HUMANA EXTERNAL MARKETING GUARDRAILS – JULY 2025

Guardrails for Medicare Communications and Marketing Materials and Activities

Last Update: 07/15/25

The purpose of this document is to provide communication and marketing guardrails to all Third-Party Marketing Organizations ("TPMOs"), Field Marketing Organizations (FMOs), Managing General Agencies (MGAs), and Strategic Alliance agency partners, or other organizations and individuals who are compensated to perform lead generation, marketing, sales, and enrollment related functions on behalf of Humana.

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

TPMOs are responsible for compliance with the following:

- 42 CFR § 422.2260 through § 422.2274 & 42 CFR § 423.2260 through 42 CFR §423.2276, as amended
- CMS' Medicare Communications and Marketing Guidelines
- Combined Medicare Advantage and Part D Enrollment and Disenrollment Guidance
- Applicable Medicare Managed Care Manual Guidance including but not limited to, Chapter 4 – Beneficiary Protections and Chapter 16b – Special Needs Plans
- Section 504 of the Rehabilitation Act as enforced by the Office of Civil Rights
- The Center for Medicare and Medicaid Services ("CMS") memos
- CMS interim sub-regulatory guidance
- Humana 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 TPMO to ensure all applicable rules and regulations are adhered to for itself, its sales agents, its employees or other contracted individuals or entities, 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 state or federal rules, regulations, or requirements are updated or revised, TPMOs are expected to adhere to those new or revised rules, regulations, or requirements and the updates or revisions take precedence over these guardrails.

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Marketing and Communication Requirements

CMS regulations require marketing and communication materials, among many other requirements, 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.

Marketing materials are a subset of Communications that include both "intent" and "content" elements as defined by CMS. Marketing materials must be filed with CMS using their HPMS system. Refer to the CMS definition of what constitutes Marketing at 42 CFR § 422.2260 and 423.2260.

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

Marketing means communications materials and activities that meet both the following standards for ***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 42 CFR § 422.134(a).

Note: As clarified within their May 10, 2023, CMS advised references to benefits such as *"dental, vision, and hearing"* were sufficient to meet the ***content*** standard. Use of these statements in materials directed to beneficiaries, meets the ***intent*** standard. The memo states: *"Content that beneficiaries can receive benefits such as dental, vision, cost-savings, and/or hearing services is sufficient information about plan benefits, benefits structure or cost sharing to meet the content standard in the definition of marketing in §§ 422.2260 and 423.2260. Further, the use of these statements in advertisements and activities directed to Medicare beneficiaries clearly meets the intent standard."*

TPMOs are responsible for reviewing the regulatory definitions of Marketing and Communication, and the sub-regulatory guidance provided by CMS to determine the appropriate category for their materials. If you are unsure if a creative should be classified as Marketing or Communication, please email the piece to SalesIntegrityReview@humana.com, copying in your Sales Integrity Liaison(s).

All creatives classified as Marketing require Humana review and acceptance prior to HPMS filing. In addition, Humana requires certain Communications be reviewed prior to use: TV commercials, videos, Permission To Contact (PTC) or Business Reply Card (BRC) creatives, any creative that includes the Humana brand, and any post-enrollment communications referencing Humana. A sampling of other material media types, classified as communications by a TPMO, may be periodically requested by Humana for compliance auditing.

Material Review and Filing Instructions

TPMOs are responsible for ensuring the submission of all multi-plan marketing materials to CMS, via the HPMS Marketing Module, **after carrier review and approval**.

- Marketing materials must be submitted in HPMS for each Plan Year.
- CMS generally opens HPMS filing for the next plan year in early June, e.g., first Monday in June.
- Materials filed in June-September for the next plan year may not be used until on or after 10/1.
- TPMOs must ensure the proper media type is selected upon submission.

Submissions to Humana

Creatives must be submitted with a fully completed **Humana Material Submission Intake Spreadsheet**.

Submit for review and approval to your Humana **Account Executive (AE),** copying SalesIntegrityReview@Humana.com and your Sales Integrity Marketing Liaison**:**

- ***All*** telephonic lead, transfer, sales, and enrollment scripts (any script within the chain of enrollment)
- ***All*** Enrollment forms
- ***All*** plan comparison websites
- ***All*** post-enrollment member communications mentioning Humana, Humana plans, Humana-specific benefits, or including the Humana brand, require Humana review before use.
- ***ALL*** creatives specific to the advertisement of Medicare Supplement plans

Submit for review and approval to Humana MarketPoint **Sales Integrity** team at SalesIntegrityReview@Humana.com and your Sales Integrity Marketing Liaison:

- ***All*** other materials that meet the definition of Marketing
- ***All*** Permission to Contact (PTC) and Business Reply Card (BRC) creatives, regardless of Marketing classification
- ***All*** Television commercials and online videos, regardless of Marketing classification

TPMOs that use or purchase leads from a lead generator, broker, and/or aggregator, must submit all marketing lead sources or forms (PTCs/BRCs) for review and approval, prior to lead collection and/or using the leads. If the lead material contains marketing, the TPMO is accountable for HPMS filing. See the next section for SMID guidance.

