

Medicare Sales Policies

for HealthSpring Plans

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"Cigna Healthcare" or "Company" are now references to "Health Care Service Corporation" and its subsidiaries



I. General Description			
Number:	MCARE-MCMG-01-009	Revision #:	7
Title:	Agent/Broker Compensation	Distribution:	Internal
Effective Date:	December 14, 2017	Last Review/ Revision Date:	September 27, 2023
Prepared By/ Last Revised By:	Sales		
Regulation:	Medicare Communications and Marketing Guidelines 42 C.F.R. §§ 422.2, 422.2274, 423.4, 423.2274		
II. Purpose and Scope			
Purpose:	This policy describes how Cigna Healthcare structures its independent Agent/Broker compensation.		
Scope:	This policy applies to all members of Cigna Healthcare's Medicare Workforce.		
III. Definitions			
AEP	Annual Enrollment Period for Cigna Healthcare's Medicare Advantage and Part D plans. During the Annual Enrollment Period, new customers may enroll in a Cigna Healthcare plan and existing customers may switch to another Cigna Healthcare plan or another sponsor's plan or return to original fee-for-service Medicare. This period is from October 15th – December 7th every year.		
Agent/Broker	Agents and Brokers (both independent and employed by Cigna Healthcare) include Plan Representatives only when they are "acting" in the role of sales agents. Meaning steering and/or marketing by the CSR/Agent which results in an enrollment request.		
Cigna Healthcare	"Cigna Healthcare" means Cigna Healthcare's Medicare Advantage, Medicare Advantage-Prescription Drug and Medicare Prescription Drug Plans.		
CMS	"Centers for Medicare and Medicaid Services" means the federal agency responsible for administering the Medicare, Medicare Advantage and Medicare Prescription Drug programs.		
Company	"Company" means Cigna Healthcare's Medicare business.		
Compensation	Includes monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commissions, bonuses, gifts, prizes, and awards. ¹ Compensation does not include: • The payment of fees to comply with State appointment laws; • Training; • Certification; • Testing costs; • Reimbursement for mileage to, and from, appointments with customers; or • Reimbursement for actual costs associated with customer sales appointments such as venue rent, snacks, and materials.		

¹ 42 C.F.R. §§ 422.2274(a), 423.2274(a); Medicare Communications and Marketing Guidelines (MCMG), § 110.6.

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Compensation Structure	The Compensation Structure includes details of how Cigna Healthcare plans to disseminate compensation, including specifying payment amounts for initial and renewal compensation. The Agent/Broker compensation year is calculated as January 1 to December 31.
Dual Enrollments	Enrollment in a MA-only plan and a stand-alone PDP. ²
FMV	Fair Market Value; CMS publishes FMV cut-off amounts annually.
Independent Agent/Broker	A licensed General Agent or Independent Agent/ Broker who is a licensed, appointed, and certified individual conducting sales and marketing activities on behalf of Cigna Healthcare.
Initial Compensation	Payment to Agents/Brokers who enroll customers for a first year.
“Like plan type” enrollment	A “Like plan type” enrollment includes: ³ • A PDP to another PDP. • An MA, MA-PD, or to another MA, MA-PD, or (e.g., SNP). • A Section 1876 cost plan to another Section 1876 cost plan.
MA Movement	When Dual Enrollments are replaced by an enrollment into a single plan, the MA movement from a MA-only plan and PDP to a MA-PD plan.
MA Plan	Medicare Advantage Plan - A plan that offers benefits under Medicare Part C.
MARx	CMS Medicare Advantage and Prescription Drug systems
“Unlike plan type” enrollment	An “Unlike plan type” enrollment includes: ⁴ • An MA or MA-PD plan to a PDP or section 1876 cost plan. • A PDP to a section 1876 cost plan or an MA (or MA-PD) plan. • A section 1876 cost plan to an MA (or MA-PD) plan or PDP.
Parent Organization	A legal entity that exercises a controlling interest, through the ownership of share, the power to appoint voting board members, or other means of an MA Organization or Part D Sponsor, directly or through a subsidiary, and which is not itself a subsidiary of any other legal entity. ⁵
PDP	Prescription Drug Plan – Medicare Prescription Drug Plan adds coverage to original Medicare.
Renewal Compensation	Payment to Agents/Brokers who enroll customers for a second year or beyond.
Rapid Disenrollment	When a customer disenrolls from a plan within the first three months of enrollment. Rapid Disenrollment applies when a customer moves from one Parent Organization to another Parent Organization, or when a customer moves from one plan to another plan within the same Parent Organization. ⁶
Workforce	“Workforce” or “Company Workforce” includes all employees, officers, and other agents, such as contract or temporary workers, of the Company.
IV. Policy	
A. Applicability: Unless otherwise noted, Compensation rules apply to independent Agents/Brokers and are applied independently to each plan for Dual Enrollments, except that when Dual Enrollments are replaced by enrollment in a single plan, compensation is paid based on the MA Movement.	

² MCMG § 110.6.7.

³ 42 C.F.R. §§ 422.2274(a), 423.2274(a); MCMG, § 110.6.7.

⁴ 42 C.F.R. §§ 422.2274(a), 423.2274(a); MCMG § 110.6.7.

⁵ 42 C.F.R. §§ 422.2, 423.4.

⁶ 42 C.F.R. §§ 422.2274(d), 423.2274(d); MCMG § 110.7.1.

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- B. **Eligibility for Compensation:** Cigna Healthcare does not pay Agents/Brokers who have not been trained and tested; who do not meet state licensure/appointment requirements or those who have been terminated for cause.
- C. **Annual Compensation Structure:** Cigna Healthcare has its full Agent/Broker Compensation Structure for initial and renewal enrollments in place by October 1 each year for the upcoming year.
1. Each year, by the last Friday in July, Cigna Healthcare informs and attests to CMS of its decision to use Agents/Brokers, including the types of Agents/Brokers and compensation payment rates or ranges, as detailed in annual HPMS memos from CMS.
 2. The Compensation Structure stays the same for the compensation year that was put in place by October 1 of the previous year. Cigna Healthcare may enter into, re-negotiate, or modify the Agent/Broker contract or payment policies, provided the payment rates fall within the ranges provided to CMS.
- D. **Compensation Payments:** Cigna Healthcare calculates compensation payments on a January to December enrollment year and it is not made on a rolling basis or on an enrollment year based on the initial enrollment month. Compensation payments are based on the number of months a customer is enrolled during a calendar year and Cigna Healthcare makes payments in full by December 31 of the calendar year of enrollment.
1. Cigna Healthcare:
 - a. Consults the MARx Agent/Broker compensation report to determine whether an initial or renewal payment is appropriate.
 - b. Pays Agents/Brokers no more than Cigna Healthcare's Initial and Renewal Compensation amounts.
 - c. Pays only the MA compensation amount when a customer enrolls in an MA-PD plan
 - d. Pays referral fees to Agents/Brokers, including independent, employed, and captive Agents/Brokers for a referral (including a recommendation, provision, or other means of referring beneficiaries):
 - i. No more than \$100 (\$25 for PDPs); and
 - ii. As part of total compensation
 - e. Does not charge a customer or allow Agents/Brokers to charge a customer a marketing fee and is responsible for all costs related to plan marketing.
- E. **Initial Compensation:** Cigna Healthcare pays Initial Compensation at or below the FMV amounts that CMS publishes annually when the customer:
1. Is in their first year of enrollment in any plan and when the MARx report has a prior plan type of "none". Compensation may be paid in full or pro-rated;
 2. Moves from an employer group plan to a non-employer group plan (either within the same Parent Organization or between Parent Organizations). Compensation may be paid in full or pro-rated;
 3. Changes plans during their initial enrollment year. Compensation is pro-rated; or
 4. Makes an "unlike plan change." Compensation is pro-rated.
- F. **Renewal Compensation:** Cigna Healthcare pays Renewal Compensation to Agents/Brokers for each enrollment in Year 2 and beyond up to 50 percent of the FMV. Cigna Healthcare pro-rates renewal compensation. Renewal Compensation is paid:
1. Following the initial year compensation;
 2. When a customer enrolls in a new "like plan" within Cigna Healthcare or between two different Parent Organizations. This includes when a customer is a dual enrollment and moves the enrollment to a single plan; or
 3. The agent compensation structure also does not apply to dual eligible enrollments (i.e. customer is eligible for both Medicare and Medicaid).
- G. **Compensation Recovery:** Cigna Healthcare recovers compensation payments from Agents/Brokers under two circumstances: Rapid Disenrollment and any other time a customer is not enrolled in a plan but compensation had been paid.

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1. Cigna Healthcare retroactively pays or recoups funds based on retroactive customer changes for the current and the previous calendar year. a. Cigna Healthcare is not required to recoup or pay compensation for years prior to the previous calendar year; and b. Should Cigna Healthcare choose to recoup payments from a prior calendar year, it also pays funds retroactively that would have been due during that same year. 2. Cigna Healthcare recovers compensation based on the Rapid Disenrollment if a customer enrolls for October 1, November 1 or December 1 and disenrolls from the plan during that same enrollment year (unrelated to the AEP). Compensation recovery applies for any of the following reasons: a. Cigna Healthcare recovers a pro-rated amount of initial compensation when a customer disenrolls from a plan. The amount recovered is equal to the number of months not enrolled; b. Cigna Healthcare recovers a pro-rated amount of renewal compensation when a customer disenrolls from a plan. This amount is equal to the number of months not enrolled; c. Cigna Healthcare has the option to pay the Agent/Broker either full or pro-rated compensation for initial enrollments that are effective later than January 1 and the customer have no prior plan history. However, if Cigna Healthcare pays a full initial compensation and the customer disenrolls during the contract year, Cigna Healthcare recoups a pro-rated amount for all months the customer is not enrolled, regardless of whether it is a change from one Parent Organization to another Parent Organization or from one PBP in one organization to another PBP within the same organization. This would include months prior to the enrollment; or d. Cigna Healthcare recovers from the Agent/Broker a pro-rated amount of compensation when there is a “like plan change” from an MA or MA-PD. Compensation is not to be paid for the months the customer is in the MMP for that compensation cycle year. H. Information upon Request: Cigna Healthcare makes Compensation Structures available to CMS upon request.	
V. Compliance Program Elements	
Reporting Violations	Any member of the Company Workforce who suspects or has observed any violation to the Compliance Program or this Policy has an obligation to report the concern and is able to report such violations to his/her manager, the Ethics Help Line, the Ethics Office, the Compliance Department, or a lawyer in the Legal Department.
Protection Against Retaliation	The Company prohibits any Workforce Member from retaliating, intimidating, harassing, threatening or taking adverse action against anyone for raising or helping to resolve an ethics or compliance concern, for reporting suspected or known violations of the law or against the Company Code of Ethics or Compliance Policies and Procedures, or for reporting suspected fraud, waste, or abuse. Individuals should immediately report any retaliation, intimidation, harassment, or threat of any of the foregoing for raising or helping to resolve a compliance concern by contacting the Ethics Help Line at cigna.ethicspoint.com or by telephone: Inside the U.S., call toll-free by dialing 800.472.8348. Outside the U.S., please follow the dialing instructions here. Such reporting may be confidential and anonymous.
Policy Enforcement	Any member of the Company's Workforce who violates Company Compliance Policies and Procedures, applicable laws or regulations, federal payor or client compliance requirements, may be subject to disciplinary actions up to and including termination.
VI. Policy Contacts	
Compliance Department	Ethics@Cigna.com

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VII. Review, Revision and Approval History				
Revision Number	Summary of Revisions	Approved By	Approval(s)	Date
Previous revision and approval history on file				
6	Annual review and updates	Amber Cowan, Sales Administration Lead Analyst	Approval on File	09/27/2022
7	Updated template and branding, definitions	Amber Cowan, Sales Administration Lead Analyst	Approval on File	09/27/2023
VIII. Attachments and/or Related Documents				
Procedure Agent-Broker Compensation [MCARE-MCMG-SA-02-009-001]				

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I. General Description			
Number:	MCARE-MCMG-01-005	Revision #:	6
Title:	Agent/Broker Training, Testing, Onboarding and Termination	Distribution:	Internal
Effective Date:	December 14, 2017	Last Review/ Revision Date:	October 5, 2023
Prepared By/ Last Revised By:	Sales		
Regulation:	Medicare Communications and Marketing Guidelines 42 C.F.R. §§ 422.504, 422.2274, 423.505, 423.2274 HPMS Memo: Calendar Year (CY) 2023 Agent and Broker Compensation Rate, Referral/Finder's Fees, Submissions, and Training and Testing Requirements, June 3, 2022.		
II. Purpose and Scope			
Purpose:	To describe Cigna Healthcare's policy for onboarding, activating, training, and testing Cigna Healthcare Agents/Brokers.		
Scope:	This policy applies to all members of the Cigna Healthcare Medicare Workforce.		
III. Definitions			
Agent/Broker	Agents and Brokers (both independent and employed by Cigna Healthcare) include Plan Representatives only when they are "acting" in the role of sales agents. Meaning steering and/or marketing by the CSR/Agent which results in an enrollment request.		
Cigna Healthcare	"Cigna Healthcare" means Cigna Healthcare's Medicare Advantage, Medicare Advantage-Prescription Drug and Medicare Prescription Drug Plans.		
CMS	"Centers for Medicare and Medicaid Services" means the federal agency responsible for administering the Medicare, Medicare Advantage and Medicare Prescription Drug programs.		
CSR	Customer Service Representative		
Employed Sales Agent	A licensed sales employee of Cigna Healthcare authorized to represent and sell Cigna Healthcare Medicare products. Agents possess a valid license and are appointed as required by state law.		
For-Cause Termination	The result of an Agent or agency violating CMS, State Regulatory requirements and/or Cigna Healthcare policies.		
MOU	Memorandum of Understanding - An agreement between CMS and the state		
Non-Employed Sales Agent	A non-Cigna Healthcare employee is a licensed General Agent or Independent Agent with an executed, contractual agreement with Cigna Healthcare to represent and sell Cigna Healthcare Medicare products. Non-Employed Agents may also be sub-Agents who are directly employed by or contracted with a General Agency or Field Marketing Organization to represent and sell Cigna Healthcare Medicare products. Non-Employed Agents must be credentialed and appointed as required by state law.		

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Not-for-Cause Termination	Any termination that is not the result of a violation of a CMS, State, and/or Cigna Healthcare regulation/requirement. Some examples include: • Agent Request to terminate his/her agreement; • Agent/Agency not meeting production/staffing requirements; and • Agent not completing annual certification requirements; Lapse of licensure; etc.
Producer	Any insurance selling (producing) entity. Both individuals and firms can be Producers.
Workforce	“Workforce” or “Company Workforce” includes all employees, officers, and other agents, such as contract or temporary workers, of Cigna Healthcare Medicare.

IV. Policy

- A. **State Law:** Cigna Healthcare complies with applicable state licensure and/or appointment laws in its relationships with Agents/Brokers.¹
1. Cigna Healthcare complies with state requests for information about the performance of a licensed Agent/Broker as part of a state investigation into the individual's conduct. CMS establishes and maintains a Memorandum of Understanding (MOU) to share compliance and oversight information with states that agree to the MOU.²
- B. **Training:** All Agents/Brokers selling Medicare products are trained annually on Medicare rules, regulations, and on details specific to the plan products that they sell. Cigna Healthcare ensures:³
1. Training and testing take place prior to the Agent/Broker selling the product;
 2. Agents/Brokers obtain a passing score of at least eighty-five percent on the test;
 3. Its Agent/Broker training/testing programs are designed and implemented in a way that maintains the integrity of the training and testing, and can provide this information to CMS upon request;
 4. Training content includes content on Medicare rules and regulations and details specific to the plan products the Agent/Broker will intend to sell.
- C. **Testing:** Cigna Healthcare ensures that all Agents/Brokers selling Medicare products are tested annually to ensure the following:⁴
1. Appropriate knowledge and understanding of Medicare rules and regulations; and
 2. Details specific to the plan products they intend to sell.
- D. **Termination:** Cigna Healthcare immediately reports the termination of any Agents/Brokers to the state and the reasons for the termination. Cigna Healthcare:⁵
1. Reports For-Cause Terminations to CMS Account Managers, via email or letter.
 2. Reports to CMS Account Managers any sales of Medicare products that were made by Agents/Brokers without a valid license.
 3. Immediately terminates the Agent/Broker and reports this action to the state when an enrollment application has been submitted by an unlicensed Agent/Broker.
 4. Notifies customers who have been enrolled by unlicensed Agents/Brokers and advises those customers of the Agents'/Brokers' status. Customers may request to make a plan change under 42 C.F.R. 422.62(b)(3)(i) or 423.38(c)(8)(i).
- E. **Documentation:** Cigna Healthcare maintains training tools, training exams, and related documentation demonstrating evidence of completion and provides this information to CMS upon request in a form

¹ 42 C.F.R. § 422.2274(b); 42 C.F.R. § 423.2274(b).

² 42 C.F.R. § 422.2274(c); 42 C.F.R. § 423.2274(c).

³ 42 C.F.R. § 422.2274(c); 42 C.F.R. § 422.2274(c); MCMG § 110.1; 2022 Agent and Broker Compensation Rate, Referral/Finder's Fees, Submissions, and Training and Testing Requirements, May 28, 2021.

⁴ 42 C.F.R. § 422.2274(c); 42 C.F.R. § 423.2274(c); MCMG, § 110.3.

⁵ 42 C.F.R. §§ 422.2274(c); 42 C.F.R. §§ 423.2274(c); MCMG § 110.3.

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consistent with current CMS guidance.⁶

V. Compliance Program Elements				
Reporting Violations	Any member of the Company Workforce who suspects or has observed any violation to the Compliance Program or this Policy has an obligation to report the concern and is able to report such violations to his/her manager, the Ethics Help Line, the Ethics Office, the Compliance Department, or a lawyer in the Legal Department.			
Protection Against Retaliation	The Company prohibits any Workforce Member from retaliating, intimidating, harassing, threatening or taking adverse action against anyone for raising or helping to resolve an ethics or compliance concern, for reporting suspected or known violations of the law or against the Company Code of Ethics or Compliance Policies and Procedures, or for reporting suspected fraud, waste, or abuse. Individuals should immediately report any retaliation, intimidation, harassment, or threat of any of the foregoing for raising or helping to resolve a compliance concern by contacting the Ethics Help Line at cigna.ethicspoint.com or by telephone: Inside the U.S., call toll-free by dialing 800.472.8348. Outside the U.S., please follow the dialing instructions here. Such reporting may be confidential and anonymous.			
Policy Enforcement	Any member of the Company's Workforce who violates Company Compliance Policies and Procedures, applicable laws or regulations, federal payor, or client compliance requirements, may be subject to disciplinary actions up to and including termination.			
VI. Policy Contacts				
Compliance Department	Ethics@Cigna.com			
VII. Review, Revision and Approval History				
Revision Number	Summary of Revisions	Approved By	Approval(s)	Date
Previous revision and approval history on file				
5	Annual review and updates	Amber Cowan, Sales Administration Lead Analyst	Approval on File	09/28/2022
6	Updated template and branding; definitions	Lara Germony, Operational Risk Advisor	Approval on File	10/5/2023
VIII. Attachments and/or Related Documents				
Procedure				
Agent and Agency Onboarding Maintenance [MCAREC-MCMG-SA-02-005-002]				
Terminations [MCAREC-MCMG-SA-02-005-001]				
Unqualified Agent Broker Process [MCAREC-MCMG-SA-02-005-003]				

⁶ 42 C.F.R. §§ 422.504 (d) and (e), 422.2274(c); 42 C.F.R. §§ 423.505(d) and (e), 423.2274(c).

