reporting – To comply with CMS reporting standards, TPMOs must:

- Report to applicable MA or PDP carriers monthly of any staff disciplinary actions associated with beneficiary interaction
- Report to applicable MA or PDP carriers monthly any violations that apply to the MA or PDP plan associated with beneficiary interaction

- Disclose to the MA or PDP carrier any subcontracted relationships used for marketing, lead generation, and enrollment

TPMO Oversight

We contractually obligate our lead vendors that are TPMOs to comply with the following as applicable:

- Disclose to the MA and PDP carriers any subcontracted relationships used for marketing, lead generation, and enrollment
- Record all sales, marketing, and enrollment calls with beneficiaries in their entirety
- Report to MA and PDP carriers monthly any staff disciplinary actions or violations of any requirements that are associated with beneficiary interaction
- Use the TPMO disclaimer as required by CMS

Our organization communicates the TPMO requirements described in the preceding section above directly to our downline agencies and agents. We also communicate to our downline agencies and agents that they must include in their vendor agreements (with vendors that are TPMOs) that the vendor is required to: disclose to MA and PDP carriers subcontracted relationships used for marketing, lead generation, and enrollment; record all sales, marketing, and enrollment calls in their entirety; report to MA and PDP carriers monthly any staff disciplinary actions or violations of any requirements that apply to beneficiary interaction; and use the TPMO disclaimer as required by CMS. Any new or pertinent information regarding changes to TPMO requirements is also communicated as needed.

Moreover, we are available to answer questions, provide agent support, and offer advice on effective and compliant practices upon request by an agent. This includes assistance with reporting staff disciplinary actions associated with beneficiary interaction, violations that apply to an MA or PDP plan associated with beneficiary action, and subcontracted relationships used for marketing, lead generation, and enrollment.

We also assist carriers in communicating the TPMO requirements to downline agents and agencies. As requested, we also assist carriers with ensuring that TPMOs are complying with any other MA or PDP requirements applicable to the activities that they are performing.

V. DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy are subject to discipline up to and including termination in accordance with our Sanctions and Disciplinary Action Policy. Other actions may include any of the following depending on the severity of the situation: coaching, training, completion of corrective action plans, and/or revocation of some or all of its responsibilities up to and including termination of carrier contract.

Agent Licensing & Certification

NEISHLOSS & FLEMING, LLC
AN INTEGRITY COMPANY

Issue Date: 4/24/2020
Last Revised: 2/1/2023

I. DEFINITIONS

Term	Definition
MA	Medicare Advantage
PDP	Prescription Drug Plan
Ready to Sell	For MA and PDP carriers, "Ready to Sell" means an agent is actively Licensed, Appointed (in each State), and Certified (for each product).
Organization, We, Us, or Our Company	

II. PURPOSE

The purpose of this policy is to ensure agents contracted in our hierarchy are Licensed, Appointed, and Certified, as required, prior to the marketing or selling of applicable insurance plans.

III. POLICY

Prior to engaging in marketing activities, every agent who is contracting under our organization's hierarchy is required to provide a current, state-appropriate insurance license and hold active appointments at each applicable carrier for each state in which they plan to market or sell. Agents must also complete yearly product certifications (when applicable) for each product they plan to market.

IV. PROCEDURE

Licensing and Appointment

We follow all state and federal guidelines, as well as any carrier specific requirements, regarding agent licensing and appointments. Agents are responsible for ensuring they maintain a current and active insurance license as well as hold appropriate state appointments within each carrier they represent for each state in which they are marketing. It is ultimately the responsibility of the carrier to ensure that agents are Licensed, Appointed, and Certified.

When required, agents are also responsible for maintaining Errors and Omissions insurance and providing us or the carrier with a current copy of such coverage when requested.

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.

Product Certifications

All agents planning to market and sell federally regulated Medicare products including all Medicare Advantage, Special Needs Plans, and/or Prescription Drug Plans are required to complete yearly certifications for each applicable product as provided by the individual carrier. Our organization relies solely on the carrier's direction and protocol for the administration of product certifications. We also rely on the carriers to provide or make available proper training and/or training materials deemed necessary to compliantly market these products. Our organization and downline agents should refrain, whenever possible, from providing supplies or marketing materials (including enrollment forms) to an agent who is not appointed and certified.

- **Recommendation:** Check agents "Ready to Sell" status prior to sending materials and provide a notification with all MA/PDP application kits reminding agencies to not distribute supplies to uncertified agents.

V. DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy are subject to discipline up to and including termination in accordance with our Sanctions and Disciplinary Action Policy.