Submission of Identical Pieces by Multiple TPMOs:

Sometimes the same material is used by multiple TPMOs. Currently, every TPMO using the material must file the material with a unique SMID changes may be made to this process within the coming months. For now, CMS has provided the following guidance:

TPMOs submitting a piece that has already received approval from all applicable carriers and CMS, will add an "[TPMO initials]" just before the "_M" for the material ID in HPMS so SMID is unique. Add a note to the comment section explaining that the piece was already approved under [original SMID material id].

Example:

Original TPMO submission:

MULTIPLAN_[Name of Creative]_M

Additional Submissions by other TPMOs:

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

MULTIPLAN_CALL US CREATIVE 1_ABC_M

Note: The ***original SMID*** will continue to appear on the material, without the changes noted above.

Materials used in a Provider's office or that Mention Providers or Other Entities

- Marketing materials must be filed in HPMS for approval, with up to a 45-day review/approval window.
- Any communication or marketing material that mentions or involves a provider or other entities must be submitted to Humana for review prior to use. The TPMO must complete the "**Provider Related**" tab on the **Humana Material Submission Intake Spreadsheet,** and the attestation section with signature.
- For any co-branded (i.e. a bank, financial advisory firm, insurance company, etc.) communication or marketing material or a material that will be mailed to another entity's clients, the TPMO must complete the **"Co-Branding"** tab on the **Humana Material Submission Intake Spreadsheet,** the attestation section with signature, and submit the material for review.

Rules of the Road for Humana's Review Process

- The SMID filed in HPMS **must** match the material ID that is published on the final creative of the material.
    - Notify Humana promptly if the SMID changes from when the piece was initially submitted.
    - There should never be more than one SMID on a single document.
- A zip file with multiple ads under the same SMID is not permissible.
- Complete ***all*** required fields (on all applicable tabs) within the **Humana Material Submission Intake Spreadsheet**. Missing information causes delays.
- Please be sure to include the **plan year** in which the materials are intended to be used.
- ***All*** PTCs must be submitted to Humana for review before being used to collect leads.

- Submit the content in a proofread, **editable Word document**, with changes since last review redlined in tracking mode. Images/mock-ups/PDFs/ should be provided for reference, but all verbiage must be typed into Word.
- 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 Humana's logo is used, include images of the logo use/placement in context of the rest of the content.
- Plan to allow time for Humana/CMS processing. Expedited requests due to lack of appropriate planning and upstream processes may not be honored. Humana recommends prioritizing those materials that require 45-day review for approval from CMS (TV, Video). Build CMS review time into your planning.
- Wording cannot be adjusted after filing without being redlined and resubmitted for review and refiled. All post-review/post-filing changes must be approved by Humana.
- Apply Humana Sales Integrity, Legal and Compliance reviewer's guidance to future related content/marketing.
- Ensure all applicable disclaimers are included in document being submitted for review. See Humana's **2025-2026 Medicare Disclaimers Quick Reference Guide.** TPMOs are responsible for understanding and applying the listed disclaimers as well as any other state or regulatory required disclaimers.
- Marketing and Communications created by **Artificial Intelligence (AI)** must have human oversight before sending to Humana 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, on-screen disclaimer should indicate:
    - *AI-generated Voice and Actor*
    - *Or AI-simulated actor portrayal*
- It is important that Humana own all Humana Branded Paid Search Keywords as these Searches are actions by users looking for Official Humana content from Humana's Official Sites. For all Paid Search ads, add the following terms as Negative Keywords for all campaigns to prevent overlap with Humana: **Humana, Humana Insurance, Humana Medicare, Humana Medicare Advantage,** etc. Also, no use of the Humana Brand Name or Trademark term, nor the Logo is allowed in TPMO paid search ad copy.

Third Party Marketing Organizations ("TPMOs")

Definition

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

TPMO Disclaimer – Standardized Model *(cannot be modified within the 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:

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

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

(iv) Prominently displayed on TPMO websites and

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

Lead Forms and Lead Sources

TPMOs are responsible for compliance oversight including ensuring all lead sources (including those purchased) used to solicit Medicare Advantage Products are compliant. TPMOs must also ensure the process of obtaining the lead and the outreach is compliant. Lead sources must abide by all CMS' requirements, including but not limited to:

- Cannot require age, date of birth, health status questions, or any other information outside of the necessary contact information, on lead forms and websites used to generate MA/PDP leads.
- **Ensure beneficiary is clearly informed before completing the form that it will result in call(s) from licensed sales agent(s) and include all applicable consent language as mandated by the TCPA, FTC, FCC, and HIPAA. This disclosure must be conspicuously placed**.
- Business Reply Cards (BRCs) and Permission to Contact (PTCs) expire after 12 months following the beneficiary's signature date.