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I. General Description			
Number:	MCARE-MCMG-01-002	Revision #:	7
Title:	Call Center Communication for Customers with Hearing or Speech Impairment	Distribution:	Internal
Effective Date:	December 19, 2017	Last Review/ Revision Date:	October 3, 2023
Prepared By/ Last Revised By:	Customer Service		
Regulation:	MMCM Ch. 4, § 110.1.1 MCMG §§ 80.1, 30.5 CMS Memo, 2020 Part C and Part D Call Center Monitoring and Guidance for Timeliness and Accuracy and Accessibility Studies, December 20, 2019		
II. Purpose and Scope			
Purpose:	This Policy establishes an effective communication channel for current and prospective customers who have a hearing or speech impairment.		
Scope:	This policy applies to all members of Cigna Healthcare’s Medicare Workforce.		
III. Definitions			
711	National TTY Service for the hearing or speech impaired		
Cigna Healthcare	“Cigna Healthcare” means Cigna Healthcare’s Medicare Advantage, Medicare Advantage-Prescription Drug and Medicare Prescription Drug Plans.		
CMS	“Centers for Medicare and Medicaid Services” means the federal agency responsible for administering the Medicare, Medicare Advantage and Medicare Prescription Drug programs.		
Company	“Company” means Cigna Healthcare’s Medicare business.		
CSR	Customer Service Representative		
TTY	Text Telephone or Teletypewriter		
Workforce	“Workforce” or “Company Workforce” includes all employees, officers, and other agents, such as contract or temporary workers, of the Company.		
IV. Policy			
A. Cigna Healthcare provides a toll-free TTY service for customers with a hearing or speech impairment to speak to a CSR according to the Call Center Operations and Monitoring Policy.			
1. Cigna Healthcare offers TTY services to ensure that all services, both clinical and non-clinical, are accessible to all customers, including those with hearing incapacity. Cigna Healthcare may provide its own toll-free TTY relay device or use a state relay service.			
2. In the event Cigna Healthcare uses an in-house TTY device then:			
a. Cigna Healthcare includes coverage for the TTY device during call center hours of operation, according to the Call Center Operations and Monitoring Policy; and			
b. Cigna Healthcare regularly tests its TTY equipment.			

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- B. Cigna Healthcare monitors the call center and its TTY service to confirm that customers are able to:
1. Reach a CSR directly rather than being directed to a recorded message during call center hours of operation;¹ and
 2. Access a CSR through the TTY service 80% within 7 minutes from the time their call is answered.²
- C. Cigna Healthcare documents customers' records to indicate their use of the TTY service for future reference.
- D. Cigna Healthcare clearly displays TTY number on its website and includes the TTY number in communication materials whenever the customer service number is provided.³

V. Compliance Program Elements

Reporting Violations	Any member of the Company Workforce who suspects or has observed any violation to the Compliance Program or this Policy has an obligation to report the concern and is able to report such violations to his/her manager, the Ethics Help Line, the Ethics Office, the Compliance Department, or a lawyer in the Legal Department.
Protection Against Retaliation	The Company prohibits any Workforce Member from retaliating, intimidating, harassing, threatening or taking adverse action against anyone for raising or helping to resolve an ethics or compliance concern, for reporting suspected or known violations of the law or against the Company Code of Ethics or Compliance Policies and Procedures, or for reporting suspected fraud, waste, or abuse. Individuals should immediately report any retaliation, intimidation, harassment, or threat of any of the foregoing for raising or helping to resolve a compliance concern by contacting the Ethics Help Line at cigna.ethicspoint.com or by telephone: Inside the U.S., call toll-free by dialing 800.472.8348. Outside the U.S., please follow the dialing instructions here. Such reporting may be confidential and anonymous.
Policy Enforcement	Any member of the Company's Workforce who violates Company Compliance Policies and Procedures, applicable laws or regulations, federal payor or client compliance requirements, may be subject to disciplinary actions up to and including termination.

VI. Policy Contacts

Compliance Department	Ethics@Cigna.com
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VII. Review, Revision and Approval History

Revision Number	Summary of Revisions	Approved By	Approval(s)	Date
<i>Previous revision and approval history on file</i>				
6	Annual review and updates	Jarel Jackson, Customer Service Director	Approval on File	09/15/2022
7	Updated template and branding; definitions	Mike Soltis, Customer Service Director	Approval on File	10/03/2023

¹ CMS Memo, 2020 Part C and Part D Call Center Monitoring and Guidance for Timeliness and Accuracy and Accessibility Studies, December 20, 2019.

² MCMG § 80.1, 42 C.F.R. §§ 422.111(h)(1), 423.128(d)(1); CMS Memo, 2020 Part C and Part D Call Center Monitoring and Guidance for Timeliness and Accuracy and Accessibility Studies, December 20, 2019.

³ MCMG § 30.5.

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VIII. Attachments and/or Related Documents

Policy

[Call Center Operations and Monitoring \[MCARE-MCMG-01-001\]](#)

Procedure

[National 711 TTY \[MCARE-MCMG-CS-02-002-001\]](#)

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I. General Description			
Number:	MCARE-MCMG-01-001	Revision #:	10
Title:	Call Center Operations and Monitoring	Distribution:	Internal
Effective Date:	December 19, 2017	Last Review/ Revision Date:	October 3, 2023
Prepared By/ Last Revised By:	Customer Service		
Regulation:	Medicare Communications and Marketing Guidelines § 80.1, 80.1.1, 80.2, 80.3, 80.4, 80.5 42 C.F.R. § 422.111, 423.128 CMS Memo, 2020 Part C and Part D Call Center Monitoring and Guidance for Timeliness and Accuracy and Accessibility Studies, December 20, 2019 National Committee for Quality Assurance 2023 HP Standards and Guidelines (NCQA), Member Experience, ME5D, ME6B and ME6C National Committee for Quality Assurance 2023 HP Standards and Guidelines (NCQA), Utilization Management, UM 3A1, 3A2		
II. Purpose and Scope			
Purpose:	This Policy describes Cigna Healthcare's commitments with respect to the operation and monitoring of its customer and provider call centers.		
Scope:	This policy applies to all members of Cigna Healthcare's Medicare Workforce.		
III. Definitions			
Average Hold Time	Time spent on hold by the caller following the Interactive Voice Response (IVR) system, touch-tone response system, or recorded greeting and before reaching a live person. ¹		
Cigna Healthcare	"Cigna Healthcare" means Cigna Healthcare's Medicare Advantage, Medicare Advantage-Prescription Drug and Medicare Prescription Drug Plans.		
CMS	"Centers for Medicare and Medicaid Services" means the federal agency responsible for administering the Medicare, Medicare Advantage and Medicare Prescription Drug programs.		
Company	"Company" means Cigna Healthcare's Medicare business.		
CSA	Customer Service Advocate		
Disconnected Call	Call that is unexpectedly dropped by Cigna while the caller was navigating the IVR or connected with a Cigna Healthcare CSA and/or tele sales agent. ²		
HPMS	Health Plan Management System – The web-enabled information system CMS uses to collect data from, and issue guidance and support to, Medicare Advantage and Part D plans.		
IVR	Interactive Voice Response - An automated phone system.		
RN	Registered Nurse		

¹ Medicare Communications and Marketing Guidelines (MCMG), § 80.1; 42 C.F.R. §§ 422.111(h)(1), 423.128(d)(1).

² MCMG, § 80.1; 42 C.F.R. §§ 422.111(h)(1), 423.128(d)(1).

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SLA	Service Level Agreement – A contract between Cigna Healthcare and another business that performs services on its behalf. SLAs are reviewed at least annually or as CMS guidance is revised. SLAs between Cigna Healthcare and businesses contracted with to operate call centers or provide customer service to Cigna Healthcare customers contain CMS requirements, including timeframes to perform each of the customer service call related functions and are used to validate their performance.
TTY	Text Telephone, Teletypewriter, or other device that permits a person with a hearing or speech disability to use the telephone system
Workforce	“Workforce” or “Company Workforce” includes all employees, officers, and other agents, such as contract or temporary workers, of the Company.
IV. Policy	
A. Call Centers: Cigna Healthcare operates toll-free call centers for current and prospective customers to speak with a CSA. In addition to responding to general questions, CSA's are available to respond to providers or customers for information related to coverage determinations, including exceptions, prior authorizations and appeals, and to provide immediate access to coverage determination and redetermination processes.³ Cigna Healthcare's pharmacy technical help call center responds to inquiries from pharmacies and providers.⁴ 1. Hours of Operation: a. Customer Call Centers. i. From October 1 through March 31, the customer call center is open at least from 8:00 a.m. to 8:00 p.m. in all service areas served by the Part C plan, except the customer call center may be closed on Thanksgiving Day and Christmas Day so long as the interactive voice response (IVR) system or similar technology records messages from incoming callers and such messages are returned within one (1) business day; and ii. From April 1 through September 30, the customer call center may be closed any Federal holiday, Saturday, or Sunday, so long as the interactive voice response (IVR) system or similar technology records messages from incoming callers and such messages are returned within one (1) business day. iii. Customer Service hours and days of operation must be the same for all individuals regardless of whether they speak English, a non-English language, or use assistive devices for communication.⁵ iv. Cigna Healthcare may use alternative technologies during holidays or weekends, see Section IV.A.2 below for more details. Pharmacy Technical Help Call Center. The Pharmacy Technical Help Call Center operates during the entire period of time in which the Cigna Healthcare network pharmacies are open.⁶ b. In the event Cigna Healthcare operates phone lines dedicated solely to marketing activities, such as sales/enrollment activities, it may operate these phone lines during business hours that are different from those described above, provided all other Call Center requirements are met. 2. Cigna Healthcare may use alternative technologies, which are answering services or voicemail, on Thanksgiving Day, Christmas Day and after hours. From October 1 to March 31 and from April 1 to September 30, Cigna Healthcare may use alternative technologies on Saturdays, Sundays, Federal holidays and after hours to allow a customer to leave a message.⁷ a. In the event Cigna Healthcare uses alternative technologies (e.g., interactive voice response), it ensures the logic does not block calls at certain times based solely upon the area code of the caller. Also, Cigna	

³ MCMG, §§ 80.3, 80.6; 42 C.F.R. §§ 422.111(h)(1), 423.128(d)(1).

⁴ MCMG, § 80.5; 42 C.F.R. § 423.128(d)(1).

⁵ MCMG, § 80.2.

⁶ 42 C.F.R. 423.128(d); MCMG, § 80.

⁷ MCMG, § 80.1.1; 42 C.F.R. §§ 422.111(h)(1), 423.128(d)(1).

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- Healthcare ensures IVR systems default to a live CSA or operator if the caller does not push any buttons or make a verbal selection from an options menu.⁸
- b. Voicemail messages indicate the mailbox is secure and lists the information that must be provided so the case can be worked.
 - c. If a customer leaves a message through alternative technologies, a CSA returns the call in a timely manner, no more than one business day later.⁹
 - d. Member Services staff are not expected to answer clinical questions. Customers may receive a return call from a pharmacist or clinician within 24 hours, or may be transferred directly to a pharmacist or clinician.
- B. **Ability to accept calls:** In the event of technology updates, Cigna Healthcare ensures updates affecting phone systems do not interfere with Cigna Healthcare's ability to accept calls.¹⁰
- C. Cigna Healthcare Call Centers are subject to the following operating standards:¹¹
- 1. Average Hold Time not to exceed 2 minutes;
 - 2. Answer 80% of incoming calls within 30 seconds;
 - 3. Limit the disconnect rate of all incoming calls to 5%;
 - 4. Cigna Healthcare Customer Call Centers:
 - a. Provide interpreter services to non-English speaking and limited English proficient callers according to the [Usage of Language Interpreter Service](#) Policy;
 - i. Cigna Healthcare informs callers that interpreter services are "free" and ensures interpreters are available for 80% of incoming calls within 8 minutes of reaching a CSA or telesales agent.
 - b. Provide TTY service to all hearing impaired callers according to the [Call Center Communication for Customers with Hearing or Speech Impairments](#) Policy;
 - c. Provide written alternate language correspondence (large print, Braille or alternative formats) as needed by the customer.
 - d. Train CSAs to identify and follow the customer complaints process according to the [Part C and D Grievances](#) Policy;
 - e. Cigna Healthcare CSA's provide accurate information according to informational scripts in response to customers inquiries as outlined in Section IV D below;
- D. **Providing Accurate Information:** Cigna Healthcare ensures CSA's receive training on Part C and Part D benefit information for the current and upcoming coverage year (if available); connection of foreign-language callers with an interpreter; review the most recent version of *Medicare & You*, and can accurately respond to customer questions within 7 minutes.
- 1. Cigna Healthcare retains informational scripts and makes them available upon request to CMS. Informational scripts are written in a manner that does not mislead or confuse customers. Informational scripts instruct CSA's to not ask the customer if s/he wants to be transferred to a sales/enrollment department unless the customer explicitly requests to enroll in a plan. Any change in nature of a call from informational to sales/telephonic enrollment clearly informs the customer of the change and are done with the full and active consent of the customer.
 - 2. At a minimum, informational scripts are available to provide responses to inquiries from prospective and current customers regarding the following topics:¹²
 - a. Best Available Evidence (BAE) policy (applicable to Part D Sponsors);

⁸ CMS Memo, 2020 Part C and Part D Call Center Monitoring and Guidance for Timeliness and Accuracy and Accessibility Studies dated December 20, 2016.

⁹ MCMG, §§ 80.1.1; 42 C.F.R. §§ 422.111(h), 423.128(d).

¹⁰ CMS Memo, 2029 Part C and Part D Call Center Monitoring and Guidance for Timeliness and Accuracy and Accessibility Studies dated December 20, 2016.

¹¹ MCMG, §§ 80.1, 80.5; 42 C.F.R. §§ 422.111(h)(1), 423.128(d)(1).

¹² MCMG, § 80.3.

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- b. Request for pre-enrollment information;
 - c. Benefit information; for pharmacy benefits, scripts are updated as of the effective date of a formulary change and as new drugs are made available or are recalled);
 - d. Cost sharing information; (i.e. including but not limited to determine the financial responsibility for a drug, based on pharmacy benefit and determining the benefit and financial responsibility for a specific service or treatment from a specified provider or intuition); Formulary information; (i.e. including but not limited to determine the availability of generic substitutes);
 - e. Pharmacy and provider information, including whether a customer's pharmacy or provider is participating on an in-network basis with Cigna Healthcare;
 - f. Out-of-network coverage;
 - g. Claims submission, processing and payment; answer customer claims questions regarding 1) state in the process, 2) amount approved, 3) the amount paid, 4) the member cost and 5) the date paid in one attempt or contact. The organization meets this requirement via a live-person or automated telephone system providing the information OR a live-person telephone transfer to another person or organization. The organization refrains from providing the member with another number to call, transferring the member to voicemail or into a phone queue.
 - h. Formulary transition process;
 - i. Grievance, organization/coverage determination (including exceptions) and appeals process;
 - j. Information on extra help, including how the beneficiary can obtain extra help;
 - k. Current true out-of-pocket status (TrOOP);
 - l. Information on how to obtain needed forms;
 - m. Information on replacing a customer identification card;
 - n. Service area information;
 - o. Order a refill for an existing, unexpired mail-order prescription;
 - p. Find the location of an in-network pharmacy and conduct a pharmacy proximity search; and
 - q. Determine how and when to obtain referrals and authorizations for specific services.
3. Telephone enrollment scripts are entered in the Health Plan Management System (HPMS) in their entirety. Telephone enrollment scripts:¹³
- a. Follow all the enrollment requirements according to the [Enrollment Process](#) Policy;
 - b. State the customer is requesting enrollment into Cigna Healthcare and the plan type;
 - c. Provide confirmation tracking number or other tracking mechanism;
 - d. Provide a statement that the customer will receive a notice acknowledging receipt of the enrollment; and
 - e. Provide contact information for questions including toll-free telephone and TTY numbers.
- E. **Workforce Planning and Business Continuity:** Cigna Healthcare forecasts call volume using current and historical call trends, plan benefit adjustments, and membership changes to ensure adequate staffing levels to meet forecasted demand. Capacity modeling is based on contact center industry standards. Capacity models are adjusted as needed to meet any changes in demand. Cigna Healthcare staffs CSAs in several locations to ensure business continuity in the event of a disaster or other emergency.
- F. **Accuracy of call center phone numbers:** Cigna Healthcare verifies the accuracy of its call center phone numbers in HPMS and immediately updates any changes according to the [HPMS User Access](#) Policy. This includes the pharmacy technical help desk number, current and prospective phone numbers, and TTY phone numbers.
- G. **Call Center Monitoring:** CMS monitors Cigna Healthcare's compliance with call center standards and issues compliance actions when Cigna Healthcare fails to maintain an average hold time of 2 minutes or less, has an average

¹³ MCMG, § 80.4.

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disconnect rate greater than 5%, has an interpreter availability score lower than 80%, has a TTY service score lower than 80 %, or has a rate of accurately answering questions lower than 80%.¹⁴

1. Cigna Healthcare conducts ongoing quality assurance to ensure call center standards are met.

V. Compliance Program Elements

Reporting Violations	Any member of the Company Workforce who suspects or has observed any violation to the Compliance Program or this Policy has an obligation to report the concern and is able to report such violations to his/her manager, the Ethics Help Line, the Ethics Office, the Compliance Department, or a lawyer in the Legal Department.
Protection Against Retaliation	The Company prohibits any Workforce Member from retaliating, intimidating, harassing, threatening or taking adverse action against anyone for raising or helping to resolve an ethics or compliance concern, for reporting suspected or known violations of the law or against the Company Code of Ethics or Compliance Policies and Procedures, or for reporting suspected fraud, waste, or abuse. Individuals should immediately report any retaliation, intimidation, harassment, or threat of any of the foregoing for raising or helping to resolve a compliance concern by contacting the Ethics Help Line at cigna.ethicspoint.com or by telephone: Inside the U.S., call toll-free by dialing 800.472.8348. Outside the U.S., please follow the dialing instructions here. Such reporting may be confidential and anonymous.
Policy Enforcement	Any member of the Company's Workforce who violates Company Compliance Policies and Procedures, applicable laws or regulations, federal payor or client compliance requirements, may be subject to disciplinary actions up to and including termination.

VI. Policy Contacts

Compliance Department	Ethics@Cigna.com
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VII. Review, Revision and Approval History

Revision Number	Summary of Revisions	Approved By	Approval(s)	Date
Previous revision and approval history on file				
9	Annual review and updates	Jarel Jackson, Customer Service Director	Approval on File	09/15/2022
10	Updated template and branding; definitions; policy detail	Mike Soltis, Customer Service Director	Approval on File	10/03/2023

VIII. Attachments and/or Related Documents

Policy

[Call Center Communication for Customers with Hearing or Speech Impairments \[MCARE-MCMG-01-002\]](#)

[Enrollment Process \[MCARE-ENRDIS-01-006\]](#)

[HPMS User Access \[CIG.GB.016\]](#)

[Part C and D Grievances \[MCARE-CDODAG-01-005\]](#)

[Usage of Language Interpreter Service \[MCARE-MCMG-01-003\]](#)

Procedure

¹⁴ CMS Memo, 2029 Part C and Part D Call Center Monitoring and Guidance for Timeliness and Accuracy and Accessibility Studies dated December 20, 2016.
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[Customer Service Call Center Requirements \[MCAREC-MCMG-CS-02-001-002\]](#)
[External Communication Etiquette \[MCAREC-MCMG-HS-CM-02-001-005\]](#)
[Primary Care Physician Change \[MCARE-MCMG-CS-02-001-004\]](#)
[Sales Call Center Requirements \[MCARE-MCMG-SA-02-001-003\]](#)

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I. General Description			
Number:	MCARE-ENRDIS-01-012	Revision #:	7
Title:	Enrollment Periods	Distribution:	Internal
Effective Date:	September 21 2018	Last Review/ Revision Date:	June 26, 2023
Prepared By/ Last Revised By:	Enrollment & Billing		
Regulation:	42 C.F.R. §§ 422.60, 422.62, 422.66, 422.68, 423.38. Medicare Managed Care Manual Ch. 2 §§ 30, 30.1, 30.2, 30.2.1, 30.3, 30.4.1, 30.4.2, 30.4.3, 30.4.4, 30.4.4.1, 30.4.4.2, 30.4.4.3, 30.4.4.4, 30.4.4.5, 30.4.4.6, 30.4.4.7, 30.4.4.8, 30.4.4.9, 30.4.4.9.A, 30.4.4.9.B, 30.4.4.9.C, 30.4.4.9.D, 30.4.4.10, 30.4.4.11, 30.4.4.12, 30.4.4.13, 30.4.4.14, 30.4.4.15, 30.4.4.16, 30.4.4.17, 30.4.4.20, 30.4.6 and 30.5. Medicare Prescription Drug Benefit Manual Ch. 3 §§ 30, 30.1, 30.2, 30.3.1, 30.3.2, 30.3.3, 30.3.4, 30.3.5, 30.3.6, 30.3.7, 30.3.8, 30.3.8.1, 30.3.8.2, 30.3.8.3, 30.3.8.4, 30.3.8.5, 30.3.8.6, 30.3.8.7, 30.3.8.8, 30.3.8.8.A, 30.3.8.8.C, 30.3.8.8.B, 30.3.8.8.D, 30.3.8.8.E, 30.3.8.8.F, 30.3.8.8.G, 30.3.8.8.H, 30.3.8.8.I, 30.3.8.9, 30.3.8.10, 30.3.8.11, 30.3.8.12, 30.3.8.13, 30.3.8.14, 30.3.8.18, 30.3.8.19, 30.3.13, 30.3.15, 30.3.16, 30.4.5.30.8.14 HPMS Memo 09/20/2017 Emergencies and Major Disasters – Additional Opportunities to Join, Drop or Switch Medicare Health and Prescription Drug Plans & Other Guidance. https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Disaster-Memo-Medicare-SEP.pdf		
II. Purpose and Scope			
Purpose:	This Policy describes the various types of election periods available to MA, MAPD and PDP customers and the requirements for each election period.		
Scope:	This policy applies to all members of the Cigna Healthcare’s Medicare Workforce.		
III. Definitions			
AEP	Annual Enrollment Period for Cigna Healthcare’s Medicare Advantage and Part D plans. During the Annual Enrollment Period, new customers may enroll in a Cigna Healthcare plan and existing customers may switch to another Cigna plan or another sponsor’s plan, or return to Original fee-for-service Medicare. This period is from October 15th – December 7th every year.		
At Risk Beneficiary	A Part D eligible individual who is determined to be at-risk for misuse or abuse of a frequently abused drug in accordance with the requirements for drug management programs.		
Authorized Representative	An individual who is legally permitted to execute an enrollment or disenrollment request on behalf of a customer. Authorized Representatives include court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws.		
Cigna Healthcare	“Cigna Healthcare” means Cigna Healthcare’s Medicare Advantage, Medicare Advantage-Prescription Drug and Medicare Prescription Drug Plans.		