Compliant Marketing & Sales Practices

NEISHLOSS & FLEMING, LLC
AN INTEGRITY COMPANY

Issue Date: 4/24/2020
Last Revised: 5/23/2023

I. DEFINITIONS

Term	Definition
CMS	Centers for Medicare and Medicaid Services
MCMG	Medicare Communication and Marketing Guidelines
MA	Medicare Advantage
PDP	Prescription Drug Plan
Carrier	Insurance Company, or Plan Sponsor as defined by CMS
Agent	For the purpose of this policy, agent refers to any individual or entity contracted with an MA/PDP Plan Sponsor (i.e. carrier) to market and sell MA/PDP plans.
AEP	Annual Election Period, or Annual Enrollment Period (Oct 15 – Dec 7)
OEP	Open Enrollment Period (Jan 1 – Mar 31)
TPMO	Third-party marketing organization — organizations and individuals, including independent sales agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment-related functions as part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA or PDP plan or plans to make an enrollment decision) on behalf of an MA or PDP plan. Ex: Agents, brokers, agencies, lead generation vendors, etc.
Organization, We, Us, or Our Company	

II. PURPOSE

The purpose of this policy is to ensure CMS regulations, CMS MCMGs, and other CMS guidance pertaining to agent marketing and sales practices are followed for the sale and marketing activities of Medicare Advantage or Prescription Drug Plans.

III. POLICY

Our organization and its agents will adhere to CMS regulations, CMS MCMGs, and other CMS guidance when marketing and selling MA and PDP products. Carriers are ultimately responsible for the compliance of their agents, but we will assist them in their efforts of ensuring compliance with the Medicare Communication and Marketing Guidelines.

IV. PROCEDURE

Our organization will assist the carrier in the communication of these guidelines to downline agents, but monitoring and auditing of agent compliance is left to the sole discretion of the carrier. We take a proactive approach in communicating these applicable guidelines to our employees, and agents, and assists in the education of the elements contained therein. Full CMS MCMGs and related CMS memos are available online at https://www.cms.gov.

Contact Rules

Agents must receive proper permission to contact before calling or meeting with prospective or potential MA or PDP clients. Agents are allowed to make unsolicited telephonic contact to their current clients in the following scenarios:

- At any time about their client's current plan
- At any time to discuss plan business if the client has not opted out of such contact

Agents **may** use the following methods to make unsolicited direct contact with potential MA or PDP clients, provided they meet all federal, state, carrier, and MCMG guidelines

- Conventional mail and other print media (ex. Direct mail, ads, banners, websites, etc.)
- Email, provided all emails contain an opt-out method and a process is in place to ensure further emails are not sent to those who opt-out

Agents **may not** use the following methods in order to contact potential MA or PDP clients

- Door-to-door solicitation, which includes:
    - Leaving information (i.e. leaflets, flyers, etc.) at a residence
    - Going to a residence without a previously schedule appointment for that date and time
    - Going to a residence on the basis of a returned Business Reply Card (BRC) or other documentation whereby a potential client requested additional information and provided their address
- Approach potential clients in common/public areas (i.e. parking lots, hallways, lobbies, sidewalks, etc.)
- Telephonic solicitation (i.e. cold-calling), texts, or electronic voicemails
- Other prohibited telephonic activities include:
    - Unsolicited call about other lines of business to generate Medicare leads (considered bait and switch)
    - Calls based on referrals (i.e. referrals from current clients are not considered permission to contact)

- Calls to market products to former clients who have disenrolled
- Calls to potential clients who attended a sales event, unless the client gave express permission at the event for a follow-up call (there must be documentation of permission to be contacted)
- Calls to prospective enrollees to confirm receipt of mailed information

Agents who have a pre-scheduled appointment with a potential enrollee who is a "no-show" may leave information at that potential enrollee's residence.

High-Pressure, Misleading, or Discriminatory Sales Practices

In order to protect Medicare consumers, our organization and its agents must not engage in misleading or high-pressure sales tactics, and will refrain from discrimination 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. In line with non-discrimination and the protection of consumers, agents may not charge beneficiaries for their services in relation to MA or PDP plan business.

Agents should not provide information that is inaccurate or misleading. In addition, agents should not use the Medicare name, CMS logo, Medicare ID card image, or products or information issued by the federal government in a misleading manner. Agents may only use the Medicare ID card image after obtaining prior approval from CMS.

AEP and Pre-AEP Marketing

Agents may not solicit/accept enrollment applications for a January 1 effective date prior to the start of the Annual Election Period (AEP), unless the client is entitled to another enrollment period (i.e. Special Election Period). Furthermore, agents cannot conduct marketing activities for an upcoming plan year prior to October 1. During the Pre-AEP period from October 1-14, agents can market for the upcoming plan year but cannot solicit/accept enrollment applications until October 15.