Note: A BRC/PTC is ***not*** a Scope of Appointment (SOA). See SOA requirements further below.

TPMOs conducting lead generating activities, either directly or indirectly for Humana, must disclose to the beneficiary that their information will be provided to a licensed sales 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 their electronic messaging platform.

High Level TCPA Guidance

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

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

TPMO to TPMO Beneficiary Data Sharing *("Single Entity Consent")*

Effective October 1, 2024, 42 CFR Section 422.2274(g)(4) requires that 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 individually named TPMO.

Beneficiary Contact

Unsolicited Contact

Unsolicited contact is expressly prohibited. Examples of "unsolicited contact" includes, but is 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 express permission for the TPMO to contact them about Medicare Products through a completed PTC or BRC.

- TPMOs may initiate unsolicited email contact with potential enrollees but must provide an opt-out process on ***each*** communication that details how those who no longer wish to receive emails can stop receiving them. In lieu of a detailed opt-out process, emails can include a working "Unsubscribe" link that removes the recipient from future emails.
    - Once an individual has utilized the opt-out option, TPMOs are responsible for ensuring that the beneficiary no longer receives emails or other electronic communications from the TPMO.

Note: Using unsolicited text messaging and other forms of electronic direct messaging, for the purpose of marketing, are not permitted. As with email messaging, an "opt-out" or "Stop" function must be included with all such messaging.

Prohibition on Medicare Advantage Open Enrollment Period (MA-OEP) Marketing

TPMOs are prohibited from knowingly targeting or sending unsolicited marketing materials to any beneficiary during the Medicare Advantage Open Enrollment Period (MA-OEP), January 1 to March 31.

During the MA-OEP, TPMOs and may:

- Conduct marketing activities that focus on other Special Enrollment Period opportunities and includes qualifying language that targets a valid Special Enrollment Period, 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 MA-OEP.
- TPMOs may include educational information, on their website about enrollment periods, including the existence of MA-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 MA-OEP, TPMOs and their agents may ***not***:

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

Prohibition on Marketing New Plan Year Information Prior to Oct. 1

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

Marketing Outside of AEP

- When marketing Medicare Advantage 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, TPMOs must not mislead members/prospects into believing they could change or "switch" their plans outside of AEP.
- Outside of AEP, both marketing and communication materials must include examples of IEP/SEP qualifiers. This properly targets those who have an initial or special enrollment period, so as not to violate the prohibition of knowingly targeting or sending unsolicited marketing material outside of AEP. These qualifiers should be included in a conspicuous way, early in the ad, and repeated in longer ads to reduce the potential for misleading and confusing beneficiaries.
    - Examples include: *"New to Medicare, Turning 65, Losing coverage, or Moving?"*
    - In television ads or digital videos, the IEP/SEP qualifiers must be both on-screen graphics and, in the voice, over/audio portion of the ad, early and periodically throughout. CMS mandates IEP/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, if that is not true and the new plan is not specifically named.
- Outside of AEP, avoid language that, directly or indirectly, encourages beneficiaries to compare/switch their existing plan with other plans to avoid the appearance of knowingly targeting those who already have coverage.
- Under 42 CFR 422.62(b), simply having both Medicare and Medicaid no longer qualifies a Medicare Advantage member to enroll in a new plan. Language like *"Have Medicare and Medicaid?"* is ***not*** an adequate SEP qualifier. While some dual-eligible beneficiaries (full benefit dual-eligibles) may qualify under 42 CFR § 423.38(c)(35) for a monthly opportunity to enroll in Highly Integrated or Fully Integrated Dual Eligible Special Needs Plans (HIDE, FIDE), this opportunity is limited to only those dually eligible individuals who are enrolled in, or in the process of enrolling in, the D-SNPs affiliated Medicaid MCO. Both the eligible population, as well as the availability of these integrated D-SNP plans, is extremely limited.

Nominal Gifts

TPMOs may not offer gifts to beneficiaries unless the gifts are of nominal value (currently $15, total per event—not per item if more than one item is given away—as noted within the 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 or agrees to any form of marketing, sales or other outreach, and are not in the form of cash or other monetary rebates and cannot be the provision of a meal. TPMOs must submit any materials or processes that propose offering nominal gifts to beneficiaries to Humana 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 in the forms:

- 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, e.g., Walmart and Target).
    - Other types of gift cards may be used as a nominal gift for beneficiaries but are subject to review.