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CMS	"Centers for Medicare and Medicaid Services" means the federal agency responsible for administering the Medicare, Medicare Advantage and Medicare Prescription Drug programs.
Company	"Company" means Cigna Healthcare's Medicare business.
Dual Eligible	An individual who is eligible for benefits under both Medicare and Medicaid.
Effective Date	The date on which a customer's coverage in an MA plan begins or ends. The MA organization must determine the Effective Date of enrollment and disenrollment for all enrollment and disenrollment requests.
EGWP	An Employer Group Waiver Plan (EGWP) is a program established by CMS in which employer and union groups contract with an MA Organization/Part D Sponsor or directly with CMS to provide customized coverage for Medical and/or Medicare Part D prescription drug benefits. All EGWPs must follow all Medicare Part C and D requirements unless explicitly waived or modified by Centers for Medicare and Medicaid Services (CMS). EGWP Plan Benefit Packages are enumerated in the CMS Health Plan Management System (HPMS) with identifiers in the 800s to distinguish them from individual plans offered by PDP sponsors.
Election Period	The time(s) during which an eligible individual may request to enroll in or disenroll from an MA, MAPD or PDP. The type of election period determines the Effective Date of MA, MAPD or PDP coverage as well as the types of enrollment requests allowed.
ESRD	End Stage Renal Disease – A medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life.
ICEP	Initial Coverage Election Period
IEP for Part D	Initial Election Period for Part D
Institutionalized Individual	An individual who resides in an institution, such as a skilled nursing facility (SNF), a nursing facility (NF), an intermediate care facility (ICF) for the intellectually disabled, a psychiatric hospital or unit, a rehabilitation hospital or unit, a long-term care hospital, or a swing-bed hospital.
LIS	Low-Income Subsidy – A premium and cost-share subsidy program available to Deemed Eligible Individuals under the Medicare Part D program.
MA	Medicare Advantage – A plan that offers medical benefits under Medicare Part C.
MA OEP	Medicare Advantage Open Enrollment Period – Effective January 1, 2019, a period where individuals enrolled in a MA plan may elect to enroll in another MA plan or to disenroll to obtain Original Medicare. The OEP is the first 3 months of the year or, for newly eligible MA individuals the first 3 months of being entitled to Medicare Parts A and B. Only 1 change of election during OEP is permitted. An MA individual who chooses to exercise this election may also make a coordinating election to enroll in or disenroll from a PDP.
MAPD	Medicare Advantage Prescription Drug – A Medicare Advantage plan that includes Medicare Part D prescription drug coverage.
OEPI	Open Enrollment Period for Institutionalized Individuals – A continuous period for customers who move into, reside in, or move out of institutions. The OEPI ends two (2) months after the month the customer moves out of the institution.
Original Medicare	Coverage managed by the federal government.

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PACE	Program of All-Inclusive Care for the Elderly – Is a Medicare and Medicaid program that helps people meet health care needs in the community.
PDP	Prescription Drug Plan – Medicare Prescription Drug Plan adds coverage to original Medicare.
Potential At-Risk Beneficiary	A Part D eligible individual who is identified as being potentially at-risk for misuse or abuse of a frequently abused drug in accordance with the requirements for drug management programs.
SEP	Special Election Period – Periods outside of the usual ICEP, IEP, AEP or MA OEP when a customer may elect a plan or change his or her current plan election. Examples of SEP include: The customer has a change of residence, the customer has coverage offered through their employer and the customer qualifies for LIS.
Service Area	Geographic area approved by CMS within which an MA-eligible individual may enroll in a particular MA plan offered by Cigna.
SPAP	State Pharmaceutical Assistance Program – State-run programs that assist low-income seniors and adults with disabilities in paying for their prescription drugs.
Special Needs Individuals	A category of customers that includes: - Medicare and Medicaid (Dual) eligible individuals, and/or - Customers with severe or disabling chronic conditions, as defined by CMS, who are also enrolled in one of Cigna's SNP-MOC Plans.
Star Rating	Ratings on a five-star scale published annually by CMS to allow Medicare customers to compare the quality of Medicare Advantage and Medicare Part D plans.
Workforce	"Workforce" or "Company Workforce" includes all employees, officers and other agents, such as contract or temporary workers, of Company.

IV. Policy

Validating Election Period Eligibility: For Cigna Healthcare to accept an enrollment election, the enrollment request must be made during a valid election period. It is Cigna Healthcare's responsibility to determine the election period of each enrollment request. Cigna Healthcare may contact the prospective customer directly by phone or other communication mechanism to make this determination. Cigna Healthcare validates the applicable election period within seven calendar days of receiving an enrollment request.¹

A. Initial Election Periods: For customers who are newly eligible for Medicare.

- ICEP for Parts A, B and C:** The ICEP is the period during which a customer newly eligible for Medicare may make an initial enrollment request to enroll in a Cigna Healthcare MA plan. This period begins three months immediately before the customer's first entitlement to both Medicare Part A and Part B and ends on the later of:
 - The last day of the month preceding entitlement to both Part A and Part B, or;
 - The last day of the customer's Part B initial enrollment period.

The initial election period for Part B is the seven-month period that begins three months before the month a customer meets the eligibility requirements for Part B and ends three months after the month of eligibility.

Once an ICEP enrollment request is made and enrollment takes effect, the ICEP election has been used.²

- IEP for Part D:** Customers who are becoming eligible for Medicare will have an IEP for Part D that is the seven-month period surrounding Medicare eligibility (same as the IEP for Part B). Customers who are not eligible to enroll in a Part D plan at any time during their IEP for Medicare Part B will have an initial enrollment

¹ Medicare Managed Care Manual (MMCM) Ch. 2 § 30; Medicare Prescription Drug Benefit Manual (MPDBM) Ch. 3, § 30.

² MMCM Ch. 2 § 30.2.

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period for Part D that starts three months before the individual becomes eligible for Part D and ends three months following the month in which the customer becomes eligible for Part D.

Customers eligible for Medicare prior to age 65 (e.g., customers with a qualifying disability) will have another IEP for Part D when they turn 65 years old.

If a Medicare eligibility determination is made retroactively, that customer's eligibility for Part D begins with the month in which the customer receives notification of his/her retroactive eligibility and ends 3 months after the month that notice is received. The Effective Date is generally the first day of the month after Cigna Healthcare receives a completed enrollment request.

CMS provides the Part D eligibility effective date.³

B. AEP: The period each year during which customers may enroll in a new plan.

1. During the AEP, customers may enroll in or disenroll from an MA, MAPD or PDP plan.

The AEP is from October 15 through December 7 of every year.

An EGWP plan may have an "open season" as determined by the employer or union. This may or may not correspond with the AEP. Cigna Healthcare may accept enrollment requests into EGWP plans submitted outside of the AEP.⁴

C. MA OEP: The MA OEP runs from January 1st through March 31st annually. The MA OEP allows customers enrolled in an MA plan, including newly MA-eligible individuals, to make a one-time election to go to another MA plan or Original Medicare.⁵

1. MA OEP eligibility dates:
 - a. For customers enrolled in MA plans as of January 1, the MA OEP occurs from January 1 – March 31.
 - b. For customers who are new to Medicare, and who enrolled into an MA plan during their ICEP, the MA OEP occurs between the month of eligibility for Part A and Part B, through the last day of the third month of eligibility.
 - c. The Effective Date of an election made during the MA OEP is the first day of the month following the receipt of the enrollment request.
2. MA OEP plan options:
 - a. Customers may add or drop Part D coverage during the MA OEP.
 - b. Individuals enrolled in either MAPD or MA-only plans can switch to MAPD, MA-Only or Original Medicare, with or without a stand-alone Part D plan.
3. MA OEP limitations and restrictions:
 - a. The MA OEP is not available to customers enrolled in Medicare Savings Accounts, Cost Plans or PACE plans.
 - b. Customers enrolled in Original Medicare may not join an MA plan during the MA OEP.
 - c. Customers enrolled in Original Medicare may not make changes to their Part D coverage.⁶

D. SEPs:

1. SEPs are periods outside of the usual ICEP, IEP, AEP or MA OEP when customers may select a new plan or change their current plan election. Depending on the nature of the SEP, the customer may:
 - a. Discontinue an enrollment in an MA plan and enroll in Original Medicare;
 - b. Switch from Original Medicare to a Cigna Healthcare plan; or
 - c. Switch from one MA plan to another MA plan.⁷

³ MMCM Ch. 2 § 30.2.1; MPDBM Ch. 3 § 30.1.

⁴ MMCM Ch. 2 § 30.1; MPDBM Ch. 3 § 30.2.

⁵ 42 C.F.R. § 422.62(a)(3); MMCM Ch. 2, § 30.5; MPDBM Ch. 3, § 30.3.8(8)D

⁶ MMCM Ch. 2, § 30.5

⁷ 42 C.F.R. §§ 422.52(b); 423.38(c).

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A customer's eligibility for a SEP provides an opportunity to make an election but does not convey eligibility to enroll in the plan; a customer must also meet all applicable eligibility criteria.

Cigna Healthcare is responsible for determining whether an individual is eligible for a SEP. The exception to this requirement would be for enrollment requests completed or approved by CMS. To make this determination, Cigna Healthcare may need to contact the customer directly. Cigna Healthcare accepts a customer's verbal or written confirmation regarding the conditions that make them eligible for the SEP. Determining eligibility for some SEPs requires that Cigna Healthcare obtain the date on which the customer's circumstances changed (i.e. change in residence, loss of special needs status, etc.). Cigna Healthcare maintains documentation of oral or written information pertaining to the customer's eligibility for the SEP.⁸

2. A SEP for a Change in Residence occurs when an:⁹
 - a. Individual moves outside of a plan's Service Area;
 - b. Incarcerated individual has been released from prison;
 - c. Individual who will have a new MA or PDP available to them as the result of a permanent move; and
 - d. Individual who was not eligible for Part D because she/he had been out of the United States but has now moved back to the United States.

The SEP begins the month before the individual's permanent move or the month the individual notifies their plan of the permanent move and continues for 2 months following the month it began or 2 months following the month of the move, whichever is later.

3. A SEP for a contract violation begins when CMS determines that a violation of the contract has occurred. The length of the SEP depends on whether the individual chooses another plan or enrolls in Original Medicare. If the individual enrolls in Original Medicare, the SEP will end 90 calendar days following disenrollment from the plan.¹⁰
4. A SEP for contract non-renewal or terminations begins December 8 and ends on the last day of February of the following year. If there is a contract termination or a modification or termination of the contract by mutual consent, the SEP begins 2 months before the Effective Date of the termination and ends 1 month following the termination.¹¹
5. SEPs for Exceptional Conditions.
 - a. SEP EGWP. Individuals making an enrollment request into or out of an employer-sponsored MA plan or PDP plan may do so any time the EGWP allows individuals to make changes to their plan choice. This SEP begins when the employer group coverage stops and ends 2 months later. The individual may choose the effective date not sooner than the first of the month following the month in which the election is made and not later than 3 months following the election.¹²
 - b. CMS may establish a SEP for individuals who disenroll in connection with a CMS-imposed sanction. The SEP starts with the imposition of the sanction and ends at the earlier of when the sanction ends or the individual makes an election.¹³
 - c. Individuals enrolled in cost plans that are not renewing their contract have a SEP that begins December 8 and ends the last day of February of the following year.¹⁴
 - d. Individuals may disenroll from an MA MAPD or PDP plan at any time in order to enroll in a PACE plan. The SEP extends for 2 months after the effective date of the disenrollment from the¹⁵

⁸ MMCM Ch. 2 § 3.4; MPDBM Ch. 3, § 30.3.

⁹ 42 C.F.R. §§ 422.62(b)(2); 423.38(c)(13); MMCM Ch. 2 § 30.4.1; MPDBM Ch. 3, § 30.3.1.

¹⁰ 42 C.F.R. §§ 422.62(b)(3); 423.38(c)(8); MMCM Ch. 2, § 30.4.2; MPDBM Ch. 3, § 30.3.3.

¹¹ 42 C.F.R. §§ 422.62(b)(1); 423.38(c)(6); MMCM Ch. 2, § 30.4.3; MPDBM Ch. 3, § 30.3.4.

¹² 42 C.F.R. § 422.62(b)(4); 423.38(c)(11); MMCM Ch. 2, § 30.4.4.1; MPDBM Ch. 3, § 30.3.8.1.

¹³ 42 C.F.R. §§ 422.62(b)(5); 423.38(c)(12); MMCM Ch. 2, § 30.4.4.2; MPDBM Ch. 3, § 30.3.8.2.

¹⁴ 42 C.F.R. §§ 422.62(b)(6); 423.38(c)(13); MMCM Ch. 2, § 30.4.4.3; MPDBM Ch. 3, § 30.3.8.3.

¹⁵ 42 C.F.R. §§ 422.62(b)(7); 423.38(c)(14); MMCM Ch. 2, § 30.4.4.4; MPDBM Ch. 3, § 30.3.8.4.

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- e. Individuals enrolled in a PACE plan may elect an MA, MAPD or PDP during a SEP that runs for 2 months following their disenrollment from the PACE plan.¹⁶
- f. Dual-Eligible Individuals and LIS-Eligible Individuals, other than those individuals who have been identified as At-Risk or Potential At-Risk Beneficiaries, may switch plans once per calendar quarter during a SEP that spans the first 3 calendar quarters of a calendar year.¹⁷
- g. There is a SEP for individuals who dropped a Medigap policy when they enrolled for the first time in an MA Plan, and who are still in a “trial period.” This SEP begins when the individual enrolls in an MA plan and ends 12 months after enrollment or when the individual disenrolls from the MA plan, whichever is earlier.¹⁸
- h. There is a SEP for individuals whose Medicare eligibility determination has been made retroactively have a SEP for MA plans only that begins the month they receive the notice of Medicare eligibility and continues for 2 months after that notice is received.¹⁹
- i. There are SEPs to coordinate with Part C and Part D enrollment periods.
 - i. Involuntary loss of creditable coverage, including a reduction in the level of coverage so that it is no longer creditable, not including any such loss or reduction due to a failure to pay premiums, gives rise to a SEP. The SEP begins with the month an individual is advised of their loss of creditable coverage and ends 2 months after either the loss (or reduction) occurs or the individual receives the notice, whichever is later.²⁰
 - ii. Individuals who are not adequately informed of a loss of creditable coverage, or that they never had creditable coverage, have a SEP to enroll in a Part D plan. This SEP begins the month of CMS approval of this SEP and continues for two additional months following this approval.²¹
 - iii. There is a SEP for individuals whose enrollment or non-enrollment in a Part D plan is erroneous due to an action, inaction or error by a Federal Employee. This SEP begins the month CMS approves the SEP and ends 2 months following the month of approval.²²
 - iv. An individual eligible for an additional Part D IEP, such as an individual currently entitled to Medicare due to a disability and who is attaining age 65, has an MA SEP to coordinate with the additional Part D IEP. This SEP begins and ends concurrently with the additional Part D IEP.²³ (MA Only)
- j. There is a SEP for individuals who lose special needs status. This SEP begins the month the individual’s special needs status changes and ends when he or she makes an enrollment request or three calendar months after the effective date of involuntary disenrollment from the SNP, whichever is earlier.²⁴
- k. Individuals who belong to a qualified SPAP or who lose SPAP eligibility have a SEP that begins either the month the individual loses eligibility or is notified of the loss, whichever is earlier, and ends 2 months after it begins.²⁵
- l. There is a SEP for individuals who gain, lose or have a change in their Dual or LIS-Eligible Status.²⁶ This SEP applies to individuals who:
 - i. Become eligible for any type of assistance from the Title XIX program (including “partial duals” who receive cost sharing assistance under Medicaid) and individuals who qualify for LIS (but who do not receive Medicaid benefits);
 - ii. Lose eligibility for any type of assistance; and

¹⁶ 42 C.F.R. §§ 422.62(b)(7); 423.38(c)(14); MMCM Ch. 2, § 30.4.4.4; MPDBM Ch. 3, § 30.3.8.4.

¹⁷ 42 C.F.R. §423.38(c)(4); MMCM Ch. 2, § 30.4.4.5; MPDBM Ch. 3, § 30.3.2.

¹⁸ 42 C.F.R. §§ 422.62(b)(8); MMCM Ch. 2, § 30.4.4.6; MPDBM Ch. 3, § 30.3.8.8.B.

¹⁹ 42 C.F.R. § 422.62(b)(7); MMCM Ch. 2, § 30.4.4.8.

²⁰ 42 C.F.R. §§ 422.62(b)(19); 423.38(c)(1); MMCM Ch. 2, § 30.4.4.9.A; MPDBM Ch. 3, § 30.3.5.

²¹ 42 C.F.R. §§ 422.62(b)(19); 423.38(c)(2); MMCM Ch. 2 § 30.4.4.9.B; MPDBM Ch. 3, § 30.3.6.

²² 42 C.F.R. §§ 422.62(b)(25); MMCM Ch. 2, § 30.4.4.9.C; MPDBM Ch. 3, § 30.3.7.

²³ 42 C.F.R. §§ 422.62(b)(22); MMCM Ch. 2, § 30.4.4.9.D.

²⁴ 42 C.F.R. §§ 422.62(b)(11); 423.38(c)(27); MMCM Ch. 2, §§ 30.4.4.10; 50.2.5; MPDBM Ch. 3, § 30.3.8.8.E.

²⁵ 42 C.F.R. §§ 422.62(b)(12); 423.38(c)(17); MMCM Ch. 2, § 30.4.4.11; MPDBM Ch. 3, § 30.3.8.9.

²⁶ 42 C.F.R. § 423.38(c)(9); MMCM Ch. 2, § 30.4.4.12; MPDBM Ch. 3, § 30.3.8.7.

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- iii. Have a change in the level of assistance they receive (e.g., stop receiving Medicaid benefits, but still qualify for LIS, those who have a change in cost sharing).

This SEP allows the individual one opportunity to make an election within three months of any of the changes noted above, or notification of such a change, whichever is later.