OEP Marketing

Our organization and its agents will adhere to all guidelines in regard to marketing during the Open Enrollment Period (OEP). Agents cannot knowingly target or send unsolicited marketing material to an MA or PDP enrollee. Agents should not:

- Send unsolicited materials advertising the ability or opportunity to make an additional enrollment change or referencing OEP as a means to do so
- Specifically target clients or prospective clients, by purchase of mailing lists or other means of identification, who are in the OEP because they made a choice during AEP
- Engage in activities intended to target the OEP as an opportunity to make further sales
- Call or contact former clients who have selected a new plan during AEP

Communication and Marketing Materials

Agents should stay abreast of all regulations and guidelines pertaining to material compliance. All materials, including generic and Multiplan materials, used by agents must comply with CMS regulations and follow all other State and Federal requirements. Marketing materials are a subset of Communication materials that meet both intent and content requirements. Any material used by an agent that meets the definition of "marketing" must be submitted to CMS via the HPMS portal for approval. Our organization will provide support and assistance to agents and agencies regarding their marketing efforts, including material review, at the request of the agent.

CMS requires the submission of marketing materials to carriers for pre-approval prior to submitting materials to CMS. Agents need to be aware of each of their carriers' process for material submission. Agents are advised to send materials to their immediate upline for review and guidance. The top of hierarchy entity will then help facilitate the carrier and CMS submission processes.

Furthermore, we monitor certain lead vendors to ensure materials available to agents are compliant with CMS guidelines. If those materials meet the definition of "marketing", we will help facilitate the CMS submission process. Agents are encouraged to only use these vendors when purchasing lead materials.

Agents that wish to create carrier branded materials must follow carrier processes and receive prior approval before using carrier branding and logos.

If our organization creates materials for agent use, both communication and marketing, we will ensure they meet CMS standards and are submitted to carriers and CMS when required.

Communications Materials

Our organization and its agents will adhere to all requirements in regard to communications materials. Agents should not:

- Use superlatives in communications without referencing the sources of documentation or supporting data that support the superlative in the communication material
- Use testimonials or product endorsements unless the endorsements or testimonials comply with CMS requirements
- Claim they are recommended or endorsed by CMS, Medicare, the Secretary or HHS
- Imply that a plan operates as a supplement to Medicare

Marketing Materials

Our organization and its agents will adhere to all requirements in regard to marketing materials. Agents should not:

- Reference products or plans, benefits, or costs, in marketing materials unless the names of the MA or PDP Carriers (or their marketing names) offering the referenced products or plans, benefits, or costs, are listed on the material as follows:
    - In print, the names must be in 12-point font and not be in the disclaimer or fine print
    - In TV, online, or social media, be either read at the same pace as the phone number or displayed throughout the entire advertisement in a font size equivalent to the advertised phone number, contact information, or benefits
    - In radio or other voice-based advertisements, be read at the same pace as the advertised phone numbers or other contact information
- Market any benefits in a service area where those benefits are not available unless the marketing is in local media and marketing to beneficiaries outside of the service area is unavoidable
- Market savings available to potential enrollees that are based on unrealized costs of a Medicare beneficiary, including but not limited to, savings available to potential enrollees that are based on comparison of typical expenses borne by uninsured individuals or unpaid costs of dually eligible beneficiaries
- Market the 5-Star Special Enrollment Period after November 30 of the contract year if the contract has not received an overall 5-star rating for the next contract year
- Display Star Rating unless: (i) it is clear that the rating is out of 5 stars; (ii) the Star Ratings contract year is clearly identified; (iii) the Star Ratings is marketed in the service area(s) for which the Star Rating is applicable (unless using Star Ratings to convey overall performance in a way that is not confusing or misleading); (iv) references to individual Star Rating measures also include references to the overall Star Rating for MAPDs and the summary rating for MA only plans; and (v) an individual underlying category, domain, or measure is not used to imply an overall higher Star Rating

TPMO Disclaimer

All Third-Party Marketing Organizations (TPMOs) must use the applicable TPMO disclaimer as required. Our organization educates agents on adding the TPMO disclaimer to all required materials including consumer facing websites, marketing materials, email communication, and online communications, such as chat. For telephonic interactions, this disclaimer must be stated within the first minute of a sales call.

There are two versions of the TPMO disclaimer. The applicable TPMO disclaimer depends on whether a TPMO sells for all plans in the service area.

If a TPMO does not sell for all plans in the service area, the disclaimer reads as follows: *"We do not offer every plan available in your area. Currently we represent [insert number 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 to get information on all of your options."*

If a TPMO sells for all plans in the service area, the disclaimer reads as follows: *"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 for help with plan choices."*

The disclaimer is not required for TPMOs that sell plans on behalf of only one MA carrier or PDP carrier.

