2013Producer Policies & Procedures

TABLE OF CONTENTS

1. Introduction to Producer Medicare Program Selling Requirements 2
2. Qualifications and Primary Duties for Producers.....4
3. Standards of Professionalism.....18
4. Required Documentation of Sales Practices 22
5. Sales Producer Training 27
6. Oversight & Reporting of Medicare Marketing/Sales Events 34
7. Scope of Appointment Documentation / 48 Hour Waiting Period and Cross Selling.....39
8. Disclosure Requirements.....50
9. Medicare Sales Materials 55
10. Sales Allegations 68
11. Rapid Disenrollment - Producer 774
12. Oversight and Monitoring of Producers 79
13. Sales Practices Involving Medicare Beneficiaries, Including Vulnerable Beneficiaries 84
14. Medicare Late Application Producer..... 103
Appendix A:..... 107
Sales Producer Code of Conduct 106
Appendix B:..... 109
Do and Don't Chart 109

1. Introduction to Producer Medicare Program Selling Requirements

Purpose:
Health Net (HN) has established the following Policies and Procedures (P&Ps) that will ensure HN is in compliance with the Centers for Medicare and Medicaid Services (CMS) marketing requirements.

Procedure:
Establishing Qualifications for Producers and Plan Sales Staff -- Initial Certification and Training

HN has established the qualifications that Producers and plan Sales Associates must meet to market and sell our Medicare Advantage and MAPD Plans. HN:

- Collects information from Producers, such as, licensure, AHIP, product training and other required information.
- Requires Producers and HN Sales Associates to obtain passing test scores on the AHIP certification training.
- Requires Producers and plan Sales Associates to complete plan-specific training that provides detailed information about the plan types and the benefits offered by HN.

Annual Recertification, Targeted Retraining and Ongoing Communication
HN has established requirements for Producers and plan Sales Associates to achieve passing test scores on annual recertification tests approved by HN and required product training. HN requires targeted training or retraining to address topics that require special attention during the year. HN provides updated information through e-mails, Web sites such as AHIP (https://healthnet.cmpsystem.com/), or other means on an ongoing basis.

Maintenance of Records
HN requires maintenance of sales records/files on all Producers and plan Sales Associates in accordance with CMS requirements. Records are a combination of electronic data maintained by HN and hard copy files maintained as described below. HN maintains sales files on HN associates and direct contractors. The Sales Entity maintains files for Producers authorized with HN through a Sales Entity respectively. HN sales leaders monitor the maintenance of hard copy files by Sales Entities. The Producer is required to retain the completed Scope of Appointment form, signed by the Medicare Beneficiary, for a time of no less than 10 years. The form is retained regardless of appointment outcome and must be readily accessible to Health Net upon request.

Monitoring Compliance and Addressing Deficiencies
HN has instituted processes for tracking and analyzing individual Producer and plan sales staff performance in such areas as rapid disenrollments, late applications and allegations. This ongoing process of evaluation allows HN to promptly identify sales conduct that merits

investigation, such as: provision of incorrect, misleading, or inaccurate information; unauthorized contact or home visits; fraudulent enrollment submission; or intimidation. Complaints are treated as grievances as required by CMS. HN's Special Investigations Unit (SIU) receives referrals and investigates complaints involving alleged fraud or misrepresentation. Corrective action against Producers and plan Sales Associates is initiated as required. HN makes reports of Producer terminations to State agencies overseeing Producer licensure, when warranted. Health Net uses rapid disenrollment data and late applications to identify and correct adverse compliance trends.

Protecting Beneficiaries
HN has instituted processes for rapidly investigating complaints and taking rapid and decisive action when complaints are verified, that may include re-qualification, suspension, or termination of the Producer or Sales Associate involved.

Compensation
Compensation arrangements must comply with CMS Medicare Marketing Guidelines and must be documented using HN's approved agreements. HN withholds or recovers payment according to CMS guidelines. CMS compensation requirements do not apply to HN Sales Associates.

Sales Allegation Committee
The Sales Allegation Committee is responsible for reviewing sales allegations to determine appropriate corrective actions. The Regional Vice President of Medicare Programs chairs the Committee.

Updating and Maintaining Policies and Procedures
These P&Ps are updated annually, or when changes are necessary. The P&Ps are available on the Producer Web site (http://ppg6.pinpointglobal.com/HealthNet/Production/Apps/Medicare/).

2. Qualifications and Primary Duties for Producers

Policy Statement:

Health Net follows the Centers for Medicare & Medicaid's (CMS) requirements contained in Chapter 3 of the Medicare Managed Care Manual and in the applicable regulations, in regard to the qualifications and primary duties of Producers. CMS requires that Medicare Advantage (MA) and MAPD plans utilize only state-licensed marketing representatives to perform marketing. In addition, the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 requires MA organizations and MAPD plans to comply with state appointment laws.

Health Net (HN) is committed to ensuring that only qualified Producers and Sales Associates sell HN Medicare products and have created this P&P to outline the qualifications for Producers and Sales Associates

Policy Purpose:

The purpose of this policy is to ensure that qualifications are met and that primary duties and responsibilities are understood by each HN Sales Associate, and contracted Producer, whether independent or affiliated with a Agency, GA, or FMO, who will represent and sell HN Medicare products.