- m. There is a SEP for enrollment into a Chronic Care SNP and for individuals found ineligible for a Chronic Care SNP. For enrollment into a Chronic Care SNP, the SEP applies for as long as the individual has the qualifying condition and ends once the individual enrolls in a Chronic Care SNP. Individuals found to no longer have a qualifying condition will have an SEP to enroll in a different MAPD plan or an MA only plan with accompanying Part D coverage. This SEP begins the month the individual is notified they no longer qualify for the Chronic Care SNP and ends 2 months after receiving the notice.²⁷
- n. SEP for Disenrollment from Part D to Enroll in or Maintain Other Creditable Coverage.²⁸ Individuals may disenroll from an MAPD or PDP to enroll in or maintain other creditable drug coverage (such as TRICARE or VA coverage).
- o. There is a SEP to enroll in a plan with a 5 Star Rating. Eligible Individuals may enroll in an MA plan, PDP or cost plan with a Plan Performance Rating of 5 stars during the year in which that plan has a 5 star overall rating. Individuals may use the 5-Star SEP to disenroll from a Medicare Advantage plan by enrolling in a 5-Star cost plan that is open for enrollment.²⁹
- p. There is a SEP for non-U.S. Citizens who become lawfully present in this country. This SEP begins the month the individual's lawful presence starts, and it ends the earlier of when the individual makes an enrollment request or two (2) full calendar months after the month it begins.³⁰
- q. CMS may grant a SEP in situations where the plan or CMS is unable to provide required notices or information in an accessible format, as requested by an individual, within the same time that it was able to provide the information to individuals who did not request an accessible format. The start and end date of the SEP depends on the situation.³¹
- r. There may be a SEP for individuals affected by a weather-related emergency or major disaster who were unable to, and did not make an election during another election period. This includes both enrollment and disenrollment elections. The SEP starts as of the date the declaration is made, the incident start date or, if different, the start date identified in the declaration, whichever is earlier. The SEP ends 2 full calendar months following the end date identified in the declaration or, if different, the date the end of the incident is announced, whichever is later.³²
- s. A SEP exists for individuals who are not entitled to premium free Part A and who enroll in Part B during the General Enrollment Period for Part B (January – March) for an effective date of July 1st. The SEP begins April 1 and ends June 30, with an effective date of July 1.³³(Part D Only)
- t. SEP for individuals involuntarily disenrolled from an MAPD plan due to loss of Part B.³⁴ This SEP begins when the individual is advised of the loss of Part B and continues for two months. (Part D Only)
- u. SEP for individuals disenrolling from a cost plan who also had the cost plan optional supplemental Part D benefit. (Part D Only)³⁵ This SEP begins the month the individual requests disenrollment from the cost plan and ends when the individual makes an enrollment election or on the last day of the second month following the month cost plan membership ended.

²⁷ 42 C.F.R. §§ 422.62(b)(13); 423.38(c)(28); MMCM Ch. 2, § 30.4.4.13; MPDBM Ch. 3, § 30.3.8.8.F.

²⁸ 42 C.F.R. §§ 422.62(b)(19); MMCM Ch. 2, § 30.4.4.14; MPDBM Ch. 3, § 30.3.11.

²⁹ 42 C.F.R. §§ 422.62(b)(15); 423.38(c)(20); MMCM Ch. 2, § 30.4.4.15; MPDBM Ch. 3, §§ 30.3.8.8.H.

³⁰ 42 C.F.R. §§ 422.62(b)(16); 423.38(c)(21); MMCM Ch. 2, § 30.4.4.16; MPDBM Ch. 3, § 30.3.13

³¹ 42 C.F.R. §§ 422.62(b)(17); 423.38(c)(22); MMCM Ch. 2, § 30.4.4.17; MPDBM Ch. 3, § 30.3.15.

³² 42 C.F.R. §§ 422.62(b)(18); 423.38(c)(23); MMCM Ch. 3, § 30.4.4.18; MPDBM Ch. 3, § 30.3. 16.

³³ 42 C.F.R. § 423.38(c)(16); MPDBM Ch. 3, § 30.3.8.6.

³⁴ 42 C.F.R. § 423.38(c)(33); MPDBM Ch. 3, § 30.3.8.8.G.

³⁵ 42 C.F.R. § 423.38(c)(29); MPDBM Ch. 3, § 30.3.8.12.

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6. SEPs for Beneficiaries Age 65.³⁶ Individuals who elect an MA plan during the ICEP surrounding their 65th birthday, have a SEP to disenroll from the MA plan during the first 12 months of enrollment. If the individual using the SEP65 is disenrolling from an MAPD plan, the individual may use this Part D SEP to enroll in a PDP plan.
 7. CMS may establish a SEP on a case-by-case basis following a significant change in an MA plan's provider network.³⁷ The SEP begins the month the individual is notified of the network change and continues for two months.
 8. There is a SEP for CMS and State-Initiated Enrollments.³⁸ Individuals who are enrolled in a plan by CMS or a state, e.g. auto-enrollment, have a SEP to disenroll from their plan and enroll in a new plan. The SEP begins when the individual is notified of the enrollment and ends 3 months after the start of coverage.
 9. There is an SEP for individuals enrolled in a plan that is placed into receivership. The SEP begins the month the receivership is effective and continues until the earliest of the when receivership is no longer in effect or when the individual makes an election.³⁹
 10. There is an SEP for individuals enrolled in a plan that is identified with the low performing icon. The SEP exists while the individual is enrolled in the low performing plan.⁴⁰
- E. **OEPI:** The OEPI is continuous for customers who move into, reside in, or moves out of an institution. The OEPI ends two months after the month the customer moves out of the institution.⁴¹
- F. **Effective Date of Enrollment:** Generally, customers may not request their Effective Date of enrollment into Cigna Healthcare. Unless provided for under a SEP (e.g., EGWP or full dual retroactive enrollments), the Effective Date of enrollment can never be prior to the receipt of an enrollment request. An enrollment cannot be effective prior to the date the customer (or their legal representative) completed the enrollment request. The Effective Date also may not be earlier than the first day of the customer's eligibility for Medicare.
- To determine the appropriate effective date, Cigna Healthcare must determine which enrollment period applies to each customer before the enrollment is transmitted to CMS. This period may be determined by reviewing information such as the customer's date of birth, Medicare card, and by the date Cigna Healthcare receives the enrollment request.

V. Compliance Program Elements

Reporting Violations	Any member of the Company Workforce who suspects or has observed any violation to the Compliance Program or this Policy has an obligation to report the concern and is able to report such violations to his/her manager, the Ethics Help Line, the Ethics Office, the Compliance Department, or a lawyer in the Legal Department.
Protection Against Retaliation	The Company prohibits any Workforce Member from retaliating, intimidating, harassing, threatening or taking adverse action against anyone for raising or helping to resolve an ethics or compliance concern, for reporting suspected or known violations of the law or against the Company Code of Ethics or Compliance Policies and Procedures, or for reporting suspected fraud, waste, or abuse. Individuals should immediately report any retaliation, intimidation, harassment, or threat of any of the foregoing for raising or helping to resolve a compliance concern by contacting the Ethics Help Line at cigna.ethicspoint.com or by telephone: Inside the U.S., call toll-free by dialing 800.472.8348. Outside the U.S., please follow the dialing instructions here.

³⁶ 42 CFR 422.62(b)(23); MMCM Ch. 2, § 30.4.5; MPDBM Ch. 3, § 30.3.8.8.A.

³⁷ 42 C.F.R. § 422.62b(23); 42 CFR 423.38(c)(30); MMCM Ch. 2, § 30.4.6; MPDBM Ch. 3, § 30.3.8.8.I.

³⁸ 42 CFR 422.60(g)(5) and 423.38(c)(10); 42 CFR 423.38(c)(10); MMCM Ch. 2, § 30.4.7; MPDBM Ch. 3, §§ 30.3.2, 30.8.14.

³⁹ 42 C.F.R. §§ 422.62(b)(24), 423.68(c)(31) MMCM Ch. 2, § 30.4.4.17; MPDBM Ch. 3, § 30.3.8.19.

⁴⁰ 42 C.F.R. §§ 422.62(b)(25), 423.68(c)(32) MMCM Ch. 2, § 30.4.4.20; MPDBM Ch. 3, § 30.3.8.18.

⁴¹ 42 C.F.R. §§ 422.62(a)(4), 423.68(c)(25); MMCM Ch. 2, § 30.3; MPDBM Ch. 3, § 30.3.8.5D; MPDBM Ch. 3, § 30.3.8.8.C.

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	Such reporting may be confidential and anonymous.			
Policy Enforcement	Any member of the Company's Workforce who violates Company Compliance Policies and Procedures, applicable laws or regulations, federal payor, or client compliance requirements, may be subject to disciplinary actions up to and including termination.			
VI. Policy Contacts				
Compliance Department	Ethics@Cigna.com			
VII. Review, Revision and Approval History				
Revision Number	Summary of Revisions	Approved By	Approval(s)	Date
Previous revision and approval history on file				
6	Annual review and updates	Jessica Purser, Enrollment & Billing Senior Manager	Approval on File	05/27/2021
7	Updated template and branding; definitions	Tina Jackson, Enrollment & Billing Manager	Approval on File	06/26/2023
VIII. Attachments and/or Related Documents				
Procedure				
Election Periods [MCAREC-ENRDIS-MAS-ENR-MAPD-02-012-002]				
Election Periods and Effective Dates [MCAREC-ENRDIS-ENR-AZ-02-012-003]				

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I. General Description			
Number:	MCARE-ENRDIS-01-006	Revision #:	7
Title:	Enrollment Process	Distribution:	Internal
Effective Date:	July 27, 2018	Last Review/ Revision Date:	March 21, 2024
Prepared By/ Last Revised By:	Service Operations		
Regulation:	42 C.F.R. § 407.14, 422.50, 422.60, 422.66, 422.110, 423.32 Medicare Managed Care Manual Ch. 2, §§ 10, 20, 30.3, 30.5, 30.9, 40, 40.2 (A-E)(I)(K), 40.2.2, 40.2.3, 40.2.3, 40.2.4, 40.4.1, 60, 60.3, 60.3.1, 60.3.3, Appendix 3 Medicare Prescription Drug Benefit Manual Ch. 3, § 10, 16b, 20, 30, 40, 40.2 (A-E)(I)(K), 40.2.2, 40.2.3, 40.4.1, 40.4.2, 60.2, Appendix 3		
II. Purpose and Scope			
Purpose:	This Policy describes Cigna Healthcare’s responsibilities when enrolling customers into MA-Only Plans, MAPD and PDP.		
Scope:	This policy applies to all members of the Cigna Healthcare’s Medicare Workforce.		
III. Definitions			
4Rx	Unique identifying data required for Medicare Part D plan claims routing and intended to facilitate real-time billing by pharmacists. 4Rx data include the (1) Rx BIN, (2) Rx PCN, (3) Rx GRP, and (4) Rx ID.		
AEP	Annual Election Period – The annual open enrollment period for Cigna Healthcare’s Medicare Advantage and Medicare Part D plans. During the Annual Election Period, new customers may enroll in a Cigna Healthcare plan and current customers may switch to another Cigna Healthcare Medicare plan or another sponsor’s plan or return to fee-for-service Medicare. This period is from October 15th through December 7th of every year.		
Application Date	The date the enrollment request is initially received by the Cigna Healthcare sponsor, except for requests submitted via the CMS On-line Enrollment Center, requests made into employer or union-sponsored plans, and auto or facilitated enrollments. ¹		
Authorized Representative POA	An individual who is legally permitted to execute an enrollment or disenrollment request on behalf of a customer. Authorized Representatives include court appointed legal guardians, persons having durable power of attorney (POA) for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws.		
Cigna Healthcare	“Cigna Healthcare” means Cigna Healthcare’s Medicare Advantage, Medicare Advantage-Prescription Drug and Medicare Prescription Drug Plans.		
CMS	“Centers for Medicare and Medicaid Services” means the federal agency responsible for administering the Medicare, Medicare Advantage and Medicare Prescription Drug programs.		

¹ Appendix 3 MMCM Ch. 2 or Medicare Prescription Drug Benefit Manual (MPDBM), Ch. 3.

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Company	"Company" means Cigna Healthcare's Medicare business.
Dual Eligible	A customer who is eligible for both Medicare and Medicaid benefits.
Effective Date	The date on which a customer's coverage in an MA plan begins. The MA organization must determine the Effective Date of enrollment for all enrollment requests.
Election	Enrollment in or voluntary disenrollment from a MA, MAPD, or PDP. ²
Election Period	The time(s) during which an eligible individual may request to enroll in or disenroll from an MA, MAPD or PDP. The type of election period determines the Effective Date of MA, MAPD or PDP coverage as well as the types of enrollment requests allowed.
ESRD	End Stage Renal Disease – A medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life.
Incarceration	Refers to the status of an individual who is in the custody of a penal authority and confined to a correctional facility or a mental health institution as a result of a criminal offense. ³
ICEP	Initial Coverage Election Period – The first time a newly eligible potential Cigna Healthcare customer can enroll in a MA only plan or delayed Part B enrollment until after the end of the IEP.
IEP	Initial Enrollment Period – The first time a newly eligible potential Cigna Healthcare customer can enroll in a MAPD or PDP plan.
Institutionalized Individual	An individual who resides in an institution, such as a skilled nursing facility (SNF), a nursing facility (NF), an intermediate care facility for the mentally retarded (ICF/MR), a psychiatric hospital or unit, a rehabilitation hospital or unit, a long-term care hospital, or a swing-bed hospital. ⁴
LIS	Low-Income Subsidy – A premium and cost-share subsidy program under Medicare Part D available to certain individuals who have limited financial resources.
MA	Medicare Advantage - A plan that offers medical benefits under Medicare Part C.
MA OEP	Medicare Advantage Open Enrollment Period – Effective January 1, 2019, a period where individuals enrolled in a MA plan may elect to enroll in another MA plan, an MAPD plan or to disenroll to obtain Original Medicare with or without a stand-alone Part D plan. The OEP is the first 3 months of the year or, for newly eligible MA individuals the first 3 months of being entitled to Medicare Parts A and B. Only 1 change of election during OEP is permitted. ⁵
MAPD	Medicare Advantage Prescription Drug – A Medicare Advantage plan that includes Medicare Part D prescription drug coverage.
MBI	Medicare Beneficiary Identifier
Medicare Medical Savings Account	Medicare Medical Savings Account (MSA) - A type of Medicare Advantage plan that combines a high-deductible health plan with a medical savings account.

² MMCM Ch. 2, § 10; Medicare Prescription Drug Benefit Manual (MPDBM) Ch. 3, § 10.

³ MMCM Ch. 2, § 10; MPDBM Ch. 3, § 10.

⁴ MMCM Ch. 2, § 10; MPDBM Ch. 3, § 10.

⁵ 42 C.F.R. § 422.62(a)(3); MMCM, Ch. 2, § 30.5, MPDBM, Ch. 3, § 30.3.8.8D.

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OEPI	Open Enrollment Period for Institutionalized Individuals - A continuous period for customers who move into, reside in, or move out of institutions. The OEPI ends two (2) months after the month the customer moves out of the institution. ⁶
PDP	Prescription Drug Plan – Medicare Prescription Drug Plan adds coverage to original Medicare.
Receipt of Enrollment Request	Cigna Healthcare may receive enrollment requests through various means (examples: a paper enrollment form, electronic enrollment through an internet website). Cigna Healthcare dates as received all enrollment requests as soon as they are initially received. This date will be used to determine the election period in which the request was made, which in turn will determine the Effective Date of the request. Please refer to the definition of “Application Date” in this section for specific information regarding the correct date to report as the application date on enrollment transactions submitted to CMS.
Reinstatement	An action that may be taken by CMS to correct an erroneous disenrollment from an MA-Only Plan, MAPD or PDP. The reinstatement corrects an individual’s records by canceling a disenrollment to reflect no gap in enrollment in an MA-Only Plan, MAPD or PDP. A reinstatement may result in retroactive disenrollment from another Medicare managed care plan.
SEP	Special Election Period - Periods outside of the usual ICEP, IEP, AEP, or MA OEP when a customer may elect a plan or change his or her current plan election. Examples of SEPs include: the customer has a change of residence, the customer has coverage offered through their employer, and the customer qualifies for LIS.
SSA	Social Security Administration
TRR/DTRR	Transaction Reply Report – A report that details the rejected and accepted enrollment transactions that CMS has processed for a Part D sponsor’s contract(s) over a specified time period.
Workforce	“Workforce” or “Company Workforce” includes all employees, officers and other agents, such as contract or temporary workers, of the Company.
IV. Policy	
A. Receipt of Enrollment Request: Cigna Healthcare accepts all enrollment requests it receives, regardless of whether they are received in a face-to-face interview, by mail, by facsimile or through other mechanisms defined by CMS.⁷ 1. Within 10 calendar days of receipt of the enrollment request, Cigna Healthcare:⁸ a. Provides an acknowledgement notice;⁹ and b. Delivers proof of health insurance coverage, including 4Rx data. c. If necessary, sends a request for additional information noting that the potential customer must respond by the later of: i. The end of the first 3 months of ICEP or within 21 calendar days of receipt of the request for additional information, for enrollment requests received prior to the month of entitlement to Part A and enrollment in Part B;	

⁶ MMCM Ch. 2, § 30.3.

⁷ 42 C.F.R. §§ 422.60(a)(1), 423.32(a) and (b); MMCM Ch. 2, § 40; MPDBM Ch. 3, § 40.

⁸ 42 C.F.R. § 423.32(d); MMCM Ch. 2, § 40; MPDBM Ch. 3, § 40.

⁹ MMCM Ch. 2, § 40, 40.4.1; MPDBM Ch. 3, § 40, 40.4.1. See Appendix 1: Summary of Notice Requirements of the MMCM or MPDBM for template acknowledgement notices.

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- ii. The end of the month in which the enrollment request was received or within 21 calendar days of receipt of the request for additional information, for enrollment requests received during the month of entitlement to Part A and enrollment in Part B or later;
 - iii. December 7 or within 21 calendar days of receipt of the request for additional information, for enrollment requests during AEP; or
 - iv. The end of the month in which the enrollment request was initially received or within 21 calendar days of receipt of the request for additional information, for all other enrollments.¹⁰
- d. A notice of denial, if necessary.
- 2. Prior to the Effective Date of coverage Cigna Healthcare explains to the potential customer¹¹:
 - a. The types of charges for which they would be liable (example: deductibles, premiums and coinsurances);
 - b. The need to disclose and exchange information about the potential customer with CMS;
 - c. That they would be required to use designated health care providers (i.e. the “lock-in requirement”);
 - d. The potential for financial liability if the potential customer uses services which they were not eligible because they were not entitled to Medicare Part A, B, and/or D; and
 - e. The effective date of coverage and how to obtain coverage prior to receiving their ID card (if the card has not been received).
- B. **Who Can Complete an Enrollment Request:** Cigna Healthcare accepts enrollment requests from Medicare eligible individuals¹² or their Authorized Representatives. Cigna Healthcare does not discriminate against prospective customers.¹³
- C. **Completed Election:** Cigna Healthcare considers an enrollment request complete when:¹⁴
 - 1. A paper enrollment form is signed by the prospective customer or her/his Authorized Representative, or an electronic enrollment request is submitted.
 - 2. For MA plans, MAPD plans and PDPs: Cigna Healthcare obtains evidence of eligibility for Medicare Part A and enrollment in Medicare Part B
 - a. From CMS systems; or
 - b. The customer’s Medicare ID card; or
 - c. SSA award letter that shows the customer’s MBI and Effective Date of Part A/B;For SNPs, verification of SNP eligibility is also required.
 - 3. All necessary elements on the form are completed or when the enrollment request mechanism is completed as CMS directs, and when applicable;
 - 4. Cigna Healthcare obtains certification of an Authorized Representative’s authority to make the enrollment request; and
 - 5. As warranted, Cigna Healthcare collects any premium amounts due from customers who were involuntarily disenrolled for failure to pay plan premiums.
- D. **Processing the Enrollment Request:** When processing potential customer enrollment requests:¹⁵
 - 1. Cigna Healthcare verifies:
 - a. Potential customer’s supplied information (e.g. Name spelling, date of birth, Medicare Beneficiary Identifier);¹⁶

¹⁰ MMCM Ch. 2, § 40.2.2; MPDBM Ch. 3, § 40.2.2.

¹¹MMCM Ch. 2, § 40, 40.4.1; MPDBM Ch. 3, § 40, 40.4.1.

¹² MMCM Ch. 2, § 20; MPDBM Ch. 3, § 20; 42 C.F.R. § 422.50.

¹³ 42 C.F.R. § 422.110.

¹⁴ MMCM Ch. 2, § 10; MPDBM Ch. 3, § 10.

¹⁵ MMCM Ch. 2, § 40.2; MPDBM Ch. 3, § 40.2.

¹⁶ MMCM Ch. 2, § 40.2; MPDBM Ch. 3, § 40.2.