Call Recording

All TPMOs, which include licensed sales agents, must record all sales, marketing, and enrollment calls with Medicare beneficiaries in their entirety, including the enrollment process and pre- and post-sales calls. This requirement pertains to telephonic, virtual, and online conversations. Only the audio of the calls using web-based technology must be recorded. Recordings must be stored in accordance with CMS storage requirements for a duration of no less than 10 years. Please note, face to face (in-person) appointments are not required to be recorded and are exempt from this guidance.

Our organization does not dictate the technology to be used for these recordings. However, we do have software solutions available through our MedicareCenter system that allow users to record and store calls with beneficiaries.

Agents must notify beneficiaries that the call is being recorded at the start of the call and must capture consent to proceed. Should a beneficiary decline to have their call recorded, the agent should attempt to schedule an in-person meeting with the beneficiary.

Call recordings should be readily available and reproducible within 24 hrs should a Carrier, CMS, or an upline entity request them.

Compliant and Thorough Sales Presentation

Agents should conduct a compliant and thorough sales presentation which includes a thorough needs assessment and presentation. Agents should use the needs assessment to determine which plan best suits the needs of their client. Finding the right plan for the client can help reduce member complaints, policy cancellations, and rapid disenrollments. Key areas should be thoroughly covered. Agents must fully discuss the following key areas:

- Primary care providers (whether or not the client's current primary care providers are in a plan's network)
- Specialist providers (whether or not the client's current specialist providers are in the plan's network)

- Pharmacies (whether or not the client's current pharmacy is in the plan's network)
- Prescription drug coverage and costs (including whether or not the client's current prescriptions are covered)
- Costs of health care services (including copays, deductibles, and other costs associated with the plan)
- Premiums
- Benefits (including additional benefits that are important to the client)
- Specific health care needs of the client

Once a plan (or plans) is identified that meets the clients needs, agents should provide a full plan presentation to ensure the client fully understands the plan. For all telephonic enrollments, agents must review the content of the Pre-Enrollment Checklist in its entirety with the client prior to completing the enrollment. Agents should reach out to us for guidance on compliant and thorough Sales Presentations.

V. DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy are subject to discipline up to and including termination in accordance with our Sanctions and Disciplinary Action Policy. Furthermore, corrective actions can include, retraining, suspension of marketing privileges, termination, and/or reporting of misconduct to the carrier and the respective State Departments of Insurance.

Event Compliance

NEISHLOSS & FLEMING, LLC
AN INTEGRITY COMPANY

Issue Date: 4/27/2020
Last Revised: 5/23/2023

I. DEFINITIONS

Term	Definition
MCMG	Medicare Communication and Marketing Guidelines
CMS	Centers for Medicare and Medicaid Services
MA	Medicare Advantage
PDP	Prescription Drug Plan
Carrier/Plan	Insurance Company, or Plan Sponsor as defined by CMS
Sales/Marketing Event	Events hosted by agents or Plans where all allowable types of Marketing Activities can occur, and is designed to steer, or attempt to steer, potential enrollees toward a plan or a limited set of plans. Events can be formal (presenter/audience format) or informal (kiosk, table, etc.) – referred to as "Sales Event" within this policy
Educational Event	Events hosted by agents or Plans that are designed to inform or educate beneficiaries about Medicare including MA, PDP, or other Medicare Programs, does not include marketing or sales activities
Agent	For the purpose of this policy, agent refers to any individual or entity contracted with an MA/PDP Plan Sponsor (i.e. carrier) to market and sell MA/PDP plans.
Organization, We, Us, or Our Company	

II. PURPOSE

The purpose of this policy is to ensure all CMS and carrier regulations are followed in regards to sales and educational events.

III. POLICY

Our organization will assist applicable carriers in their efforts to ensure all CMS regulations, CMS MCMGs, other CMS guidance, and carrier guidelines are followed in regards to sales and educational events. Agents should report all sales events, and, when required, educational events to the appropriate carriers. Furthermore, agents should follow all CMS regulations, CMS MCMGs, other CMS guidance, and carrier guidelines during these events.

IV. PROCEDURE

Marketing/Sales Events:

Agents should report all sales events using the applicable carrier methods. In most cases, agents need to report their event at least two weeks prior to the date of the event.