    - Marketing should not promote, or appear to promote, cash prizes, cash give-aways, coupons redeemable for cash, or monetary prize offerings of any kind. This extends to both words ***and*** images that may be used in an advertisement.
- Gifts may ***not*** be in the form of drug or health benefits (e.g., a free checkup), including optional or 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, provided the educational event meets all CMS regulations and falls under the CMS definition of communication.
- 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
- 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 included 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 TPMO, prior to the appointment
- Market additional health related products not identified prior to the appointment without a separate Scope of Appointment identifying the additional health related products to be discussed; and
- Market non-health related products, such as annuities or life insurance.

Scope of Appointment Requirements

CMS regulations within 42 CFR § 422.2274 (b)(3) require agents who represent MA organizations, to secure and document a Scope of Appointment prior to meeting with potential enrollees. Sales agents must obtain a valid Scope of Appointment at least **48 hours prior** to the scheduled personal marketing appointment or meeting, ***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 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.

A 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 Humana (by mail for paper forms, recorded for telephonic, or through Enrollment Hub) with all enrollment applications. (See SOA Job Aid in Vantage).
- SOAs are valid for up to 12 months following the date of the beneficiary's signature date.
- SOAs must be signed for hard copy, telephonically recorded for telephonic appointments only, or electronically signed.
- 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 include all required details of a valid SOA and be recorded.

See additional resources in MarketPoint University:

- SOA-48 Hour Waiting Period Guidance
- Scope of Appointment – 48 hour Waiting period FAQ

Combining Scope Of Appointment with Permission to Contact Consent

Combining a PTC and an SOA may be confusing or misleading, if it is not clear that each form has a separate objective. The PTC/BRC provides consent by the beneficiary to allow the agent to contact the beneficiary by phone. In contrast, the

SOA is an agreement between the agent and the beneficiary of a specific date to conduct the marketing appointment and discuss specific product types. Therefore, it should be clear to the beneficiary that they are not required to complete either form, and can choose to actively consent to one or both forms, based on their preference.
It is possible for a TPMO to compliantly obtain a permission to contact (PTC) while also obtaining a Scope of Appointment (SOA), as long as all applicable regulatory requirements are met and the guardrails below are implemented:

- The elements of the PTC and SOA must be separate and distinct from one another so that the beneficiary understands they are completing two separate forms.
- The SOA must include all required elements, as outlined in sub-regulatory guidance by CMS
- The SOA must include a beneficiary signature (hard copy, telephonically or electronic). TPMOs will need to ensure whichever method of signature used is considered a legally valid signature, and it must be clear to the beneficiary which form they are signing and the purpose of the form.
- The date of the appointment must be the day the beneficiary agreed for the appointment to take place.
- The appointment date and the date the SOA was obtained must comply with the 48- hour waiting period, unless subject to exception. TPMOs are required to submit any PTC or lead forms and SOAs for review to Humana prior to use.

Anti-Discrimination

TPMOs may ***not***:

- Discriminate based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, or geographic location.
- Engage in any discriminatory activity such as targeting potential enrollees from higher income areas, stating, or implying that plans are only available to seniors rather than to all Medicare beneficiaries, or stating or implying that plans are only available to Medicaid beneficiaries unless the plan is a Dual Eligible Special Needs Plan (D-SNP) or Medicare-Medicaid Plan.
- Target potential enrollees based on income levels unless it is a dual eligible special needs (D-SNP) plan or comparable plan.
- Target potential enrollees based on health status unless it is a chronic condition special needs plan (C-SNP) 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 an eligible chronic medical condition when applying for enrollment in a Chronic Condition Special Needs Plan (C-SNP). This diagnosis must be verified by a physician within 30 days of enrollment.

Note: TPMOs are reminded that, due to Executive Order, the collection of information tied to sexual orientation, gender identity, race or ethnicity, is no longer permitted during the enrollment process. This includes, but is not limited to, enrollment forms, online enrollment flows, and enrollment scripting.

Disability

TPMOs must ensure questions and language used in permission to contact forms, plan comparisons, sales, and enrollment processes/scripts, do not directly, or indirectly, request or require disability related information.

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

General Requirements Applicable to Communication and Marketing Materials

TPMOs are prohibited from distributing communications and marketing materials that are materially inaccurate, misleading, or otherwise make misrepresentations or engage in activities that could mislead or confuse beneficiaries or misrepresent the MA organization or TPMO. CMS is particularly concerned with and prohibits national advertisements that promote MA plan benefits or cost savings unlikely to be realized, 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, or 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 a TPMO 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.