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- b. Whether the potential customer resides within Cigna Healthcare's service area.¹⁷
 - c. Medicare entitlement for all enrollment requests except those from a customer enrolled currently in a Cigna Healthcare plan.¹⁸
 2. When possible, Cigna Healthcare notifies its customers of the Effective Date of coverage prior to the Effective Date. For enrollments received late in a month with an Effective Date of the first of the next month, Cigna Healthcare will notify the customer of their Effective Date within 10 calendar days of receipt of the enrollment request.¹⁹
 3. Cigna Healthcare does not ask health screening questions during the completion of an enrollment request and only sends health assessment forms after enrollment.²⁰
 - a. Cigna Healthcare may ask whether a prospective customer is enrolled in *Medicaid*, or is currently admitted to a certified Medicare/Medicaid institution.
 - b. Cigna Healthcare may also ask whether a prospective customer who is attempting to enroll in a Chronic Condition SNP has the eligible condition.
 4. For Medicare Advantage plans, the potential customer acknowledges the rules of the Cigna Healthcare plan by signature and/or initials and signature showing that they understand and will follow the rules of the plan. Cigna Healthcare may decide whether to itemize the rules of its plan for potential customer acknowledgement during the enrollment process. If the rules are itemized, Cigna Healthcare may consider the potential customer's signature on the form and initials next to each statement to signify they have read and understand the statements. Whichever Cigna Healthcare plan is chosen by a potential customer, rules are applied consistently.²¹
 5. For PDP, a signature is required on the enrollment form that the potential customer agreeing to the rules of the Cigna Healthcare plan by signing the form.²²
 6. Cigna Healthcare requires the customer or their Authorized Representative to sign the enrollment request form or complete the enrollment request mechanism. If a Cigna Healthcare representative helps a potential customer complete an enrollment form, the representative must clearly indicate their name on the form. Unless the Cigna Healthcare representative assisted the potential customer with the following:
 - a. Pre-fill the potential customer name, mailing address, or phone number on the form when a potential customer asked the representative to send them an enrollment form
 - b. The representative is writing in the section of the enrollment form that is "office use only."
 - c. The representative is correcting information on the form that was verified with the potential customer.
 7. Cigna Healthcare determines the Application Date based on the method by which the application was submitted.²³
- E. Completed Elections when potential customer previously disenrolled for not paying premiums:**
1. **MA-Only Plan:** Cigna Healthcare may choose to wait for the customer's payment of the plan premium before considering the enrollment request complete.²⁴ Cigna Healthcare cannot consider an enrollment request incomplete if the potential customer has indicated that he or she wants the plan premium withheld from an SSA benefit check.²⁵
 2. **MA-Only and MAPD Plan:** Cigna Healthcare may consider an enrollment request incomplete if there are premium amounts due from a prior enrollment, whether or not premium withholds from an SSA benefit check

¹⁷ MMCM Ch. 2, § 40.2(A); MPDBM Ch. 3, § 40.2(A).

¹⁸ MMCM Ch. 2, § 40.2(B); MPDBM Ch. 3, § 40.2(B).

¹⁹ MMCM Ch. 2, § 40.2(C); MPDBM Ch. 3, § 40.2(C).

²⁰ MMCM Ch. 2, § 40.2(D); MPDBM Ch. 3, § 40.2 (D).

²¹ MMCM Ch. 2, § 40.2(E); MMCM Ch. 16b, § 40.2.1.

²² MPDBM Ch. 3, § 40.2 (E).

²³ MMCM Ch. 2, § 40.2(I); MPDBM Ch. 3, § 40.2 (I); MMCM Ch. 2 and MPDBM Ch. 3; Appendix 3.

²⁴ MMCM Ch. 2, § 10.

²⁵ MMCM Ch. 2, § 40.2(K).

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is selected.²⁶ Whichever option is chosen to consider the application complete or incomplete, it is applied consistently to all potential customers of the plan.

3. **Optional Exception for Dual-Eligible Individuals and Individuals who Qualify for the Low Income Subsidy (Medicare Advantage Plans):** Cigna Healthcare may consider enrollment requests submitted by Dual-Eligible customers and customers who qualify for LIS complete if there are premium amounts due to the organization from a prior enrollment, even if Cigna Healthcare considers such enrollment requests incomplete.²⁷

F. **Enrollment Periods:** Cigna Healthcare accepts enrollment requests and follows CMS rules related to the following Election Periods: AEP, ICEP, OEPI, SEP, MA OEP or IEP. These election rules do not apply to Medicare Medical Savings Account plans, a CMS-approved capacity limit, or a CMS-issued plan enrollment sanction.²⁸

1. Enrollment requests considered complete must be submitted to CMS within seven (7) calendar days of the plan's receipt. If insufficient information has been supplied to determine the Election Period, Cigna Healthcare must attempt to contact the individual, and determine within the seven (7) day requirement if the potential customer is eligible to make an election at that time.²⁹
2. Cigna Healthcare assigns Effective Dates for customers based on the election period.³⁰ To determine the Effective Date of a customer's coverage, Cigna Healthcare determines which election period and Effective Date applies to each customer before the enrollment may be transferred to CMS.³¹
3. Cigna Healthcare does not solicit submission of paper enrollment forms or accept telephone or on-line enrollment requests prior to the beginning of the AEP.³²
 - a. When Cigna Healthcare receives unsolicited paper enrollment forms on or after October 1st but prior to the start of the AEP, it retains and processes the form by;
 - i. Providing the customer with a written notice that acknowledges receipt of the complete enrollment request within 7 calendar days;
 - ii. Indicates that the enrollment takes effect on January 1 of the following year; and
 - iii. Submits a transaction to CMS systems on the first day of the AEP with an "Application Date" of the same date.

G. **Incomplete Enrollment Requests:** Upon receiving an incomplete enrollment request, Cigna Healthcare does not immediately deny the enrollment.³³ Instead, Cigna Healthcare checks CMS systems to see if it can obtain the missing information. If it cannot, Cigna Healthcare notifies the customer that additional information is needed within the time frames specified in Section IV.A.1.iii, above.³⁴ Cigna Healthcare documents all efforts to obtain additional documentation to complete the enrollment request and has an audit trail to document why the enrollment request needed additional documentation before it could be considered complete.

H. **Denial of Enrollment:** Cigna Healthcare denies an enrollment request within 10 calendar days of its receipt, if Cigna Healthcare determines the applicant is not eligible for the selected plan or has not timely provided requested information.³⁵

1. Cigna Healthcare denies enrollment by sending notice of the denial to the individual that includes an explanation of the reason for denial within 10 calendar days of either the Receipt of Enrollment Request or the expiration of the time frame for receipt of requested additional information.³⁶

²⁶ MMCM Ch. 2, § 40.2(K).

²⁷ MMCM Ch. 2, § 40.2(K); MPDBM Ch. 3, § 40.2.2

²⁸ 42 C.F.R. § 422.60(a)(2), 422.66(a); MMCM Ch. 2, § 30, 30.9; MPDBM Ch. 3, § 30.

²⁹ MMCM Ch. 2, § 30; MPDBM Ch. 3, § 30.

³⁰ MMCM Ch. 2, § 40.2(C); MPDBM Ch. 3 § 40.2 (C).

³¹ MMCM Ch. 2, §§ 30.6, 40.2(B); MPDBM Ch. 3, § 30.

³² MMCM Ch. 2, § 40; MPDBM Ch. 3, § 40.

³³ MMCM Ch. 2, § 40.2.

³⁴ MMCM Ch. 2, § 40.2.2; MPDBM Ch. 3, § 40.2.2.

³⁵ MMCM Ch. 2, § 40.2.3; MPDBM Ch. 3, § 40.2.3.

³⁶ MMCM Ch. 2, § 40.2.3; MPDBM Ch. 3, § 40.2.2.

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- I. **Acceptance/Rejection of Enrollment:** Cigna Healthcare notifies the individual of CMS' acceptance or rejection of the enrollment within 10 calendar days of when Cigna Healthcare receives a TRR from CMS indicating whether the customer's enrollment has been accepted or rejected. The enrollment confirmation notice explains the charges for which the prospective customer is liable and any amount that is attributable to the Medicare deductible and coinsurance. For those eligible for the low-income subsidy, the enrollment confirmation notice must specify the limits applicable to the level of subsidy to which the person is entitled.³⁷
1. When Cigna Healthcare rejects an enrollment request and later receives additional information from the customer substantiating their eligibility, Cigna Healthcare obtains a new enrollment request from the customer to be able to enroll the customer, and processes the enrollment with a current Effective Date (not retroactive).
- J. **Reinstatements:** When a disenrolled customer contacts Cigna Healthcare to state that they were disenrolled due to an erroneous death indicator, erroneous loss of Medicare Part A or Part B indicator, or a plan error, and states they want to remain in the plan, Cigna Healthcare instructs the customer in writing to continue to use plan services within 10 calendar days of the customer's contact with Cigna Healthcare to report the erroneous disenrollment.³⁸
1. If a disenrolled customer contacts Cigna Healthcare about disenrollment because of erroneous Incarceration or unlawful presence information, Cigna Healthcare checks CMS' systems to confirm the Incarceration or unlawful presence status has been removed. If the status has been removed, Cigna Healthcare sends a reinstatement request to the CMS Retroactive Processing Center. If it has not, Cigna Healthcare refers the customer to 1-800-MEDICARE.
2. If a disenrolled customer contacts Cigna Healthcare about reinstatements based on customer cancellation of new enrollment, Cigna Healthcare informs the customer that reinstatement is an option only if the customer successfully cancels enrollment in the "new" plan and refers the individual to the "new" plan to inquire about their options.

V. Compliance Program Elements

Reporting Violations	Any member of the Company Workforce who suspects or has observed any violation to the Compliance Program or this Policy has an obligation to report the concern and is able to report such violations to his/her manager, the Ethics Help Line, the Ethics Office, the Compliance Department, or a lawyer in the Legal Department.
Protection Against Retaliation	The Company prohibits any Workforce Member from retaliating, intimidating, harassing, threatening or taking adverse action against anyone for raising or helping to resolve an ethics or compliance concern, for reporting suspected or known violations of the law or against the Company Code of Ethics or Compliance Policies and Procedures, or for reporting suspected fraud, waste, or abuse. Individuals should immediately report any retaliation, intimidation, harassment, or threat of any of the foregoing for raising or helping to resolve a compliance concern by contacting the Ethics Help Line at cigna.ethicspoint.com or by telephone: Inside the U.S., call toll-free by dialing 800.472.8348. Outside the U.S., please follow the dialing instructions here. Such reporting may be confidential and anonymous.
Policy Enforcement	Any member of the Company's Workforce who violates Company Compliance Policies and Procedures, applicable laws, or regulations, federal payor, or client compliance requirements, may be subject to disciplinary actions up to and including termination.

VI. Policy Contacts

³⁷ MMCM Ch. 2, § 40.4.2; MPDBM Ch. 3, § 40.4.2.

³⁸ MMCM Ch. 2, §§ 60.3, 60.3.1, 60.3.3; MPDBM Ch. 3, § 60.2.

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Compliance
Department

Ethics@Cigna.com

VII. Review, Revision and Approval History

Revision Number	Summary of Revisions	Approved By	Approval(s)	Date
Previous revision and approval history on file				
6	Updated template and branding; definitions	Jessica Purser, Enrollment & Billing Senior Manager	Approval on File	06/08/2023
7	Annual review and updates	Tina Jackson, Enrollment & Billing Manager	Approval on File	03/21/2024

VIII. Attachments and/or Related Documents

Procedure

[Benefit Plan Change \[MCAREC-ENRDIS-CE-02-006-017\]](#)
[Cancellation of Enrollment Request \[MCAREC-ENRDIS-MAS-ENR-MAPD-02-006-022\]](#)
[CMS Enrollment and Disenrollment Rejects \[MCAREC-ENRDIS-ENR-AZ-02-006-010\]](#)
[Election Denials \[MCAREC-ENRDIS-ENR-AZ-02-006-014\]](#)
[Eligibility to Enroll in Cigna MA Plans \[MCARE-ENRDIS-ENR-AZ-02-006-013\]](#)
[Employer Subsidy Reject \[MCAREC-ENRDIS-MAS-EEI-02-006-006\]](#)
[Enrollment Procedures \[MCARE-ENRDIS-ENR-AZ-02-006-005\]](#)
[Enrollment Reject Due to Employer or Union Group Coverage \[MCAREC-ENRDIS-ENR-AZ-02-006-025\]](#)
[Incomplete Enrollments \[MCAREC-ENRDIS-ENR-AZ-02-006-004\]](#)
[Receiving the Enrollment Request and Determining Eligibility \[MCAREC-ENRDIS-MAS-ENR-MAPD-02-006-008\]](#)
[Reinstatement Erroneous Disenrollment by Customer \[MCAREC-ENRDIS-CE-02-006-018\]](#)
[Reinstatement Erroneous Loss of Eligibility \[MCAREC-ENRDIS-MAS-EEI-02-006-024\]](#)
[Sales Enrollment Process \[MCARE-ENRDIS-SA-02-006-023\]](#)
[Timeliness of Enrollment Request to Enrollment Department \[MCARE-ENRDIS-SA-02-006-009\]](#)
[Upload Validations to CMS \[MCAREC-ENRDIS-MAS-DCM-02-006-016\]](#)
[Validation of CMS TRR Customer Correspondence \[MCAREC-ENRDIS-ENR-AZ-02-006-015\]](#)

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I. General Description			
Number:	MCARE-ENRDIS-01-013	Revision #:	6
Title:	Format and Sources of Enrollment	Distribution:	Internal
Effective Date:	August 8, 2018	Last Review/ Revision Date:	June 26, 2023
Prepared By/ Last Revised By:	Enrollment & Billing		
Regulation:	42 C.F.R. §§ 407.14, 422.60, 422.66, 422.504, 423.505 Medicare Managed Care Manual Ch. 2, §§ 10, 30, 40, 40.1, 40.1.1, 40.1.2, 40.1.3, 40.1.6, 40.1.6.1, 40.1.7, 40.1.9, 40.2.1, 60.9 Medicare Prescription Drug Benefit Manual Ch. 3, §§ 10, 40, 40.1, 40.1.1, 40.1.2, 40.1.3, 40.1.6, 40.1.7, 40.2.1, 60.8		
II. Purpose and Scope			
Purpose:	This Policy describes how Cigna Healthcare accepts and processes enrollment requests. Refer to the EGWP Enrollment and Disenrollment Policy for employer group requirements.		
Scope:	This policy applies to all members of the Cigna Healthcare's Medicare Workforce.		
III. Definitions			
Authorized Representative	An individual who is legally permitted to execute an enrollment or disenrollment request on behalf of a customer. Authorized Representatives include court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws. ¹		
Cigna Healthcare	“Cigna Healthcare” means Cigna Healthcare’s Medicare Advantage, Medicare Advantage-Prescription Drug and Medicare Prescription Drug Plans.		
CMS	“Centers for Medicare and Medicaid Services” means the federal agency responsible for administering the Medicare, Medicare Advantage and Medicare Prescription Drug programs.		
Company	“Company” means Cigna Healthcare’s Medicare business.		
Direct Bill	A billing arrangement whereby Cigna Healthcare sends invoices for premiums or other amounts due directly to the customer.		
Effective Date	The date on which a customer’s coverage in an MA plan begins or ends. The MA organization must determine the Effective Date of enrollment and disenrollment for all enrollment and disenrollment requests. ²		
Enrollment Mechanism	The method (paper, telephone, or website) used by a prospective customer to enroll in a Medicare plan.		
ICEP	Initial Coverage Election Period		

¹ Medicare Managed Care Manual (MMCM), Ch. 2, § 10; Medicare Prescription Drug Benefit Manual (MPDBM), Ch. 3, § 10.

² MMCM Ch. 2, § 10; MPDBM Ch. 3, § 10.

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LEP	Late Enrollment Penalty - A penalty that Medicare customers may incur if there is a continuous period of 63 days or more at any time after the end of the customer's Part D initial enrollment period during which the customer was eligible to enroll but was not enrolled in a Medicare Part D plan and was not covered under any creditable prescription drug coverage. ³
MA	Medicare Advantage – A plan that offers medical benefits under Medicare Part C.
MAPD	Medicare Advantage Prescription Drug - A Medicare Advantage plan that includes Medicare Part D prescription drug coverage.
PDP	Prescription Drug Plan – A type of plan that offers prescription drug benefits under Part D.
Workforce	"Workforce" or "Company Workforce" includes all employees, officers, and other agents, such as contract or temporary workers, of Company.

IV. Policy

- A. **Paper Enrollment Requests:** Cigna Healthcare has a paper enrollment form that potential customers may use to enroll in an MA plan, MA-PD plan or PDP plan.⁴
- B. **Electronic Enrollment Requests:** Cigna Healthcare offers electronic Enrollment Mechanisms, via an electronic device or secure Internet website. The electronic Enrollment Mechanisms:⁵
1. Provide current and potential customers with all the information required by CMS' Marketing Guidelines for Cigna Healthcare's MA and Part D programs;
 2. Comply with CMS' data security policies;
 3. Advise each customer at the beginning of the electronic enrollment process that they are completing an actual enrollment request to Cigna Healthcare;
 4. Capture the same data as required on the model paper enrollment forms.⁶
 - a. For enrollment requests that involve moving from one Cigna Healthcare plan to another, the data required on the model short enrollment form are sufficient if Cigna Healthcare can verify that the customer is enrolled with Cigna Healthcare at the time the customer submits the enrollment request.
 5. Include a clear and distinct step that requires the customer to confirm their intention to enroll in a plan.
 - a. The electronic Enrollment Mechanism makes clear to the customer that, by taking this action, they agree to the release and authorization language as provided on the model enrollment form, and attest to the truthfulness of the data provided. The process also reminds the customer of the penalty of providing false information.
 6. Capture accurately the time and date when the customer confirms enrollment;
 - a. The time stamp marks the start of the seven-day timeframe for processing the enrollment request.
 7. Include an attestation from any Authorized Representative completing the enrollment request that they have authority to make the enrollment request and that proof of this authority is available upon request by Cigna Healthcare or CMS;
 8. Inform the customer of the effects of completing the electronic enrollment, including that the customer will be enrolled if approved by CMS and that they will receive notice of acceptance or denial following submission of the enrollment request to CMS;
 9. Include a tracking mechanism to provide the individual with evidence that Cigna Healthcare has received the electronic enrollment request;

³ MMCM Ch. 2, § 10.

⁴ MMCM, Ch. 2, § 40.1; MPDBM, Ch. 3, §§ 40, 40.1.1.

⁵ MMCM, Ch. 2 § 40.1.2; MPDBM, Ch. 3, § 40.1.2.

⁶ MMCM, Ch. 2, § 40.1.2; MPDBM Ch. 3, § 40.1.2.

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10. Store electronic records securely and in a manner that enables them to be readily reproduced for later reference;⁷ and
 - a. A data extract file alone is insufficient for this requirement.
 - b. These electronic records are maintained for the current contract period plus ten years.
 11. If Cigna Healthcare obtains services from outside entities to support its electronic Enrollment Mechanisms, Cigna Healthcare works with that entity to ensure its compliance with enrollment policies and that it appropriately handles customer information provided as part of the online enrollment.
- C. **Telephone Enrollment Requests:** Cigna Healthcare may accept requests for enrollment into its MA plans via an incoming telephone call to a plan representative or agent.⁸
1. Cigna Healthcare only accepts enrollment requests during an incoming telephone call from a customer, including inbound calls to an incorrect department or extension transferred internally.
 2. Cigna Healthcare ensures that the telephone enrollment request is effectuated entirely by the customer or their Authorized Representative and that the plan representative, sales agent, or broker is not physically present with the customer or on the phone at the time of the request;
 3. Customers are advised that they are completing an enrollment request;
 4. Each telephonic enrollment request is recorded and includes:
 - a. A statement of the customer's agreement to be recorded,
 - b. All required elements necessary to complete the enrollment, and
 - c. A verbal attestation of the intent to enroll.
 5. All telephonic enrollment recordings are securely stored and readily reproducible for the current contract period plus ten years;⁹
 6. The telephonic enrollment process includes a tracking mechanism to provide the customer with evidence that the telephonic request was received;
 7. Cigna Healthcare provides a notice of acknowledgement and confirmation that the enrollment request was received;
 8. Telephonic enrollment requests from one Cigna Healthcare plan to another may be based on the model short enrollment form or the model plan selection form instead of the comprehensive individual enrollment form; and
 9. Telephonic ICEP enrollment requests from customers enrolled in a Cigna Healthcare non-Medicare plan transitioning to a Cigna Healthcare MA plan without a break in coverage may be based on a simplified opt-in enrollment mechanism.¹⁰
- D. **Acknowledgements:** All Enrollment Mechanisms include the applicant's acknowledgement of:¹¹
1. Understanding of the requirement to have Medicare Part A and B to continue enrollment in a MAPD Plan or be entitled to benefits in Part A or enrolled in Part B to continue enrollment in a PDP;
 2. Agreement to abide by Cigna Healthcare's membership rules, as outlined in member materials;
 3. Consent to the disclosure and exchange of information necessary for the operation of the MA program;
 4. Understanding that the customer can be enrolled in only one Medicare health plan and PDP and that enrollment in Cigna Healthcare's MA plan automatically disenrolls the customer from any other Medicare health plan and PDP; and
 5. Understanding of the right to appeal service and payment denials made by Cigna Healthcare.
- E. **Enrollment Requests Between Cigna Healthcare Plans:** Cigna Healthcare may develop processes to provide seamless enrollment in an MA plan for newly eligible customers who are currently enrolled in other

⁷ 42 C.F.R. §§ 422.60(c)(2), 422.504(e)(4), 423.505(e)(1)(iii); MMCM, Ch. 2, §§ 40.1.2, 60.9; MPDBM, Ch. 3, §§ 40.1.2, 60.8.