Cancellations or changes to the sales event must be made 48 hours prior to the event or as the carrier or CMS requires. The following CMS requirements apply to all marketing/sales events:

- Marketing/sales events may not occur within twelve (12) hours of an educational event at the same location, which means the same building or adjacent buildings
- Agent will provide talking points and/or presentation to Plans prior to use to submit to CMS. Agent must adhere strictly to the submitted talking points.
- Sign in sheets must clearly be labeled as optional
- Health screens or other activities that may be perceived as, or used for, "cherry picking" are not permitted
- Agents may not require attendees to provide contact information as a prerequisite for attending an event
- Contact information provided for raffles or drawings may only be used for that purpose (agents may not retain the contact information as a lead)

Educational Events:

Should a carrier require the reporting of educational events, agents should also report them according to the carrier's methods. The following CMS requirements apply to Educational events:

- Must be explicitly advertised as educational
- Must be hosted in a public venue
- May answer beneficiary-initiated questions
- Must not set up a future marketing appointment
- May collect beneficiary contact information, such as Business Reply Cards (BRCs)
- Must not make available or collect Scope of Appointment forms
- Must not include marketing or sales activities or distribution of marketing materials or enrollment forms

Even though ultimate responsibility for compliance lies with the agent, our organization will make reasonable efforts to communicate and educate agents in regard to sales and educational event compliance. We utilize various methods for communication and education including, but not limited to: email blasts, phone conversations, website postings, job aids/ guides, and webinars.

V. DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy are subject to discipline up to and including termination in accordance with our Sanctions and Disciplinary Action Policy. Furthermore, corrective actions can include, retraining, suspension of marketing privileges, termination, and/or reporting of misconduct to the carrier and the respective State Departments of Insurance.

Scope of Appointment

NEISHLOSS & FLEMING, LLC
AN INTEGRITY COMPANY

Issue Date: 4/27/2020
Last Revised: 5/23/2023

I. DEFINITIONS

Term	Definition
MCMG	Medicare Communication and Marketing Guidelines
CMS	Centers for Medicare and Medicaid Services
MA	Medicare Advantage
PDP	Prescription Drug Plan
SOA	Scope of Appointment — a form Medicare beneficiaries must complete within a specified timeframe prior to their appointment with an agent, defining the terms of the appointment
Agent	For the purpose of this policy, agent refers to any individual or entity contracted with an MA/PDP Plan Sponsor (i.e. carrier) to market and sell MA/PDP plans
Organization, We, Us, or Our Company	

II. PURPOSE

The purpose of this policy is to ensure that CMS regulations, CMS MCMG, other CMS guidance, and carrier guidelines are followed in regards to Scope of Appointment (SOA) forms.

III. POLICY

While conducting MA or PDP marketing activities, agents are required to follow all CMS regulations, CMS MCMGs, other CMS guidance, and carrier guidelines in regards to SOA forms. Agents may not market any healthcare related product during a marketing appointment beyond the scope agreed upon by the client prior to that appointment. Our organization will assist applicable carriers in their efforts to ensure all CMS regulations, CMS MCMG, other CMS guidance, carrier SOA guidelines are followed.

IV. PROCEDURE

Agents must complete an SOA at least forty-eight (48) hours prior to any personal/individual marketing appointment, subject to the following two exceptions:

1. Walk-in in person meetings that are unscheduled and at the request of a beneficiary; or
2. Enrollments within the last four (4) days of a beneficiary's valid enrollment period (Annual Election Period, Open Enrollment Period, Initial Coverage Election Period, or a Special Election Period).

Agents must complete an SOA regardless of whether the appointment is face-to-face, virtual, or telephonic, including walk-ins to an agent's office.

The SOA form must be submitted and stored according to carrier guidelines. Agents may not market any health care related product during a marketing appointment beyond the scope of products the beneficiary agreed to prior to the meeting.

The following requirements must be on the scope of appointment form:

- Product types to be discussed
- Date of appointment
- Beneficiary and agent contact information
- Statement stating:
    - No obligation to enroll
    - Current or future Medicare enrollment status will not be impacted
    - Automatic enrollment will not occur

A new SOA is required if, during an appointment, the beneficiary requests information regarding a different plan type than previously agreed upon.

Documentation of SOA forms should be kept for a duration of at least 10 years in accordance with CMS retention guidelines. Additionally, agents should be able to provide, upon request, copies of all SOA forms.

Even though ultimate responsibility for compliance lies with the agent, our organization will make reasonable efforts to communicate and educate agents in regards to SOA compliance. We utilize various methods for communication and education including, but not limited to: email blasts, phone conversations, website postings, job aids/guides, and webinars.

V. DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy are subject to discipline up to and including termination in accordance with our Sanctions and Disciplinary Action Policy. Furthermore, corrective actions can include, retraining, suspension of marketing privileges, termination, and/or reporting of misconduct to the carrier and the respective State Departments of Insurance.