TPMO or Advertising Entity's Name Must Be Clearly Displayed

- The TPMO's name (who the solicitation is coming from and whom the beneficiary will reach if they respond), must be clearly and prominently visible and legible to consumers on all marketing and communication creatives.
- To help avoid misleading or confusing beneficiaries, TPMOs that include *"Medicare"* or other terms that may imply association with CMS or the government, within their operational or entity name, must include a non-governmental tagline (e.g., ***An Insurance Agency with No Government Affiliation***) and a prominently placed disclaimer that clearly explains that an entity or website is not affiliated with, endorsed by, or otherwise related to the federal government, CMS, HHS, or Medicare.
- For direct mail solicitations, the TPMO 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).

Reminder: In situations where an entity's name includes *"Medicare,"* CMS may still find these efforts insufficient and find the material or the TPMO name to be misleading. TPMOs should also refer to state regulations to ensure the use of *"Medicare"* within the entity name is not otherwise prohibited.

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

TPMOs are prohibited from using the Medicare name, CMS logo, and products or information issued by the Federal Government, including the Medicare card, in a misleading way in any materials. The Medicare ID card image may only be used with written 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 Medicare card image the following steps must be followed:

- Send an email to the marketing mailbox at Marketing@cms.hhs.gov with an attached copy of the material that includes Medicare ID card image.
- Receive either an approval or disapproval from the CMS HPMS marketing mailbox.
- 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 TPMO is not affiliated or endorsed by CMS, HHS, the Federal Government, etc.
- **Evidence of CMS approval** must be included when submitting content for Humana's internal 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

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

All marketing materials must include the name of the MA and Part D organization(s) offering the products or plans, benefits, or costs identified in the materials. Including only a partial listing of the MA and Part D organization(s) offering the products or plans, followed by "and more," is not acceptable. The name(s) must be included in the following format and each name should be bracketed individually as a variable:

- MA/Part D organization names must be in 12-point font 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, "unique" 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 Affordable Care Act references with respect to Medicare Products, e.g., Healthcare Marketplace, Exchange, ACA, etc.
- ***Do not*** market or reference any federal programs to obtain MA/MAPD leads (I.e., Medicare Savings Program, Food Stamps, Low-Income Subsidy, etc.). This tactic may be seen as a bait and switch" These programs are not administered by private carriers or TPMOs and sales agents do not have the capacity to enroll or approve beneficiaries for these programs.

Marketing of Savings Not Realized

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

Examples of Prohibited "Savings":

- Advertising that beneficiaries can "save $9000 or more" on prescription drugs in a MA or PDP plan
- Advertising that beneficiaries can save "save over $7000" in health care expenses if they enroll in a MA plan
- Advertising Dual Eligible Special Needs Plans that provide a "savings" of over $7000 to the beneficiary
- Generic references to "save" or "switch and save" or similar which may make is seem like savings are guaranteed

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 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.

Marketing Part B Premium Reduction "Giveback" Benefit

When including the Part B Premium Reduction Giveback benefit within marketing materials, the content must be clearly communicated keeping the following information in mind:

- A person must enroll in a plan offering the benefit and be paying for Part B to receive reimbursement through the giveback benefit; how much a person pays for Part B can impact the amount of reimbursement.
- Part B Giveback Benefit is a potential "savings" to members, not something they "earn."
- **A check is not physically cut reflecting this giveback, nor does the beneficiary receive the amount back in an allowance card or other cash equivalent.** No image or content in the ad should reflect cash, checks in mailboxes, or other misleading imagery.
- Reimbursement varies based on how Part B is paid. If the Part B premium is paid as a Social Security deduction, the giveback benefit will appear as a reduction in the amount deducted from the Social Security check. If Part B is paid directly, the beneficiary will receive a credit on their premium statement.
- Giveback amount is paid by the carrier and, where available, varies by plan ($0.10+). Only a very few plans offer "full" premium ($185/month in 2025) reimbursement.
- When advertising specific amounts, TPMOs are to use the lowest amount of reimbursement available the targeted audience and not the highest if the highest is not available to all. Amount can be expressed as "$[Amt] or more."
- **Giveback is not immediate.** It may take one or more payment cycles for a beneficiary to realize the benefit and advertising should take this into account.
- Part B Premium Reduction Giveback is not the same as a Medicare Savings Program (MSP). MSPs are provided by the government and not plan carriers, and should not be used in TPMO marketing. MSPs and Part B Giveback often look similar when described (e.g., *Get help paying your Part B premium*.)
- Materials advertising the Part B Giveback benefit must include the Part B Giveback benefit disclaimer, either within the disclaimer section or incorporated into the text so that it is clear that *The Part B Giveback Benefit pays part of your Part B premium and the amount may change based on the amount you pay for Part B.*

Marketing Dual-Eligible and Chronic Condition Special Needs Plans

When marketing **Dual-Eligible Special Needs Plans** (D-SNP), TPMOs must:

- **Make it clear that a beneficiary must have both Medicare and Medicaid to qualify for the plan.**
- Spell out Medicare Advantage "Dual-Eligible Special Needs Plan" before using the "D-SNP" acronym.
- Refrain from calling out the specific State Medicaid Programs by name.
- Full benefit dual-eligibles have a monthly opportunity to enroll in either Highly Integrated or Fully Integrated Dual Eligible Special Needs Plans (HIDE, FIDE). This opportunity is limited to those dually eligible individuals who are enrolled in, or in the process of enrolling in, the D-SNPs affiliated Medicaid MCO. The limited eligible population and extremely limited availability of these integrated SNPs, necessitate **very targeted marketing efforts**. These materials may also be subject to specific State filing requirements.
- If materials mention SSBCI benefits (such as flexible allowances for living expenses like groceries, rent or utilities), refer to the SSBCI Benefits and Disclaimer section below. C-SNP marketing materials that include supplemental benefits (e.g., certain over-the-counter allowances, dental, vision and hearing coverage) that are not SSBCI benefits are not required to include the SSBCI disclaimer.

- **It must be clear that beneficiaries must have both Medicare and Medicaid to qualify for the D-SNP. If SSBCI benefits are mentioned, it must be equally clear that they must qualify for these benefits separately, by virtue of having an eligible chronic condition.** See the SSBCI Benefits and Disclaimer section below for additional requirements.

When marketing **Chronic Condition Special Needs Plans (C-SNP),** TPMOs must:

- Make it clear that the beneficiary must have both Medicare Parts A and B ("Original Medicare") and be **diagnosed with** an eligible (or "qualifying") chronic condition.
- Spell out Medicare Advantage "Chronic Condition Special Needs Plan" before using the "C-SNP" acronym.
- If materials mention SSBCI benefits (such as flexible allowances for living expenses like groceries, rent or utilities), refer to the SSBCI Benefits and Disclaimer section below. C-SNP marketing materials that include supplemental benefits (e.g., certain over-the-counter allowances, dental, vision and hearing) that are not SSBCI benefits are not required to include the SSBCI disclaimer.
- Communicate that individuals enrolling in a C-SNP will be required to have their doctor complete a Verification of Chronic Condition form, confirming the eligible diagnosis, within 30 days of enrollment. If not completed within an additional 30 days, the enrollment will be voided. This could be as simple as adding that **formal physician verification of the chronic condition will be required post-enrollment.**

SSBCI Benefits and Disclaimer

When a Communication or Marketing material mentions a benefit that is filed as a Special Supplemental Benefit for the Chronically Ill (SSBCI), then the following requirements apply:

- Use the carrier's **SSBCI disclaimer**, as updated for 2026.
- The benefit(s) should be denoted with an asterisk that ties back to the SSBCI disclaimer.
- CMS requires that the SSBCI disclaimer include the specific chronic condition(s) that the carrier recognized an enrollee must have to be eligible for the SSBCI. If multiple carriers' chronic conditions are the same, the same disclaimer may be used for those carriers.
- For television, online, social media, radio, or other voice-based ads, the disclaimer must be read at the same pace as, or displayed in the same font size as, the advertised phone number or other contact information.
- For outdoor advertising (as defined in § 422.2260), the disclaimer must be displayed in the same font size as the advertised phone number or other contact information.
- It must be clear that some plans may require ***multiple chronic conditions*** to access the SSBCI benefit(s).
- Materials that include supplemental benefits that are not SSBCI benefits, are not required to include the SSBCI disclaimer.
- Whether a benefit is offered as an SSBCI benefit, along with the qualifying chronic condition(s) or other requirements necessary for accessing the SSBCI benefit, may vary by carrier.

Scare and High-Pressure Tactics:

Avoid the following tactics that are likely misleading and/or confusing to beneficiaries:

- Language that creates undue fear/anxiety, such as "beware of plans whose copays could bust your budget", etc.
- Words that may 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 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.
    - For example, avoid using "**URGENT!**" on a material with font that is in all caps, oversized and red.

Superlatives and Absolute Language

TPMOs may not use superlatives in communications and marketing unless sources of documentation or data supportive of the superlative is also referenced in the material. Such supportive documentation or data must reflect data, reports, studies, or other documentation that applies to the current or prior contract year. TPMO may incorporate evidence/sources of the superlative within the material or as footnote/citation. Refer to 42 CFR § 422.2262(a)(1)(ii).

- Examples of superlative language that require substantiation are: "best," "top plans," "greatest," "#1" or "outstanding" when describing Medicare Products. Remember if it cannot be supported, it cannot be stated.
- Do not use absolute language such as "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 Humana 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.
- TPMOs must not use "highly rated" in describing 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.
- When marketing dental, vision or hearing benefits, ensure more than *"routine"* coverage is available ***or*** ensure the word *"routine"* is included in the benefit description.