⁸ MMCM, Ch. 2, § 40.1.3; MPDBM, Ch. 3, § 40.1.3.

⁹ 42 C.F.R. §§ 422.60(c)(2), 422.504(e)(4), 423.505(e)(1)(iii); MMCM, Ch. 2, §§ 40.1.2, 60.9; MPDBM, Ch. 3, §§ 40.1.2, 60.8.

¹⁰ MMCM, Ch. 2, §§ 40.1.3, 40.1.9.

¹¹ MMCM, Ch. 2, § 40.1.1; MPDBM, Ch. 3, § 40.1.

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health plans offered by Cigna Healthcare. Cigna Healthcare sends proposals to the appropriate Regional Office account manager for approval.¹²

- F. **State Pharmaceutical Assistance Programs:** Cigna Healthcare may accept enrollment requests in an agreed-upon electronic file format from qualified State Pharmaceutical Assistance Programs (SPAPs). If Cigna Healthcare accepts mass enrollment requests from SPAPs, it processes the requests like any other enrollment and according to notification timeframes. To be accepted for Cigna Healthcare processing, the SPAPs:¹³
1. Attest that they have the authority under state law to enroll on behalf of their customers;¹⁴
 2. Coordinate with Cigna Healthcare to provide the required data elements for Cigna Healthcare to process and submit an enrollment request to CMS; and
 3. Provide a notice to their customers before submitting the requests that explains that they are enrolling on their behalf, how the enrollment works with the SPAP, and how customers can decline such enrollment.
- G. **Part D:** For Part D, no PDP enrollment request mechanism, regardless of format, includes any question regarding health screening information.¹⁵
- H. **Premium Payment:** All enrollment request mechanisms include the option for potential customers to be Direct Billed or have the premiums withheld from their Social Security Administration (SSA) benefit check. For all Enrollment Mechanisms, Cigna Healthcare advises potential customers that if they do not select a premium payment option, the default action is Direct Bill.¹⁶
1. MA-only plans that do not have a premium may omit this section from their enrollment request mechanism.
 2. MA-PD Plans that do not have a plan premium still include the direct bill and SSA withhold options for potential customers subject to the LEP to select how they will pay that penalty. Such plans may include language to indicate that the premium payment section applies only to the LEP.
 3. Cigna Healthcare offers all potential customers affiliated with the Railroad Retirement Board (RRB) the option to have their premiums withheld from their RRB retirement payments.¹⁷
 4. MA-PD Plans include on all enrollment request mechanisms a statement in the premium payment section advising those potential customers who qualify for extra help that, if the extra help does not cover the entire plan premium, the potential customer is responsible for the amount that Medicare does not cover.
- I. **Attestations:** When someone other than the customer completes an enrollment or disenrollment request, that person 1) attests to having the authority under state law to do so, 2) confirms that proof of authorization, if any, required by state law empowers the individual to make an enrollment or disenrollment request on behalf of the individual is available and can be provided upon request by CMS, and 3) provides contact information.¹⁸
1. Cigna Healthcare retains the record of this attestation as part of the record of the enrollment or disenrollment request.¹⁹

V. Compliance Program Elements

Reporting Violations	Any member of the Company Workforce who suspects or has observed any violation to the Compliance Program or this Policy has an obligation to report the concern and is able to report
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¹² 42 C.F.R. § 422.66(d).

¹³ MMCM, Ch. 2, § 40.1.7; MPDBM, Ch. 3, § 40.1.7.

¹⁴ MMCM, Ch. 2, §§ 40.1.7, 40.2.1; MPDBM, Ch. 3, §§ 40.1.7, 40.2.1.

¹⁵ MPDBM, Ch. 3, § 40.

¹⁶ MMCM, Ch. 2, § 40.2.M; MPDBM, Ch. 3, § 40.2.L

¹⁷ MMCM, Ch. 2, § 40.2.M; MPDBM, Ch. 3, § 40.2.L.

¹⁸ MMCM, Ch. 2, § 40.2.1; MPDBM, Ch. 3, § 40.2.1.

¹⁹ MMCM, Ch. 2, § 40.2.1; MPDBM, Ch. 3, § 40.2.1.

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	such violations to his/her manager, the Ethics Help Line, the Ethics Office, the Compliance Department, or a lawyer in the Legal Department.			
Protection Against Retaliation	The Company prohibits any Workforce Member from retaliating, intimidating, harassing, threatening or taking adverse action against anyone for raising or helping to resolve an ethics or compliance concern, for reporting suspected or known violations of the law or against the Company Code of Ethics or Compliance Policies and Procedures, or for reporting suspected fraud, waste, or abuse. Individuals should immediately report any retaliation, intimidation, harassment, or threat of any of the foregoing for raising or helping to resolve a compliance concern by contacting the Ethics Help Line at cigna.ethicspoint.com or by telephone: Inside the U.S., call toll-free by dialing 800.472.8348. Outside the U.S., please follow the dialing instructions here. Such reporting may be confidential and anonymous.			
Policy Enforcement	Any member of the Company's Workforce who violates Company Compliance Policies and Procedures, applicable laws or regulations, federal payor or client compliance requirements, may be subject to disciplinary actions up to and including termination.			
VI. Policy Contacts				
Compliance Department	Ethics@Cigna.com			
VII. Review, Revision and Approval History				
Revision Number	Summary of Revisions	Approved By	Approval(s)	Date
Previous revision and approval history on file				
5	Annual review and updates	Tina Jackson, Enrollment & Billing Manager	Approval on File	05/25/2022
6	Updated template and branding; definitions	Tina Jackson, Enrollment & Billing Manager	Approval on file	06/26/2023
VIII. Attachments and/or Related Documents				
Policy				
EGWP Enrollment and Disenrollment [MCARE-EGWP-01-001]				
Procedure				
Downloading CMS Electronic Applications [MCAREC-ENRDIS-ENR-AZ-02-013-001]				
EGWP Eligibility File Testing Process [MCARE-ENRDIS-EG-02-013-003]				
Storage of Enrollment and Disenrollment Records [MCAREC-ENRDIS-MAS-ENR-MAPD-013-002]				

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I. General Description			
Number:	MCARE-MCMG-01-015	Revision #:	4
Title:	General Communications Materials and Activities Requirements	Distribution:	Internal
Effective Date:	September 28, 2021	Last Review/ Revision Date:	January 29, 2024
Prepared By/ Last Revised By:	Medicare Marketing		
Regulation:	42 C.F.R. §§ 422.2260, 422.2262, 422.2263, 423.2260, 423.2262, 423.2263 §§ 1857(i) and 1860D-22(b) of the Social Security Act; 42 C.F.R. §§ 422.2276, 423.458, 423.2276 Medicare Prescription Drug Benefit Manual, Ch. 12 Medicare Managed Care Manual, Ch. 9 Medicare Communications & Marketing Guidelines		
II. Purpose and Scope			
Purpose:	This Policy describes the general principles that govern all Communications related to Cigna Healthcare's Medicare Advantage, Medicare/Medicaid, and Part D Plans, whether conducted by Cigna Healthcare or by an FDR or other person or entity acting on Cigna Healthcare's behalf. This includes the distribution of Communication Materials through the Cigna Healthcare website, targeted at or involving Providers, operation of a call center, or any other Communication. In addition to these general requirements, this Policy supports Cigna Healthcare's compliance with rules governing Communications and Marketing, as described in this Policy and the General Marketing Requirements Policy. ¹		
Scope:	This policy applies to all members of Cigna Healthcare's Medicare Workforce.		
III. Definitions			
Banner	Means a type of advertisement feature typically used in television ads that is intended to be brief, and flashes limited information across a screen for the sole purpose of enticing a prospective enrollee to contact the MA plan (for example, obtain more information) or to alert the viewer that information is forthcoming. ²		
Banner-like	An advertisement that uses a banner-like feature that is typically found in some media other than television (for example, outdoors and on the internet). ³		
Cigna Healthcare	"Cigna Healthcare" means Cigna Healthcare's Medicare Advantage, Medicare Advantage-Prescription Drug and Medicare Prescription Drug Plans.		
CMS	"Centers for Medicare and Medicaid Services" means the federal agency responsible for administering the Medicare, Medicare Advantage and Medicare Prescription Drug programs.		

¹ 42 C.F.R. §§ 422.2262, 422.2263, 423.2262, 423.2263.

² 42 C.F.R. §§ 422.2260, 423.2260.

³ 42 C.F.R. §§ 422.2260, 423.2260.

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Company	"Company" means Cigna Healthcare's Medicare business.
Communications	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. ⁴
D-SNP	Dual Eligible Special Needs Plan - A plan for special needs customer who are eligible for both Medicare and Medicaid.
EGWP	An Employer Group Waiver Plan is a program established by CMS in which employer and union groups contract with an MA Organization/Part D Sponsor or directly with CMS to provide customized coverage for Medical and/or Medicare Part D prescription drug benefits. All EGWPs must follow all Medicare Part C and D requirements unless explicitly waived or modified by Centers for Medicare and Medicaid Services (CMS). EGWP Plan Benefit Packages are enumerated in the CMS Health Plan Management System (HPMS) with identifiers in the 800s to distinguish them from individual plans offered by PDP and MAPD sponsors.
HHS	Health and Human Services Department
Marketing	Communications materials and activities that meet both the following standards for intent and content: - Intended, as determined under paragraph (1)(ii) of this definition, to do any of the following: - Draw a beneficiary's attention to a MA plan or plans. - Influence a beneficiary's decision-making process when making a MA plan selection. - Influence a beneficiary's decision to stay enrolled in a plan (that is, retention-based marketing). - In evaluating the intent of an activity or material, CMS will consider objective information including, but not limited to, the audience of the activity or material, other information communicated by the activity or material, timing, and other context of the activity or material and is not limited to the MA organization's stated intent. - Include or address content regarding any of the following: - The plan's benefits, benefits structure, premiums, or cost sharing. - Measuring or ranking standards (for example, Star Ratings or plan comparisons). (iii) Rewards and incentives as in the Customer Rewards and Incentives Policy.⁵
Outdoor Advertising	Means outdoor material intended to capture the attention of a passing audience (for example, billboards, signs attached to transportation vehicles). Outdoor Advertising may be communications or marketing material.
Secretary	Secretary of Health and Human Services Department
SMID	Standardized Material Identification number
SNP	Special Needs Plan - A type of Medicare Advantage plan specifically designed to provide targeted care and limit enrollment to special needs individuals, including institutionalized individuals, individuals dually eligible for Medicare and Medicaid, and individuals with a severe or disabling chronic condition.

⁴ 42 C.F.R. §§ 422.2260, 422.2260.

⁵ 42 C.F.R. §§ 422.2260, 423.2260.

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Workforce	"Workforce" or "Company Workforce" includes all employees, officers and other agents, such as contract or temporary workers, of the Company.
IV. Policy	
A. General Rules. Cigna Healthcare's Communications activities and materials do not:⁶ 1. Communicate information that is inaccurate or misleading; a. Make unsubstantiated statements, except when used in logos or taglines; b. Engage in activities that could mislead or confuse Medicare beneficiaries or misrepresent Cigna Healthcare; c. Use superlatives unless sources of documentation or data supportive of the superlative is also referenced in the material. d. Include source data older than the prior contract year; e. Engage in any discriminatory activities such cherry-picking; f. Target potential customers based on income levels, unless it involves a DSNP; g. Target potential enrollees based on health status, unless it is a special needs plan; h. State or imply plans are only available to seniors rather than to all Medicare beneficiaries; i. Use plan names that suggest a plan is not available to all Medicare beneficiaries, unless it is a SNP; j. Display names and/or logos of co-branded network providers on a customer's ID card, unless the provider is a member of specific provider organizations chosen by the customer; k. Use a plan name that does not include the type of plan; l. Claim the plan is recommended or endorsed by CMS, HHS, Medicare, or the Secretary; m. State or imply that failure to pay premium will not result in disenrollment, unless true; n. Use the term "free" for zero premium, any reductions in premium, cost-sharing, low-income subsidy, or cost sharing related to dual eligibles. o. Imply the plan is a supplement to Medicare; p. Claim the plan is only available to dual eligibles, unless in fact true; q. Market a plan as a DSNP when it is not; or r. Claim a relationship with Medicaid unless a contract with the state Medicaid agency exists. 2. Cigna Healthcare's Communications activities and materials may:⁷ a. State it has contracted to administer Medicare benefits or is approved to participate in Medicare programs; b. Use "Medicare approved" to describe benefits; and c. Use the word "free" to describe supplemental and preventative benefits that have zero cost share. B. Endorsements and testimonials. 1. Cigna Healthcare may use endorsement and testimonials in television or video, radio, social media, print and other advertisements.⁸ 2. Cigna Healthcare may use individual endorsements/testimonials for its products provided:⁹ a. The individual identifies Cigna Healthcare or its products by name; b. The individual making the endorsement/testimonial was enrolled in a Cigna Healthcare plan at the time;	

⁶ 42 C.F.R. §§ 422.2262(a)(1), 423.2262(a)(1).

⁷ 42 C.F.R. §§ 422.2262(a)(2), 423.2262(a)(2).

⁸ 42 C.F.R. §§ 422.2262(b)(1), 423.2262(b)(1).

⁹ 42 C.F.R. §§ 422.2262(b)(2), 423.2262(b)(2).

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- c. If paid, the endorsement/testimonial must so state; and
- d. If someone other than the individual is used, the endorsement/testimonial must state actor portrayal.
- C. **Requirements when including phone numbers in materials.**¹⁰
 - 1. When the customer service number is included, the hours of operation must be prominently displayed at least once and a toll-free TTY must also be included in the same font size
 - 2. On all materials where 1-800 Medicare or the Medicare TTY number appears, Cigna Healthcare prominently includes 24 hours a day/7 days a week at least once.
 - 3. The requirements listed above do not apply to outdoor, banner or banner like or radio advertisements and sponsorship advertisements.
- D. **SMID.**¹¹ Cigna Healthcare uses a standard method of identification for oversight and tracking of materials.
 - 1. The SMID consists of 3 parts:
 - a. Contract or Multi-Contract Entity (MCE) number (that is, “H” for MA or Section 1876 Cost Plans, “R” for Regional PPO plans (RPPOs), or “Y” for MCE, a means of identification available for Plans/Part D sponsors that have multiple MA contracts) followed by an underscore, except that the SMID for multi-plan marketing materials must begin with the word “MULTI-PLAN” instead of the MA organization’s contract number (for example, H1234_abc123_C or MULTI-PLAN_efg456_M);
 - b. A series of alpha numeric characters (chosen at the MA organization’s discretion) unique to the material followed by an underscore; and
 - c. An uppercase “C” for communications materials or an uppercase “M” for marketing materials (for example, H1234_abc123_C or H5678_efg456_M).
 - 2. The SMID is required on all materials except:
 - a. Membership ID card;
 - b. Envelopes, radio ads, outdoor advertisements, banners, banner-like ads, and social media comments and posts;
 - c. OMB-approved forms/documents, except those materials specified in §422.2267;
 - d. Corporate notices or forms (that is, not MA/Part D specific) meeting the definition of communications (see §422.2260) such as privacy notices and authorization to disclose protected health information (PHI);
 - e. Agent-developed communications materials that are not marketing;
- E. Non-English and alternate format materials, based on previously created materials, may have the same SMID as the material on which they are based. Cigna Healthcare EGWP plans follow all rules in this policy unless explicitly waived by CMS:
- F. For specific guidance regarding these waivers, refer to Chapter 9 of the Medicare Managed Care Manual and Chapter 12 of the Medicare Prescription Drug Benefit Manual and the Medicare Communications & Marketing Guidelines.

V. Compliance Program Elements

Reporting Violations	Any member of the Company Workforce who suspects or has observed any violation to the Compliance Program or this Policy has an obligation to report the concern and is able to report such violations to his/her manager, the Ethics Help Line, the Ethics Office, the Compliance Department, or a lawyer in the Legal Department.
Protection Against Retaliation	The Company prohibits any Workforce Member from retaliating, intimidating, harassing, threatening or taking adverse action against anyone for raising or helping to resolve an ethics or compliance

¹⁰ 42 C.F.R. §§ 422.2262(c), 423.2262(c).

¹¹ 42 C.F.R. §§ 422.2262(d), 423.2262(d).

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	concern, for reporting suspected or known violations of the law or against the Company Code of Ethics or Compliance Policies and Procedures, or for reporting suspected fraud, waste, or abuse. Individuals should immediately report any retaliation, intimidation, harassment, or threat of any of the foregoing for raising or helping to resolve a compliance concern by contacting the Ethics Help Line at cigna.ethicspoint.com or by telephone: Inside the U.S., call toll-free by dialing 800.472.8348. Outside the U.S., please follow the dialing instructions here. Such reporting may be confidential and anonymous.			
Policy Enforcement	Any member of the Company's Workforce who violates Company Compliance Policies and Procedures, applicable laws or regulations, federal payor or client compliance requirements, may be subject to disciplinary actions up to and including termination.			
VI. Policy Contacts				
Compliance Department	Ethics@Cigna.com			
VII. Review, Revision and Approval History				
Revision Number	Summary of Revisions	Approved By	Approval(s)	Date
Previous revision and approval history on file				
3	Updated template and branding, definitions	Lindsay Preach, Segment Marketing, Senior Manager	Approval on File	08/31/2023
4	Annual review	Lindsay Preach, Segment Marketing, Senior Manager	Approval on File	01/29/2024
VIII. Attachments and/or Related Documents				
Policy				
Customer Rewards and Incentives [MCAREC-BEN-01-011]				
General Marketing Requirements [MCARE-MCMG-01-016]				
Procedure				
Employed Agents Conducting Online Presentations [MCARE-MCMG-SA-02-015-004]				
External Agents Brokers Conducting Online Presentations [MCARE-MCMG-SA-02-015-003]				
General Communications and Marketing Requirements and Restrictions [MCARE-MCMG-MK-02-015-001]				
Health Services Material Submission Process [MCARE-MCMG-HS-QL-02-015-002]				

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I. General Description			
Number:	MCARE-MCMG-01-014	Revision #:	8
Title:	Gifts and Promotional Activities for Current and Prospective Customers	Distribution:	Internal
Effective Date:	December 14, 2017	Last Review/ Revision Date:	February 1, 2024
Prepared By/ Last Revised By:	Sales		
Regulation:	42 C.F.R. §§ 422.2263, 422.2274 (f), 423.2263, 423.2274 (f), Medicare Marketing Guidelines (2/9/22)		
II. Purpose and Scope			
Purpose:	This policy describes the rules and restrictions that apply to gifts that Cigna Healthcare may offer or provide to current or prospective customers. This policy does not address Provider incentive arrangements or other financial relationships that Cigna Healthcare may have with Providers or others in a position to refer, recommend, or arrange for another individual's selection of or enrollment in a Cigna Healthcare plan.		
Scope:	This policy applies to all members of Cigna Healthcare's Medicare Workforce.		
III. Definitions			
Cigna Healthcare	"Cigna Healthcare" means Cigna Healthcare's Medicare Advantage, Medicare Advantage-Prescription Drug and Medicare Prescription Drug Plans.		
CMS	"Centers for Medicare and Medicaid Services" means the federal agency responsible for administering the Medicare, Medicare Advantage and Medicare Prescription Drug programs.		
Company	"Company" means Cigna Healthcare's Medicare business.		
Educational Event	An event designed to inform Medicare customers about Medicare Advantage, Medicare Part D, or other Medicare programs. Educational Events are explicitly advertised as "educational," may not include Marketing Activities, and are not held in an in-home or one-on-one setting.		
First Tier, Downstream and Related Entities (FDR)	"First Tier" means any party that enters a written arrangement, acceptable to CMS, with Cigna Healthcare to provide administrative services or health care services to a Medicare-eligible individual under the Medicare Advantage program or Part D program. "Downstream Entity" means any party that enters a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between Cigna Healthcare and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. "Related Entity" means any entity that is related to Cigna Healthcare by common ownership or control and: • Performs some of Cigna Healthcare's management functions under contract or delegation; • Furnishes services to Medicare customers under an oral or written agreement; or		

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	Leases real property or sells materials to Cigna Healthcare at a cost of more than \$2,500 during a contract period.
Marketing Activity	Any activity designed or intended to steer potential customers toward or otherwise promote a plan or limited number of plans, or a plan sponsor, including Marketing Activities directed at Providers. Marketing Activities include Promotional Activities.
Marketing/Sales Appointment	An individual appointment designed to steer or attempt to steer potential customers toward a plan or a limited number of plans. All individual appointments between an agent and a Medicare or Medicaid customer are considered Marketing/Sales Appointments regardless of the content discussed.
Marketing/Sales Event	An event designed to steer or attempt to steer potential customers toward a plan or a limited number of plans.
Nominal Value	An individual item/service worth \$15 or less (based on the retail value of the item/service)
Promotional Activity	Any activity performed by a Cigna Healthcare for Medicare Advantage or Part D plans, or by an individual or organization on behalf of Cigna Healthcare, to inform current and potential customers of the plans available to those enrollees.
Provider (Medicare Advantage and Part D)	- Any individual who is engaged in the delivery of health care services in a state and is licensed or certified by the state to engage in that activity in the state (e.g., a physician or pharmacist); or - Any entity that is engaged in the delivery of health care services in a state and is licensed or certified to deliver those services if such licensing or certification is required by state law or regulation (e.g., a hospital).
Workforce	"Workforce" or "Company Workforce" includes all employees, officers and other agents, such as contract or temporary workers, of the Company.