CMS Call Center Compliance

NEISHLOSS & FLEMING, LLC
AN INTEGRITY COMPANY

Issue Date: 4/27/2020
Last Revised: 2/1/2023

I. DEFINITIONS

Term	Definition
CMS	Centers for Medicare and Medicaid Services
Carrier	Insurance Company, or Plan Sponsor as defined by CMS
MA	Medicare Advantage
PDP	Prescription Drug Plan
Telesales	For the purpose of this policy, Telesales refers to all telephonic marketing, sales, and enrollment activities for MA/PDP products done within a call center environment
Call Center	Businesses that conduct Telesales activities (see above) under a "call center" contract
Organization, We, Us, or Our Company	

II. PURPOSE

The purpose of this policy is to ensure that all MA/PDP Telesales activity conducted in a call center setting is done so in accordance with CMS and carrier regulations.

III. POLICY

All agents and agencies conducting Telesales activities within a call center setting for federally regulated Medicare products must adhere to all CMS and carrier regulations. Demonstrated competence regarding these regulations is crucial for downline call center businesses wanting to conduct Telesales activities.

IV. PROCEDURE

Pre-Approval

Approval from each applicable carrier is required before any Telesales activities can be conducted within a call center. Each carrier has their own approval process and requirements, and the call center or Telesales agency must adhere to each carrier's pre-approval process. Employees of our organization wanting to onboard a call center should contact the compliance department. Downline agencies wanting to get contracted as a call center for federally regulated Medicare products must complete our Call Center Onboarding Packet to initiate the onboarding process. Once this is complete and submitted, representatives from the Call Center business will work directly with representatives from the applicable Carriers and our organization to complete all requirements within each carrier's approval process.

Carrier requirements of pre-approval can include, but are not limited to: formal application requests, on-site reviews, audits (both pre-approval and annually), attestations, script submission/approval, call recording capability reviews, quality control documentation, checklists, policies and procedure documentation containing all requirements for compliant Telesales activities including TCPA (Telephone Consumer Protection Act) and CMS regulations, enrollment systems, security/privacy protocols and capabilities, agent performance tracking, and marketing and lead generation practices.

Oversight and Quality Assurance

1. Call Center businesses must have an internal oversight and quality assurance program in place to ensure compliance with Federal, State, and carrier regulations; and also to ensure that quality customer service is being provided by all call center agents.
    - Call Centers should have Policies & Procedures in place that describe how their business will go about meeting these regulations, requirements, and standards. This documentation must be provided to our Compliance Officer during the onboarding process and should detail the processes in place to ensure the call center is operating compliantly.
    - As part of the quality assurance program, Call Center businesses must complete call reviews to ensure agents are operating compliantly and exhibiting quality customer service. Call Centers can use their own call evaluation forms and methods, or they can adopt ours if they so choose.
    - At a minimum, Call Center businesses must review one call per agent per month per carrier, unless otherwise instructed, and have a process to address corrective actions when issues are identified during the call review process. Each carrier has their own standard in regard to call reviews, so our organization has developed its minimum standard based on compilations of multiple carrier requirements.
        - For oversight and monitoring purposes, Call Centers will upload three call reviews (including the call recordings) per month, per carrier to our secure FTP site in order to demonstrate compliance with this requirement.
    - Call Center businesses should have a policy and processes in place to review and monitor lead sources for compliance.
    - Call Centers should have Policies & Procedures in place that outline a process for self-reporting issues of non-compliance to applicable carriers.
2. Our organization will also maintain an effective oversight and quality assurance program to ensure downline call center businesses are operating compliantly and meeting certain minimum standards in terms of customer service. Our oversight program includes:
    - Completion of the Call Center Onboarding Packet
    - Collection of call center's applicable Policies and Procedures

- Monthly call reviews when required by the carrier.
    - The number of call reviews may vary in number based on a variety of factors, but when it is required, we will review three calls per month for each carrier that requires we do so. We will review the call and score/rate it using our Telesales Call Review Evaluation Form and then compare it to the downline call center's review of that same call to ensure call review effectiveness.
    - Our organization will utilize secure File Transfer Protocol (FTP) to receive or transmit call recordings. Requests for call recordings will be initiated via email or phone call. When requested, downline call centers shall transmit call recordings within two business days via this method.
- Annual Telesales Compliance Review completed by all downline Telesales agencies.
    - Compliance personnel from our organization will initiate the review, and they will work with representatives from the call center throughout completion of the review. The review will consist of various compliance questions, the request for certain compliance metrics and reports, and an attestation of compliance. Once completed, the call center representative should return it within the specified timeframe given by our compliance representative.
- Oversight will also include continued monitoring and ongoing support by our organization, which can include:
    - Review of complaints and violations received by the carrier
    - Identification of coaching opportunities and/or possible risk areas that need addressed
    - Ongoing support with compliance and marketing strategies
    - Communication of compliance requirements
    - Support with audits, investigation, and call reviews/evaluations (which can include corrective action plans and coaching opportunities identified in call reviews falling below the acceptable threshold of 85%)
        - Corrective actions taken can vary depending on the severity of risk, but most often will include coaching and or re-training on identified risk areas