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 material, it must clearly indicate before the number that it will direct callers to a "licensed sales agent" or "licensed insurance agent".
- "Unbiased" should not be used in reference to the services provided by the TPMO 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 inclusive of the disabled Medicare population as well as Medicare beneficiaries aged 65 and over. CMS prohibits stating or implying that plans are only available to seniors rather than all Medicare beneficiaries. TPMOs should 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 beneficiaries" should 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 may be used to reference language in a legible footnote or disclaimer section.

- 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.

Use of Value-Added Items or Services (VAIS) Prohibited in Pre-Enrollment Marketing

VAIS are items and services that are not plan benefits, are not part of the plan's benefit package, and may not be marketed to prospective enrollees or used as an inducement or incentive for enrollment. VAIS generally take the form of discount programs or other "perks" so TPMOs should avoid using words or descriptions of "discounts" or vague references to "perks" or "extras."

"Partnership" or "Alliance"

Avoid words like "partnership" or "alliance" in reference to the relationship between Humana and the TPMO or Humana and a vendor when no legal partnership exists. Acceptable terms would be "teamed up" or "working together."

Phone Number/Hours of Operation/TTY Requirements

- Customer service numbers, including TTY, must be toll-free numbers.
- Hours and days of operation are required to be prominently included at least once when any 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 each reference of the customer service number, in the same font size and style as the other phone numbers, on all materials except as outlined below. TPMOs can use either their own TTY numbers or State relay services, so long as the number included is accessible from TTY equipment. TTY 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 Requirements

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 a TPMO uses a beneficiary's previous post it is considered an endorsement or testimonial.
- Any testimonials that beneficiaries would believe are actual customers of the TPMOs or Medicare Products they are endorsing must use actual consumers who have used the product or service they are endorsing in both the audio and video. If actual customers are not leveraged, the TPMO must clearly and noticeably 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 medium, such as on a website.
- If an individual is paid to endorse or promote the TPMO, or Medicare plans or products, it must be clearly stated (e.g., "paid endorsement").
- If an individual, such as an actor, is paid to portray a real or fictitious situation, the ad must clearly state it is a "Paid Actor Portrayal."
- If a fictional AI-generated person or voice is used as talent within an ad, and on-screen disclaimer should indicate *"AI-generated Voice and Actor," "AI-simulated actor portrayal,"* or similar disclosure. Any endorsement or testimonial that is made by a health care provider (even if another individual quotes the provider), is generally not permissible and must be discussed with and reviewed by Humana prior to use. TPMOs ***may not*** pay or compensate provider for testimonial in any way.
- Any claim made in an endorsement or testimonial must be substantiated.
- An endorsement or testimonial cannot use negative testimonials about other Plans/Part D Sponsors.
- An endorsement must reflect the honest opinions, findings, beliefs, or experience of the endorser.

Communications and Materials with Provider/Celebrity Spokesperson

Humana recognizes that TPMOs may use materials that involve a provider spokesperson and/or celebrity personality, to promote their agency.

The TPMO is responsible for submitting these materials for Humana's review. The materials will go through the normal Humana review process. The Sales Partner should complete the intake form, and must include the following information in the provider tab of the intake form:

- Name of provider/celebrity personality:
- Are they currently a practicing physician? If not, please list the date that they stopped practicing.
- Are they contracted with any medical groups?
- Are they contracted with any MA Organization or Part D Plan sponsors?
- What is their specialty?
- If a TV personality, please provide a brief description of their program (is it on TV, internet, etc.)

- Ads cannot use AI-generated talent designed to mimic or replicate the appearance, mannerisms or voice of a real person or known celebrity without that individual's express, demonstrated consent.

Materials that include (or give the appearance of including) a provider must **not**:

- Include a contracted provider.
- Market or steer a beneficiary toward a particular Medicare Product or a set of Medicare Products, such as Humana MA/PDP plans.
- Include the host promoting or appearing to promote the Sales Partner or the plans offered by the Sales Partner, such as stating, "ABC agency is the best and only represents the best plans." The host may state the Sales Partner's name and number and advise beneficiaries to call the Sales Partner to learn about plans that may be right for them.

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

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

Once Humana has reviewed and approved a material that includes a provider spokesperson, the TPMO may move forward with using the approved materials, with all edits and comments incorporated.

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 marketed in the service area(s) for which the Star Rating is applicable, unless using Star Ratings to convey overall MA organization performance (for example, ''Plan X has achieved 4.5 stars in Montgomery, Chester, and Delaware Counties), in which case the TPMO must do so in a way that is not confusing or misleading. TPMOs must not market the 5-star special enrollment period after November 30 of each year if the contract did not receive an overall 5 star for the next contract year.

Websites

In addition to adhering to all other guidance provided, the following requirements and expectations apply to all websites, leveraged by TPMOs whether owned and operated or utilized for leads. The TPMOs are accountable to ensure compliance to all websites involved in their business operations.