IV. Policy

A. No Cash, Cash Equivalents, or Rebates

- Cigna Healthcare does not provide gifts in the form of cash, cash equivalents (e.g., check, pre-paid debit card), or rebates to current or prospective customers, whether as an inducement to enroll in a Cigna Healthcare plan or for any other reason.¹
- Cigna Healthcare does not make a charitable donation or provide cash, a cash equivalent, or a rebate to a third party as a substitute for a gift given directly to a customer.
- Cigna Healthcare may provide gift cards or like items as long as the item is not redeemable for cash and meets the requirements for nominal gifts defined below.

B. Restrictions on Meals

- Cigna Healthcare does not provide or pay for meals for current or prospective customers at Marketing/Sales Events, Marketing/Sales Appointments, or for any other purpose primarily related to Marketing Activities, regardless of the value of the meal.²
- Cigna Healthcare may provide refreshments and light snacks at Marketing/Sales Events, but does not combine or present such items in a way that would reasonably be viewed as a meal. In addition, these items meet the requirements for nominal gifts defined below.
- Cigna Healthcare may provide or pay for meals at Educational Events, provided the event meets the definition of an Educational Event and the meal would meet the requirements for nominal gifts defined below.

¹ 42 C.F.R. §§422.2263(b)(1), 423.2263(b)(1).

² 42 C.F.R. §§ 422.2263(b)(3), 423.2263(b)(3).

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C. Promotional Activities and Nominal Gifts

Cigna Healthcare may engage in Promotional Activities to attract the attention of prospective customers or encourage retention of current customers, including by offering gifts of nominal value to current and prospective customers without discrimination. Promotional Activities and gifts are allowed only if they meet the requirements of this section.

1. An individual activity or gift does not exceed \$15 in value, based on the fair market value of the activity or item. If Cigna Healthcare provides an individual with more than one item or participation in more than one activity, the total value of those items and activities and items does not exceed \$75 in a calendar year.
 - a. Cigna Healthcare is required to track and document items or activities provided to current customers to ensure that the \$75 annual limit is not exceeded. Cigna Healthcare is not required to track and document items or activities provided to prospective customers, but does not intentionally structure Promotional Activities or other pre-enrollment activities with the intent to give a person more than \$75 in value per year.
 - b. For items or activities provided to a group of individuals (e.g., a table of refreshments or light snacks at a Marketing/Sales Event), Cigna Healthcare may estimate the per-person value of the item or activity based on attendance. For example, refreshments provided at an event expected to draw 10 attendees has a total value of no more than \$150 (\$15 for each of the 10 attendees). The number of expected attendees need be reasonable based on the type of event, space, and number invited.
2. If Cigna Healthcare offers an item or activity to customers, it offers that item or activity to any prospective or current customer, regardless of whether the prospective customer enrolls or the current customer renews enrollment, and without discrimination against any prospective or current customer.
3. Cigna Healthcare does not tie the gift directly or indirectly to the provision of any other item or service that may be covered under a Cigna Healthcare plan.
4. Cigna Healthcare may occasionally provide a gift at a health fair or other large-scale event through a raffle or drawing, provided that the gift meets the above requirements, and is offered to the general public and not only Medicare eligible individuals.

D. Customer Referral Programs

Cigna Healthcare may ask for referrals from customers, including names and mailing addresses, but cannot request phone numbers or email addresses. Cigna Healthcare uses customer provided referral names and mailing addresses to solicit potential new customers by conventional mail only.

1. Cigna Healthcare may offer items of value to a customer through a customer referral program, provided that the referral program meets the requirements of Cigna Healthcare's [General Marketing Requirements](#) Policy.
2. Items of value provided under a referral program meet the requirements for nominal gifts described above (including the annual maximum of \$100 for a referral into an MA or MAPD plan and \$25 for a referral into a PDP plan per customer), are made be available to all current customers, and are not contingent on the actual enrollment of the person being referred.
3. Cigna Healthcare does not mention the availability of items of value in communications with current customers requesting referrals.

V. Compliance Program Elements

Reporting Violations	Any member of the Company Workforce who suspects or has observed any violation to the Compliance Program or this Policy has an obligation to report the concern and is able to report such violations to his/her manager, the Ethics Help Line, the Ethics Office, the Compliance Department, or a lawyer in the Legal Department.
Protection Against Retaliation	The Company prohibits any Workforce Member from retaliating, intimidating, harassing, threatening or taking adverse action against anyone for raising or helping to resolve an ethics or compliance concern, for reporting suspected or known violations of the law or against the Company Code of Ethics or Compliance Policies and Procedures, or for reporting suspected fraud, waste, or abuse.

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	Individuals should immediately report any retaliation, intimidation, harassment, or threat of any of the foregoing for raising or helping to resolve a compliance concern by contacting the Ethics Help Line at cigna.ethicspoint.com or by telephone: Inside the U.S., call toll-free by dialing 800.472.8348. Outside the U.S., please follow the dialing instructions here . Such reporting may be confidential and anonymous.			
Policy Enforcement	Any member of the Company's Workforce who violates Company Compliance Policies and Procedures, applicable laws or regulations, federal payor or client compliance requirements, may be subject to disciplinary actions up to and including termination.			
VI. Policy Contacts				
Compliance Department	Ethics@Cigna.com			
VII. Review, Revision and Approval History				
Revision Number	Summary of Revisions	Approved By	Approval(s)	Date
Previous revision and approval history on file				
7	Updated template and branding; definitions	Amber Cowan, Sales Administration Lead Analyst	Approval on File	10/03/2023
8	Annual review and updates	Leslie Gordon, Operations Senior Manager	Approval on File	2/1/2024
VIII. Attachments and/or Related Documents				
Policy General Marketing Requirements [MCARE-MCMG-01-016] Procedure Gifts to Medicare Customers [MCARE-MCMG-SA-02-014-001]				

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I. General Description			
Number:	MCARE-MCMG-01-013	Revision #:	9
Title:	Live Interactions with Customers and Prospective Customers	Distribution:	Internal
Effective Date:	August 8, 2017	Last Review/ Revision Date:	June 8, 2023
Prepared By/ Last Revised By:	Sales Operations		
Regulation:	42 C.F.R. §§ 422.2264, 423.2264 Medicare Managed Care Manual, Ch. 2, § 40 Medicare Prescription Drug Benefit Manual, Ch. 3, § 40		
II. Purpose and Scope			
Purpose:	This Policy describes the rules governing live interactions with customers and prospective customers, including telephone conversations and in-person discussions, whether conducted by Cigna Healthcare or by an FDR or other person or entity acting on Cigna Healthcare's behalf.		
Scope:	This policy applies to all members of Cigna Healthcare's Medicare Workforce.		
III. Definitions			
AEP	Annual Enrollment Period for Cigna Healthcare's Medicare Advantage and Part D plans. During the Annual Enrollment Period, new customers may enroll in a Cigna Healthcare plan and existing customers may switch to another Cigna Healthcare plan or another sponsor's plan or return to Original fee-for-service Medicare. This period is from October 15th – December 7th every year.		
Company	"Company" means Cigna Healthcare's Medicare business.		
Cigna Healthcare	"Cigna Healthcare" means Cigna Healthcare's Medicare Advantage, Medicare Advantage-Prescription Drug and Medicare Prescription Drug Plans.		
CMS	"Centers for Medicare and Medicaid Services" means the federal agency responsible for administering the Medicare, Medicare Advantage and Medicare Prescription Drug programs.		
Communications	Activities and uses of materials to provide information to current and prospective customers. All activities and materials aimed at prospective and current customers and their caregivers or other decision makers of a prospective or current customer are Communications.		
Educational Event	An event designed to inform Medicare customers about Medicare Advantage, Medicare Part D, or other Medicare programs. Educational Events are explicitly advertised as "educational," may not include Marketing Activities, and may not be held in an in-home or one-on-one setting.		
First Tier, Downstream and Related Entities (FDR)	"First Tier" means any party that enters into a written arrangement, acceptable to CMS, with Cigna Healthcare to provide administrative services or health care services to a Medicare-eligible individual under the Medicare Advantage program or Part D program. "Downstream Entity" means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between Cigna Healthcare and a First Tier Entity. These written		

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	arrangements continue down to the level of the ultimate provider of both health and administrative services. “Related Entity” means any entity that is related to Cigna Healthcare by common ownership or control and: • Performs some of Cigna Healthcare’s management functions under contract or delegation; • Furnishes services to Medicare customers under an oral or written agreement; or • Leases real property or sells materials to Cigna Healthcare at a cost of more than \$2,500 during a contract period.
HPMS	Health Plan Management System – A web-enabled information system operated by CMS that facilitates data collection and reporting activities and provides support for ongoing operations of enrollment and compliance business functions for Medicare Advantage and Part D Plans.
LIS	Low-Income Subsidy – A premium and cost-share subsidy program available to Deemed Eligible Individuals under the Medicare Part D program.
Marketing	A subset of Communications and includes activities and the use of materials with the intent to draw the attention and influence the customer or prospective customer’s decision to enroll in a plan or to stay in their current plan. Additionally, marketing contains information about the plan’s benefit structure, cost sharing, measuring or ranking standards.
Marketing Materials	Marketing Materials include any informational materials targeted to customers which: • Promote Cigna Healthcare or any Cigna Healthcare plan; • Inform customers that they may enroll in, or remain enrolled in, a Cigna Healthcare plan; • Explain the benefits of enrollment in a Cigna Healthcare plan, or rules that apply to customers; Explain how Medicare services are covered by Cigna Healthcare, including conditions that apply to such coverage.
Marketing/Sales Appointment	An individual appointment designed to steer or attempt to steer potential customers toward a plan or a limited number of plans. All individual appointments between an agent and a Medicare or Medicaid customer are considered Marketing/Sales Appointments regardless of the content discussed.
Marketing/Sales Event	An event designed to steer or attempt to steer potential enrollees toward a plan or a limited number of plans.
Promotional Activity	Any activity performed by Cigna Healthcare, or by an individual or organization on behalf of Cigna Healthcare, to inform current and potential customers of the plans available to them.
TTY	Teletypewriter – A communication device used by people who are deaf, hard-of-hearing, or have severe speech impairment.
Workforce	“Workforce” or “Company Workforce” includes all employees, officers and other agents, such as contract or temporary workers, of the Company.
IV. Policy	
A. No Unsolicited Contact	
Unless specifically permitted by this policy or another Cigna Healthcare policy, Cigna Healthcare does not market Medicare Advantage, Medicare Part D, or Medicare-Medicaid plans through unsolicited direct contacts, including unsolicited live interactions such as unsolicited telephone calls or in-person visits.¹	
B. Telephone Contact with Customers or Prospective Customers	

¹ 42 C.F.R. §§ 422.2264(a), 423.2264(a).

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1. Cigna Healthcare may call its current customers (and Cigna Healthcare agents may call their own clients) at any time to discuss plan business, unless the call is specifically prohibited.²
2. **Prohibited Calls.** The following telephone activities are generally prohibited. However, calls that are normally prohibited under this paragraph may be permitted under specific circumstances described in the permitted calls section described below.³
 - a. Cigna Healthcare does not make unsolicited calls about other business as a means of generating leads for Medicare Advantage or Medicare Part D plans.
 - b. Cigna Healthcare does not call a prospective customer based on a referral from a current customer or other individual.
 - c. Cigna Healthcare does not call former customers who have disenrolled, or a current customer who is in the process of voluntarily disenrolling, for the purpose of marketing plans or products or to request consent to further sales contacts, except as permitted below.
 - d. Cigna Healthcare does not call a prospective customer who attended a sales event, unless the customer gave express permission at the event for a follow-up call, and the permission is documented (e.g., on a business reply card).
 - e. Cigna Healthcare does not call a prospective customer to confirm receipt of mailed information, except as permitted below.
3. **Permitted Calls.** Cigna Healthcare is permitted to make calls to current or prospective customers under the following specific circumstances:
 - a. Current and/or prospective customers:
 - i. The individual has submitted an enrollment application for a Medicare Advantage or Medicare Part D plan, for the purpose of verifying enrollment, conducting quality control, and/or conducting oversight of agents and brokers.⁴
 - ii. The individual has given express permission for Cigna Healthcare or its agent to contact him or her, e.g., by filling out a business reply card, sending an email requesting a return call, asking a customer service representative to have Cigna Healthcare or its agent contact him or her or the customer called or left a message with Cigna Healthcare and Cigna Healthcare is returning the call or message. These calls are made only by the entity from which the individual requested contact, for the duration of the transaction, for the scope of product (e.g., Medicare Advantage or Part D) as discussed or indicated in the individual's request.⁵
 - iii. Cigna Healthcare may call former customers after the disenrollment effective date, for the purpose of conducting disenrollment surveys for quality improvement purposes. Disenrollment surveys do not include sales or marketing information.⁶
 - b. Current customers (but only current customers):
 - i. The individual is a current Cigna Healthcare customer (whether in a Medicare, Medicaid, Medicare Supplement, or other product) and Cigna Healthcare is calling the customer about enrolling in a Medicare Advantage or Part D plan, such as calls to current customers aging into Medicare from commercial procedures or enrolled in MMP plans to discuss enrolling in a Medicare plan.⁷
 - ii. The individual is a current customer in a Medicare Advantage plan, Medicare Part D plan, or Medicare-Medicaid Plan, and Cigna Healthcare is calling: (1) to discuss or provide the customer with general plan information, such as the Annual Enrollment Period dates, availability of flu shots, upcoming plan changes, educational events, or other important plan information; (2) to conduct normal business related to enrollment in a plan, including calls to former customers who have been involuntarily

² 42 C.F.R. §§ 422.2264(b), 423.2264(b).

³ 42 C.F.R. §§ 422.2264(a)(2) and (b), 423.2264(a)(2) and (b).

⁴ 42 C.F.R. §§ 422.2264(b)(1), 423.2264(b)(1).

⁵ 42 C.F.R. §§ 422.2264(a)(3), 423.2264(a)(3).

⁶ 42 C.F.R. §§ 422.2264(a)(2), 423.2264(a)(2).

⁷ 42 C.F.R. §§ 422.2264(b)(1), 423.2264(b)(1).

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- disenrolled to resolve eligibility issues; or (3) to encourage LIS-eligible customers that Cigna Healthcare is prospectively losing due to reassignment, for the purpose of encouraging the customer to remain enrolled in his or her current plan, but only subject to advance approval from the appropriate CMS account manager.⁸
- iii. When contacting customers under this Section 3(b), Cigna Healthcare offers the customer the ability to opt out of future calls on these subjects.⁹
4. **Marketing/Sales Talking Points.** Cigna Healthcare submits all telephone talking points verbatim (bullets are not sufficient) to CMS for review via HPMS according to the [CMS Review of Marketing Materials](#) Policy.
- a. **Hold Messages.** If Cigna Healthcare plays a message when a caller is on hold that promotes Cigna Healthcare's Medicare Advantage or Part D plans or includes benefit information, the message is submitted to CMS for review in accordance with the [CMS Review of Marketing Materials](#) Policy.
5. **Primary Informational Purpose and Informational Talking Points.** The primary purpose of Cigna Healthcare's call center is to provide information to current and prospective customers, not to sell, market, or enroll customers in Cigna Healthcare plans and are conducted according to the [Call Center Operations and Monitoring](#) Policy. Calls to the call center are limited to the purpose of providing information unless the caller requests, on his or her own initiative, to begin the enrollment process.
- a. Informational talking points do not:
- i. Include information about lines of Cigna Healthcare business other than those the caller requested, although they may ask callers if they would like to receive such information;
 - ii. Ask callers whether they want to be transferred to the sales or enrollment departments, unless the caller first expresses interest in enrollment;
 - iii. Request callers' identification numbers (e.g., Social Security number, Medicare number), except as required to verify membership, determine enrollment eligibility, or process an enrollment request; or
 - iv. Use language implying that Cigna Healthcare is recommended or endorsed by or is speaking on behalf of CMS, Medicare, or the U.S. Department of Health and Human Services.
- b. Cigna Healthcare maintains records of all talking points according to the [Global Records Management](#) Policy and makes such records available to CMS upon request.
6. **Enrollment by Telephone.** Enrollment by telephone is limited to inbound calls initiated by customers or prospective customers. If a customer or prospective customer requests enrollment over the telephone via an outbound call, Cigna Healthcare can provide information on how to enroll in the plan telephonically (with a call initiated by the prospective customer) or set-up an in-person appointment for application assistance.
7. **Enrollment Discussion and Enrollment Talking Points.** If the customer requests information about enrollment or asks to enroll in a plan, the call center employee may assist the customer in enrolling or transfer the caller to an appropriate sales/enrollment department. Refer to the [Call Center Operations and Monitoring](#) Policy.
- a. The call center employee clearly informs the caller about and receives the caller's approval to change from an information call to a sales/enrollment call or transfer the caller to the sales/enrollment department.
- b. Telephone talking points used for such sales/enrollment calls are submitted verbatim (talking points or bullets are not sufficient) to CMS for review via HPMS in accordance with the [CMS Review of Marketing Materials](#) Policy.
- c. Telephone talking points used for enrollment: Refer to the [Call Center Operations and Monitoring](#) Policy.
- i. Clearly state that the prospective customer is requesting enrollment into Cigna Healthcare's plan and the plan type;
 - ii. Provide confirmation of having accepted the telephone enrollment request, such as a confirmation tracking number or other tracking mechanism;

⁸ 42 C.F.R. §§ 422.2264(b)(1), 423.2264(b)(1).

⁹ 42 C.F.R. §§ 422.2264(b)(2), 423.2264(b)(2).

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- iii. Provide a statement that the prospective customer will receive a notice acknowledging receipt of the enrollment (e.g., acknowledging request for additional information or denial of enrollment);
- iv. Provide contact information for questions including toll-free telephone and TTY numbers;
- v. Provide a statement that the prospective customer must agree to his or her enrollment request being recorded to proceed with the enrollment by telephone;¹⁰ and
- vi. Abide by Cigna Healthcare's Enrollment Policy.

C. In-Person Contact with Current Customers and Prospective Customers

1. Educational Events

- a. Cigna Healthcare may hold an Educational Event as follows:¹¹
 - i. Must be explicitly advertised as educational;
 - ii. May include communications activities and distribution of communication materials;
 - iii. Does not distribute Marketing Materials, or any other material with plan-specific information (including plan-specific premiums, co-payments, or contact information), except on promotional items as provided below;
 - iv. May answer beneficiary initiated questions even if the information provided in response otherwise would be prohibited;
 - v. May set up a marketing appointment, and distribute business cards and contact information for beneficiaries to initiate contact (this includes completing and collecting a Scope of Appointment (SOA) form); or
 - vi. Distribute promotional items, including those with a plan name, logo, and toll-free customer service number and/or website, provided such items comply with the [Gifts and Promotional Activities for Customers](#) Policy.