3. When carriers allow a downline call center to contract call center agencies underneath their hierarchy, said call center must have an appropriate oversight plan in place to ensure compliance standards are being met by those downline agencies. Call center entities can adopt our oversight plan or utilize their own. If using their own, the call center should be prepared for reviews or audits to prove the effectiveness of their oversight plan.

CMS Telephonic Contact Rules

1. Pursuant to Section 40.3 of the Medicare Communications and Marketing Guidelines, Telesales agents must have compliant "Permission to Contact" prior to making outbound

calls to prospective clients in regard to federally regulated Medicare products (i.e. Medicare Advantage and Prescription Drug Plans, and certain Carrier's Medicare Supplement Plans). Examples of permission to contact include Business Reply Cards (BRC) including electronic submissions via a website or some other electronic or online form, emails requesting a return call, or recorded requests for agent contact made by the consumer. Verbal requests to be contacted via inbound calls must be recorded and stored for a duration of 10 years. Permission to contact applies only to the individual that made the request and only to the entity from which the individual requested contact from; for the duration of that transaction, and for the scope of the product indicated. Each telephonic enrollment request must be recorded (audio) and include a statement of the individual's agreement to be recorded, all required elements necessary to complete the enrollment (as described in Appendix 2 of the Managed Care Manual), and a verbal attestation of the intent to enroll. If the request is made by someone other than the beneficiary, the recording must include the attestation regarding the individual's authority under State law to complete the request, in addition to the required contact information. All telephonic enrollment recordings must be reproducible and maintained as provided in section §60.9 (Medicare Managed Care Manual).

2. Telesales agents are allowed to contact current customers at any time to discuss their current plan business per Medicare Marketing Guideline regulations. Calls to current customers can be made to discuss plan business, promote other Medicare plan types, and conduct normal business activities related to enrollment; as well as to discuss benefits, plan information, upcoming plan changes, AEP dates, conduct disenrollment surveys (after the disenrollment date), and other related activities that meet CMS standards.

3. Telesales agents are prohibited from using bait and switch strategies, making outbound calls based on referrals, calling former customers who have disenrolled or are in the process of disenrolling (disenrollment surveys are permitted), calling customers from a sales event (unless express permission is given with documentation of permission), and calling customers to confirm the receipt of mailed information. Calls to former enrollees after the disenrollment effective date are permitted in order to conduct disenrollment surveys for quality improvement purposes (disenrollment surveys conducted telephonically, email or conventional mail may not include sales or marketing information)

Sales Script and Telephonic Enrollment

1. Only pre-approved telephonic scripts can be used for the purposes of marketing and/or enrollment into federally regulated Medicare products.

2. Sales and Enrollment scripts must be reviewed and approved annually and/or when CMS guidance is updated to ensure compliance.

3. A thorough needs assessment must be completed and a complete sales presentation covering all necessary elements of a plan must be given prior to enrollment, in order for the consumer to make an informed and educated decision. Agents should also fully review the Summary of Benefits with each client in order to ensure understanding.

4. Call center agents should not discriminate based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, medical history, genetic information, evidence of insurability, or geographic location.

5. If the consumer requests an in-home appointment for further information, pursuant to Section 50.3, Telesales agents should record a verbal Scope of Appointment for the future in-home appointment. If any revisions or amendments to the SOA are needed in the field, the agent may need to complete a paper form at that time.

6. Sales calls must include a privacy statement clarifying that the customer is not required to provide any health-related information to the plan representative unless it will be used to determine enrollment eligibility.

7. **May only enroll consumers telephonically as a result of an inbound call.**

8. Inbound calls made directly to a sales department or a sales agent must clearly inform the customer if/when the nature of the call moves from a sales presentation to telephonic enrollment. This must be done with the full and active concurrence of the customer, ideally with a yes/no question.

9. Once an enrollment request has been identified and recorded, the Telesales agent will transition from the approved Telephonic Sales Script to an approved Telephonic Enrollment Script which is to be utilized verbatim.

10. Each telephonic enrollment must be recorded (audio) and include a statement of the individual's agreement to be recorded, along with all required elements necessary to complete the enrollment and a verbal confirmation of the intent to enroll ("Statement of Understanding" must be read verbatim from the CMS approved enrollment application). If the request is made by someone other than the consumer, a recording of the individual's such authority under State Law along with their contact information is required.