- Websites must be clear and easy to navigate. Entity/agency must be clearly identified so user understands who is operating the site.
- 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., 2025 and 2026 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. Other questions may be asked but they must be clearly noted as optional or skippable. Requesting a Social Security Number is ***NEVER*** permitted.
- 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 Humana and filed with CMS (file and use since July 24, 2023). This requirement applies to contact centers **and** field marketing organizations that conduct sales telephonically. Humana has developed Humana's Multiplan Sales and Enrollment Script that TPMOs who engage in telephonic sales/enrollments may use as reference when creating their own scripts. Contact your AE with questions.

TPMO Telephonic Sales and Enrollment and Scripting Oversight

Humana and TPMOs are required to have oversight of their agents' and any downlines' telephonic sales and enrollment activity. Oversight should include:

- Ensuring compliance for telephonic sales
- Current CMS-filed scripting is used
- Calls are recorded.

When submitting scripting for review to Humana, and when filing with CMS, please indicate all downlines/affiliated partners that will be using the filed script. Additionally, TPMOs must ensure all content from the CMS-approved scripting is transferred verbatim to downlines and within any agent portal technology or tool and ensure a quality control process is in place to double check.

Informational, Sales, Pre-Enrollment and Enrollment Script Requirements

TPMOs must ensure that their agents who represent MA organizations are licensed and appointed (if applicable) per state law to sell Medicare Products. Representation includes:

- Selling products (including Medicare Advantage plans, Medicare Advantage-Prescription Drug plans, Medicare Prescription Drug plans, and section 1876 Cost plans)
- 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/producer.

Sales and Pre-Enrollment Scripts:

All Call Centers and Field Agent/Agency TPMOs are required to use a CMS approved sales script. Scripts must be reviewed annually and adhere to all CMS guidance. For scripting requirements and best practices, please refer to Multiplan Sales and Enrollment Script created for plan year 2026 for use when creating or updating scripts. When creating and/or updating sales and pre-enrollment scripts, remember the following:

- 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.
    - A sales agents may ask if the beneficiary would like to provide additional information (Medicare ID number, Part A or Part B effective dates, etc.), but the beneficiary can say no
    - If the beneficiary declines to provide this information agent **must continue the call** and provide plan options
    - The agent cannot end the call if the beneficiary does not disclose this information
- Ensure a valid Scope of Appointment is documented 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 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 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 another 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 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 a recording 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. If you have Tricare, your coverage may be affected 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.

Sales 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:

- Confirm beneficiary's desired providers are included in the plan network or discuss other plan or provider options for beneficiary to consider. Beneficiary should understand they have the option to choose to use any provider in the plan's network and should not be pressured to choose a certain provider.
- Inform beneficiaries of all network providers that are available and ensure beneficiaries always feel completely free to choose any provider in the network.
- Provide accurate and objective information to beneficiaries about the availability of all participating providers near their place of residence as part of a general description of a Medicare Product's provider network.
- ALWAYS use the carrier specific Physician Finder to look up provider participation as it is the most up-to-date and comprehensive list of participating providers. Please note, the Humana and CarePlus physician finder differ. If Physician Finder is not available, agents may call Agent Support for assistance.

- Agents ***may***:
    - Provide factual information about a particular provider that is included in the Physician Finder, such as ratings available through the Care Highlights program.
- Agents ***must not****:*
    - Distribute materials describing a provider's services or marketing a provider's practice.
    - Provide information about any free services or cost-sharing waivers offered by a provider unless they are part of the Humana plan benefit (e.g., complementary transportation).
    - Recommend a provider or share opinion about which provider is best (e.g., do not use superlatives when describing a particular provider).
    - Use aggressive marketing or high-pressure tactics when discussing providers.
    - Use superlatives (e.g., "better care", "best care", etc.) when describing providers to beneficiaries.
    - Offer or give anything to beneficiaries to persuade them to choose a particular provider.
    - Accept anything, directly or indirectly, from a provider in exchange for communicating about or helping a beneficiary choose a particular provider (e.g., do not accept promises that provider's patients will choose Humana plans, charitable donations, sponsorships, gifts, cash, etc.).
    - Engage with providers in a way that may influence the agent's interaction with a member or prospect regarding their choice of a Provider, including but not limited to, entering into any arrangements with Providers, or offering or accepting anything of value from a Provider or a Provider's representative unless the arrangement complies with all applicable laws and regulations, e.g., the Federal Anti-kickback Statute.
    - 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 toward Humana plans.

Medicare Supplement Insurance Plan Marketing Guidelines

For TPMOs that are engaged in selling of Medicare Supplement Plans, Humana has compiled the following high-level guidance. It is the TPMO'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.