2. Marketing/Sales Events and Marketing/Sales Appointments¹²

- a. *Marketing in the Health Care Setting.* If Cigna Healthcare conducts Marketing/Sales Events or Marketing/Sales Appointments in a health care setting, it does so according to the [Marketing with Health Care Providers and in Health Care Settings](#) Policy.
- b. *CMS Approval of Talking points and Presentations.* Cigna Healthcare submits all Sales talking points and presentations to CMS for approval before they are used during the Marketing/Sales Event or Appointment, in accordance with the [CMS Review of Marketing Materials](#) Policy.
- c. *Prohibited Activities.* At Marketing/Sales Events and Marketing/Sales Appointments, Cigna Healthcare does not:¹³
 - i. Conduct health screening or similar activities that could be perceived as “cherry picking” or selecting for healthy or lower cost customers;
 - ii. Require individuals to provide any contact information as a prerequisite for attending the event, including requiring an email address or any other contact information as a condition to RSVP for the event online or through the mail, although Cigna Healthcare may request such information if it clearly indicates that providing it is optional; or,
 - iii. If Cigna Healthcare collects personal contact information for the purpose of conducting a raffle or drawing, use that information for any other purpose.
- d. *Marketing/Sales Appointments*

Cigna Healthcare conducts Marketing/Sales Appointments with an individual customer or prospective customer, provided Cigna Healthcare complies with the following requirements:¹⁴

¹⁰ Medicare Managed Care Manual (MMCM), Ch. 2, § 40.1.3; Medicare Prescription Drug Benefit Manual (MPDBM), Ch. 3, § 40.1.3.

¹¹ 42 C.F.R. §§ 422.2264(c)(1), 423.2264(c)(1).

¹² 42 C.F.R. §§ 422.2264(c)(2), 423.2264(c)(2).

¹³ 42 C.F.R. §§ 422.2264(c)(2)(iii), 423.2264(c)(2)(iii).

¹⁴ 42 C.F.R. §§ 422.2264(c)(3), 423.2264(c)(3).

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	i. The individual requests the Marketing/Sales Appointment and Cigna Healthcare documents the scope of the appointment before the appointment begins. The scope of the appointment lists the individual plans or products, or categories of plans or products (e.g., Medicare Advantage, Medicare Part D), that the individual has agreed to discuss. ii. Cigna Healthcare obtains the customer's agreement to the scope of the appointment in a variety of ways (e.g., by fax, pre-paid envelope, email, telephone call). Documentation of the scope of the agreement is in writing or, if the customer agrees to the scope of the appointment orally, then in a recording of that oral agreement. Documentation includes the date of appointment, the individual's contact information, the written or verbal documentation of the individual's agreement to the scope, the product type(s) agreed to, and agent information (if applicable). iii. As part of the documentation of the appointment, Cigna Healthcare obtains oral or written acknowledgement by the individual that he or she is not obligated to enroll in a plan, that current or future Medicare enrollment status is not affected by his or her decision about whether to enroll, and that he or she is not automatically enrolled in the plan(s) discussed. If acknowledgement is given orally, Cigna Healthcare documents that oral acknowledgement in writing. iv. If an individual visits a Cigna Healthcare location or an agent or broker of Cigna Healthcare on his or her own initiative, Cigna Healthcare documents, as described above, the scope of the appointment as described by the individual before discussing any Medicare Advantage, Part D, or other Medicare plan or product. v. At the appointment, Cigna Healthcare does not discuss or market any health care related product or plan that is beyond the scope of the appointment. If the individual indicates interest in a product or plan beyond the original scope of the appointment, Cigna Healthcare documents a second scope of the appointment (following the requirements above) for the additional product or plan before discussing or marketing that product or plan. vi. At a sales or marketing appointment, Cigna Healthcare does not market non-health care related products (e.g., annuities, life insurance), ask the individual for referrals, or solicit or accept an enrollment application for a January 1 effective date before the start of the AEP, unless the individual is entitled to a separate enrollment period. 3. <i>Documentation of Educational Events and Marketing/Sales Events.</i> Cigna Healthcare keeps accurate records of all Educational Events and Marketing/Sales Events, and such records are made available to CMS upon request. This requirement does not apply to Marketing/Sales Appointments.
V. Compliance Program Elements	
Reporting Violations	Any member of the Company Workforce who suspects or has observed any violation to the Compliance Program or this Policy has an obligation to report the concern and is able to report such violations to his/her manager, the Ethics Help Line, the Ethics Office, the Compliance Department, or a lawyer in the Legal Department.
Protection Against Retaliation	The Company prohibits any Workforce Member from retaliating, intimidating, harassing, threatening or taking adverse action against anyone for raising or helping to resolve an ethics or compliance concern, for reporting suspected or known violations of the law or against the Company Code of Ethics or Compliance Policies and Procedures, or for reporting suspected fraud, waste, or abuse. Individuals should immediately report any retaliation, intimidation, harassment, or threat of any of the foregoing for raising or helping to resolve a compliance concern by contacting the Ethics Help Line at cigna.ethicspoint.com or by telephone: Inside the U.S., call toll-free by dialing 800.472.8348. Outside the U.S., please follow the dialing instructions here. Such reporting may be confidential and anonymous.

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Policy Enforcement	Any member of the Company's Workforce who violates Company Compliance Policies and Procedures, applicable laws or regulations, federal payor or client compliance requirements, may be subject to disciplinary actions up to and including termination.			
VI. Policy Contacts				
Compliance Department	Ethics@Cigna.com			
VII. Review, Revision and Approval History				
Revision Number	Summary of Revisions	Approved By	Approval(s)	Date
Previous revision and approval history on file				
8	Annual review and updates	Amber Cowan, Sales Administration Lead Analyst	Approval on File	11/15/2022
9	Updated template and branding; definitions	Amber Cowan, Sales Administration Lead Analyst	Approval on File	06/08/2023
VIII. Attachments and/or Related Documents				
Policy				
Call Center Operations and Monitoring [MCARE-MCMG-01-001]				
CMS Review of Marketing Materials [MCARE-MCMG-01-010]				
Gifts and Promotional Activities for Customers [MCARE-MCMG-01-014]				
Global Records Management [CIG.RM.001]				
Marketing with Health Care Providers and in Health Care Settings [MCARE-MCMG-01-012]				
Procedure				
Activities That Do Not Require the Use of State-licensed Benefit Advisors Telesales Agents [MCARE-MCMG-SA-02-013-011]				
Ad-hoc Customer Communication Requests [MCAREC-MCMG-CE-02-013-009]				
CS Department Email Handling Process [MCARE-MCMG-CS-02-013-008]				
Educational Events [MCAREC-MCMG-SA-02-013-002]				
Marketing_Sales Events [MCAREC-MCMG-SA-02-013-006]				
Requirements for Sales Enrollment Scripts [MCARE-MCMG-SA-02-013-003]				
Requirements for Telephonic Sales Scripts Pre-sale Inbound or Outbound [MCARE-MCMG-SA-02-013-010]				
Scope of Appointment [MCARE-MCMG-SA-02-013-001]				
Telephonic Contact [MCARE-MCMG-SA-02-013-004]				
Unable to Reach [MCAREC-MCMG-HS-CM-02-013-013]				
Unsolicited E-mail and Marketing Through Unsolicited Contacts [MCMG-SA-02-013-007]				

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I. General Description			
Number:	MCARE-MCMG-01-012	Revision #:	9
Title:	Marketing with Health Care Providers and in Health Care Settings	Distribution:	Internal
Effective Date:	December 14, 2017	Last Review/ Revision Date:	January 30, 2024
Prepared By/ Last Revised By:	Marketing		
Regulation:	Medicare Communications and Marketing Guidelines 42 C.F.R. §§ 422.2266, 422.2267, 423.2266, 423.2267		
II. Purpose and Scope			
Purpose:	This Policy describes the rules governing marketing that involves Providers or that take place in a Health Care Setting, whether conducted by Cigna Healthcare or by an FDR or other person or entity acting on Cigna Healthcare's behalf. If Marketing also involves live interactions with customers or prospective customers, then Cigna Healthcare also complies with the requirements of the Live Interactions with Customers and Prospective Customers Policy .		
Scope:	This policy applies to all members of Cigna Healthcare's Medicare Workforce.		
III. Definitions			
Cigna Healthcare	"Cigna Healthcare" means Cigna Healthcare's Medicare Advantage, Medicare Advantage-Prescription Drug and Medicare Prescription Drug Plans.		
CMS	"Centers for Medicare and Medicaid Services" means the federal agency responsible for administering the Medicare, Medicare Advantage and Medicare Prescription Drug programs.		
Company	"Company" means Cigna Healthcare's Medicare business.		
Workforce	"Workforce" or "Company Workforce" includes all employees, officers, and other agents, such as contract or temporary workers, of the Company.		
IV. Policy			
A. Marketing Involving Providers. When Cigna Healthcare engages in Marketing that involves Providers (whether or not these Marketing Activities take place in a Health Care Setting) it complies with the following requirements:			
1. <i>Provider Initiated Activities.</i> ¹			
a. Permissible Provider Initiated Activities:			
i. Distributing unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the "Medicare & You" handbook, or "Medicare Options Compare" (from https://www.medicare.gov), including in areas where care is delivered;			
ii. Providing the names of MA organizations with which they contract or participate or both;			

¹ 42 C.F.R. §§ 422.2266(c), 423.2266(c).

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- iii. Answering questions or discussing the merits of a MA plan or plans, including cost sharing and benefit information, including in areas where care is delivered;
- iv. Referring patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, State Medicaid Office, local Social Security Offices, CMS' website at <https://www.medicare.gov> or 1-800-MEDICARE;
- v. Referring patients to MA plan marketing materials available in common areas;
- vi. Providing information and assistance in applying for the LIS; and
- vii. Announcing new or continuing affiliations with MA organizations, once a contractual agreement is signed. Announcements may be made through any means of distribution.
 - (a) Any Provider affiliation announcement materials that describe plan benefits, premiums, or cost-sharing are submitted through HPMS according to Cigna Healthcare's [CMS Review of Marketing Materials](#) Policy.

2. *Cigna Healthcare Initiated Provider Activities.*²

- a. Prohibited Cigna Healthcare Initiated Provider Activities:
 - i. Offering forms for individuals to use in requesting a Marketing/Sales Appointment or setting the scope of such an appointment;
 - ii. Accepting Medicare enrollment applications;
 - iii. Calling, directing, urging or attempting to persuade individuals to enroll in a specific plan based on financial or any other interests of the Provider;
 - iv. Mail marketing materials on behalf of the Cigna Healthcare;
 - v. Offer inducements to persuade patients to enroll in a particular Cigna Healthcare plan;
 - vi. Conduct health screenings as a marketing activity;
 - vii. Distribute marketing materials or enrollment forms in areas where care is being delivered;
 - viii. Offer anything of value to induce enrollees to select the provider; or
 - ix. Accept compensation from Cigna Healthcare for any marketing or enrollment activities.
- b. Permitted Cigna Healthcare Initiated Provider Activities:³
 - i. Make available, distribute, and display communications materials, including in areas where care is being delivered; and
 - ii. Provide or make available marketing materials and enrollment forms in common areas.

(NOTE: Any Cigna Healthcare marketing materials that are available in common areas are subject to a CMS 45-day review.)

3. *Provider Co-Branding.* If Cigna Healthcare conducts Marketing Activities that involve Co-Branding with Providers, then Cigna Healthcare complies with the following.

- a. Cigna Healthcare includes the required disclaimer language on any Marketing Materials advertising the Co-Branding relationship, as described in Cigna Healthcare's [General Communications Materials and Activities Requirements](#) Policy.
- b. Cigna Healthcare does not display the names and/or logos of Co-Branded Providers on a Medicare Advantage or Medicare Advantage-Part D plan's member ID card, unless the Provider's name or logo is related to a member's selection of a specific Provider. Cigna Healthcare does not display the name or logo of Co-Branded Providers on a Part D plan's member ID card under any circumstances.⁴

² 42 C.F.R. §§ 422.2266(d)(1), 423.2266(d)(1).

³ 42 C.F.R. §§ 422.2266(d)(2), 423.2266(d)(2).

⁴ MCMG Disclaimers (CMS doesn't use numbers for section numbers, so I changed it to the name of the section).

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- B. **Marketing in a Health Care Setting.** When Cigna Healthcare conducts Marketing Activities in a Health Care Setting, it complies with the following rules:⁵
1. Within a Health Care Setting, Cigna Healthcare conducts Marketing Activities only in common areas, such as common entryways, vestibules, hospital or nursing home cafeterias; community, recreational, or conference rooms; or any other space outside of where individuals wait for services from or interact with Providers.
 2. Cigna Healthcare does not conduct Marketing Activities, including distribution of Marketing Materials, in areas used primarily for individuals to receive health care services or wait to receive health care items or services, including but not limited to the following:
 - a. Waiting rooms;
 - b. Exam rooms;
 - c. Hospital patient rooms;
 - d. Dialysis center treatment areas (i.e., where individuals interact with their clinical team and receive treatment); and
 - e. Pharmacy counter areas (i.e., where individuals interact with pharmacy staff and obtain medications).
 3. The rules above apply whether the activities are to occur during or outside of normal business hours.
 4. Cigna Healthcare schedules and conducts Marketing/Sales Appointments with individuals residing in long-term care facilities, such as a nursing home or assisted living facility, only upon request by the individual.

V. Compliance Program Elements

Reporting Violations	Any member of the Company Workforce who suspects or has observed any violation to the Compliance Program or this Policy has an obligation to report the concern and is able to report such violations to his/her manager, the Ethics Help Line, the Ethics Office, the Compliance Department, or a lawyer in the Legal Department.
Protection Against Retaliation	The Company prohibits any Workforce Member from retaliating, intimidating, harassing, threatening or taking adverse action against anyone for raising or helping to resolve an ethics or compliance concern, for reporting suspected or known violations of the law or against the Company Code of Ethics or Compliance Policies and Procedures, or for reporting suspected fraud, waste, or abuse. Individuals should immediately report any retaliation, intimidation, harassment, or threat of any of the foregoing for raising or helping to resolve a compliance concern by contacting the Ethics Help Line at cigna.ethicspoint.com or by telephone: Inside the U.S., call toll-free by dialing 800.472.8348. Outside the U.S., please follow the dialing instructions here. Such reporting may be confidential and anonymous.
Policy Enforcement	Any member of the Company's Workforce who violates Company Compliance Policies and Procedures, applicable laws or regulations, federal payor or client compliance requirements, may be subject to disciplinary actions up to and including termination.

VI. Policy Contacts

Compliance Department	Ethics@Cigna.com
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VII. Review, Revision and Approval History

Revision Number	Summary of Revisions	Approved By	Approval(s)	Date
Previous revision and approval history on file				

⁵ 42 C.F.R. §§ 422.2266(a) and (b), 423.2266(a) and (b).

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8	Updated template and branding; definitions	Lindsay Preach, Segment Marketing Senior Manager	Approval on File	10/4/2023
9	Annual review	Lindsay Preach, Segment Marketing Senior Manager	Approval on File	01/29/2024

VIII. Attachments and/or Related Documents

Policy

[CMS Review of Marketing Materials \[MCARE-MCMG-01-010\]](#)

[General Communications Materials and Activities Requirements \[MCARE-MCMG-01-015\]](#)

[Live Interactions with Customers and Prospective Customers \[MCARE-MCMG-01-013\]](#)

Procedure

[No Engagement in Activities Which Mislead, Confuse or Misrepresent \[MCAREC-MCMG-NO-02-012-001\]](#)

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I. General Description			
Number:	MCARE-MCMG-01-003	Revision #:	7
Title:	Usage of the Language Interpreter	Distribution:	Internal
Effective Date:	December 19, 2017	Last Review/ Revision Date:	October 3, 2023
Prepared By/ Last Revised By:	Customer Service		
Regulation:	42 C.F.R. §§ 422.111, 423.128 Medicare Managed Care Manual Ch. 4, § 110.1.1 Medicare Communications and Marketing Guidelines §§ 30.3, 80.1 CMS Memo, 2020 Part C and Part D Call Center Monitoring and Guidance for Timeliness and Accuracy and Accessibility Studies, December 20, 2019		
II. Purpose and Scope			
Purpose:	This Policy addresses customer service call center requirements for providing access to interpreter services for non-English speaking or limited English proficient customers.		
Scope:	This policy applies to all members of Cigna Healthcare’s Medicare Workforce.		
III. Definitions			
Cigna Healthcare	“Cigna Healthcare” means Cigna Healthcare’s Medicare Advantage, Medicare Advantage-Prescription Drug and Medicare Prescription Drug Plans.		
CMS	“Centers for Medicare and Medicaid Services” means the federal agency responsible for administering the Medicare, Medicare Advantage and Medicare Prescription Drug programs.		
Company	“Company” means Cigna Healthcare’s Medicare business.		
CSR	Customer Service Representative		
Workforce	“Workforce” or “Company Workforce” includes all employees, officers, and other agents, such as contract or temporary workers, of the Company.		
IV. Policy			
A. Cigna Healthcare provides language interpreter services to call center personnel to answer questions from non-English speaking and limited English proficient customers. ¹ 1. Cigna Healthcare uses a language interpreter service that is familiar with healthcare terms and Medicare benefit concepts. ² 2. Cigna Healthcare utilizes an interpretation service to identify the customer’s language. ³ B. Cigna Healthcare CSRs are trained to:			

¹ Medicare Communications and Marketing Guidelines (MCMG) § 30.3; MCMG Ch. 4, § 110.1.1; 42 C.F.R. §§ 422.111(h)(1), 423.128(d)(1).

² CMS Memo, 2020 Part C and Part D Call Center Monitoring and Guidance for Timeliness and Accuracy and Accessibility Studies, December 20, 2019.

³ CMS Memo, 2020 Part C and Part D Call Center Monitoring and Guidance for Timeliness and Accuracy and Accessibility Studies, December 20, 2019.

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1. Ensure language interpreters are available within 8 minutes of reaching the CSR;⁴ 2. Transfer calls to the language vendor to identify the appropriate interpreter, if the CSR does not know the language the customer needs;⁵ 3. Remain on the line when a foreign-language interpreter joins the call;⁶ and 4. Inform the customer that interpreter services are free.⁷ C. CSRs document the customer's record with the customer's preferred language to use for future contact.⁸				
V. Compliance Program Elements				
Reporting Violations	Any member of the Company Workforce who suspects or has observed any violation to the Compliance Program or this Policy has an obligation to report the concern and is able to report such violations to his/her manager, the Ethics Help Line, the Ethics Office, the Compliance Department, or a lawyer in the Legal Department.			
Protection Against Retaliation	The Company prohibits any Workforce Member from retaliating, intimidating, harassing, threatening or taking adverse action against anyone for raising or helping to resolve an ethics or compliance concern, for reporting suspected or known violations of the law or against the Company Code of Ethics or Compliance Policies and Procedures, or for reporting suspected fraud, waste, or abuse. Individuals should immediately report any retaliation, intimidation, harassment, or threat of any of the foregoing for raising or helping to resolve a compliance concern by contacting the Ethics Help Line at cigna.ethicspoint.com or by telephone: Inside the U.S., call toll-free by dialing 800.472.8348. Outside the U.S., please follow the dialing instructions here. Such reporting may be confidential and anonymous.			
Policy Enforcement	Any member of the Company's Workforce who violates Company Compliance Policies and Procedures, applicable laws or regulations, federal payor or client compliance requirements, may be subject to disciplinary actions up to and including termination.			
VI. Policy Contacts				
Compliance Department	Ethics@Cigna.com			
VII. Review, Revision and Approval History				
Revision Number	Summary of Revisions	Approved By	Approval(s)	Date
Previous revision and approval history on file				
6	Annual review and updates	Jarel Jackson, Customer Service Director	Approval on File	09/15/2022
7	Updated template and branding; definitions	Mike Soltis, Customer Service Director	Approval on File	10/03/2023
VIII. Attachments and/or Related Documents				

⁴ MCMG § 80.1, 42 C.F.R. §§ 422.111(h)(1), 423.128(d)(1).

⁵ CMS Memo, 2020 Part C and Part D Call Center Monitoring and Guidance for Timeliness and Accuracy and Accessibility Studies, December 20, 2019.

⁶ CMS Memo, 2020 Part C and Part D Call Center Monitoring and Guidance for Timeliness and Accuracy and Accessibility Studies, December 20, 2019.

⁷ MCMG § 80.1, 42 C.F.R. §§ 422.111(h)(1), 423.128(d)(1).

⁸ CMS Memo, 2020 Part C and Part D Call Center Monitoring and Guidance for Timeliness and Accuracy and Accessibility Studies, December 20, 2019.

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Procedure

[Interpreter Services Alternative Language Written Requests \[MCARE-MCMG-CS-02-003-001\]](#)

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