11. All telephonic enrollment recordings must be reproducible and maintained in a manner that meets CMS and carrier standards.

12. Consumers must be advised they are completing an enrollment into a Medicare Part C or Part D plan.

13. Collection of financial information (i.e. credit card number or bank account) is prohibited at any time during the call.

14. Upon completion of the telephonic enrollment, the Telesales agent must provide the consumer with a confirmation number for tracking purposes.

15. A notice of acknowledgement and any other required information must be provided to the consumer.

Operational Standards and Reporting Requirements

1. Certain operational standards must be met in order to be approved for Telesales activities and to maintain good standing and the ability to continue Telesales activities. These standards can be dependent upon the individual carrier and can include, but are not limited to the following:
    - The use of alternative technologies such as voice-mail or an answering service for weekends, holidays, and off business hours is permitted/required. Must indicate the voicemail is secure
    - All licensed agents must complete the following:
        - FWA Training (administered by the Plan Sponsor or AHIP)
        - AHIP Training or other CMS specific (administered by the Plan Sponsor or AHIP)
        - Plan specific training
        - Resident and non-resident state licensing (as applicable)
    - Provide free interpreter services to all non-English speaking and LEP consumers or have the ability to transfer such calls to the carrier for interpreter services
    - Bi-lingual agents are required to complete plan specific language certifications when required
    - Provide TTY service to all hearing impaired current or potential customers or have the ability to transfer such calls to the carrier for TTY services
    - Call Centers shall provide interpreter services free of charge to callers when required
    - Establish and follow an explicitly defined process for handling member complaints
    - Licensed call center agents are expected to adhere to all applicable Medicare and TCPA regulations, Code of Conduct, Information Protection and Ethics standards
    - Establish and follow a policy for maintenance and monthly scrubbing against the Federal Do Not Call and the Call Center's own Internal Do Not Call lists (when applicable)
    - Branded and generic marketing materials must receive Plan and CMS approval prior to use, when required. Materials must be reviewed for compliance prior to submitting to carriers for their pre-approval prior to CMS submission.
    - Secret Shopper compliance (standard threshold set by each applicable carrier)
    - Call Centers cannot use non-licensed customer service representatives to perform functions that require State marketing licensure

- Call Centers must ensure that associates (both agents and employees) who support Medicare Advantage or Part D products complete a General Compliance and Fraud, Waste, and Abuse Training course within 90 days of hire and annually thereafter. Call Center organizations should either independently provide the training or help facilitate through other means (ex. AHIP or Plan Sponsor trainings).
- Call Centers are allowed to use non-licensed administrative support staff to conduct certain customer service activities such as:
    - Conducting Plan Changes
    - Answering Calls
    - Setting Appointments
    - Providing Information as outlined in this policy
    - Providing factual information
    - Fulfilling material requests
    - Taking Demographic Information for the purpose of enrollment when initiated by enrollee
    - "For-Cause" review of materials and activities for complaint investigation
    - "Secret shopper" activities where CMS requests materials such as enrollment packets
    - In the event the call center uses licensed benefit advisors and/or Telesales agents as customer service representatives to answer inbound calls or make outbound calls, sales management ensures (when/if applicable):
        - The licensed benefit advisors and/or Telesales agents are trained on customer service processes and systems
        - The licensed benefit advisors and/or Telesales agents are removed from inbound sales queues that are assigned in the phone system
        - The phone queue supervisor is provided a list of benefit advisors and/or Telesales agents' names via email to remove agents from sales queues
            - Confirm benefit advisors and/or Telesales agents have been removed by receiving a screen print of their active queue list.
        - Benefit advisors and/or Telesales agents are added back to assigned sales queues once the customer service project has been completed

2. Telesales businesses must also be able to track certain metrics for reporting purposes. Each Carrier may have its own set of metrics it requires to be tracked for those reporting purposes. These metrics can include, but are not limited to the following, and must be **reproducible for a period of ten (10) years** upon request:

    - Average hold times
    - Average ring times / # of rings
    - Disconnect rates
    - Abandoned/Dropped call rates
    - Average “handle” or “talk” time
    - Total calls handled
    - Enrollments (both total and per agent)
    - Call to Enrollment ratio
    - Call volume data
    - Adherence %
    - Quality measurement

V. DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy are subject to discipline up to and including termination in accordance with our Sanctions and Disciplinary Action Policy. Furthermore, corrective actions can include, retraining, suspension of marketing privileges, termination, and/or reporting of misconduct to the respective State Departments of Insurance.