Scope/Limitations:

This P&P applies to all internal Sales Associates and external Producers contracted by HN, including independent Producers, Agency, General Agents (GA's), Managing Agency (MAGY) and Field Marketing Organizations (FMO's).

Related Policies:

TR920-113534	Disclosure Requirements
TR0-114053	Introduction to Producer Medicare Program Selling Requirements
TR920-103355	Oversight and Monitoring of Producers
TR920-122549	Medicare Sales Materials
TR920-111825	Rapid Disenrollment - Producer
TR920-123318	Qualification and Primary Duties for Producers
TR920-124259	Required Documentation of Sales Practices
TR920-1182	Sales Allegations
TR920-132651	Monthly Sales and Marketing Event Reporting to Medicare Compliance
TR920-11030	Sales Producer Training
TR920-11273	Standards of Professionalism
EJ914-154237	Auditing Sales
TR930-102915	Sales Practices Involving Vulnerable Beneficiaries
TR920-124854	Scope of Appointment/48 Ht Waiting Period and Cross Selling

References:

Title 42 of the CFR 422.2268
Title 42 of the CFR 422.2272
Title 42 of the CFR 423.2268
Title 42 of the CFR 423.2272

Chapter 3 of the CMS Medicare Managed Care Manual – Update: June 7, 2012. Sections 10: Introduction; 30.5 Submission of Materials for CMS Review: 30.6 Anti-Discrimination; 120 Marketing and Sales Oversight and Responsibilities.

Definitions:

CMS	Centers for Medicare and Medicaid Services. The federal agency within the Department of Health and Human Services that administers the Medicare program.
Medicare	The Federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End Stage Renal Disease (ESRD).
Medicare Advantage (MA)	A Medicare program that allows for more choices among Medicare health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (ESRD).
Part D Plan	A prescription drug plan (PDP), an MA-PD plan, or a PACE plan offering qualified prescription drug coverage. This includes employer- and union- sponsored plans.
Sales Entity	Field Marketing Organization (FMO), General Agency (GA) or Agency.
Field Marketing Organization (FMO)	An FMO is an agency contracted to provide broad coverage for the marketing and sales of a health plan. Areas of support will include, but are not limited to, Marketing / Lead Generation, Call Center capabilities,
General Agency (GA)	A GA is an agency contracted to provide sales of a health plan. Typically its focus is on Producer recruitment and sales. Areas of support will include, but are not limited to, Producer Certification, Sales Training, Product Training and Compliance Oversight.
Agency	An agency that allows Producers to write underneath them.
Producer	Any person who is authorized to sell Health Net Medicare products, including persons who are directly contracted with Health Net (Individual Producers) and persons who are affiliated with a contracted Sales Entity (Authorized Producers).
Sales Associate	A person directly employed by Health Net or contracted as a vendor to sell Health Net Medicare Products.

Managing Agency (MAGY)	A MAGY is an agency contracted to provide sales of a health plan. Typically its focus is on limited Provider recruitment and sales within a narrow territory. Areas of support include, but are not limited to, Producer Certification, Sales Training, Product training, Compliance Oversight and Application Enrollment Processing.
Third Party Marketing Organization (TMO)	An entity such as a Field Marketing Organization (FMO), General Agent (GA), or similar type of organization that has been retained to sell or promote a plan sponsor's Medicare products on the plan sponsor's behalf either directly or through sales agents or a combination of both.
Right Fax	The fax software used by Health Net to accept enrollment applications from Producers and Sales Associates electronically.

Procedure:

A. General Qualifications

The following qualifications are applicable to all HN internal Sales Associates and Sales Entities:

1. Be appropriately and currently licensed by each state in which the individual or entity plans to sell HN products.
2. Must be appointed pursuant with state appointment laws, as detailed in the Attachments to this policy.
3. Not be censured, restricted, or otherwise sanctioned by any regulatory body within the past two years.
4. Sales Entities must have a Federal Tax ID. Contracting under a Social Security number or a Federal Tax ID is only permitted for individual producers.
5. Review, acknowledge and agree to abide by Health Net's Sales Producer Code of Conduct, Do and Don't Chart, the Medicare Marketing guidelines, HN Policies & Procedures, the HN Code of Business Conduct and Ethics, the Compliance Program/Fraud Waste & Abuse (FWA) Training and product specific training acknowledgement on-line at the HN AHIP web site (https://healthnet.cmpsystem.com/)
6. Abide by the requirements in the applicable Producer/Sales Entity agreement.

*The following qualifications are **applicable to All Sales Entities:***

Must have minimum experience requirements operating as a Sales Entity or have equivalent experience and expertise as determined by HN.

B. Summary of Producer Duties and Responsibilities

The following are applicable to HN internal Sales Associates, all individual Producers and/or Sales Entities:

1. Represent HN and all HN's Medicare products with the highest level of honesty and integrity, always putting the needs of the each Medicare beneficiary ahead of any personal consideration.
2. Offer all available HN Medicare products to each eligible Medicare beneficiary with whom the producer meets (non-discrimination). Help the prospect determine the most appropriate product based on their personal needs and situation.
3. Solicit and sell HN's products using **only** HN/CMS-approved advertising, sales presentations/seminars (as it applies to a specific region), and marketing/enrollment materials.
4. Validate the accuracy and completeness of all applications prior to submitting to HN.
5. Provide HN with all required and/or requested reports and information within timeframes determined by HN.
6. Abide by all applicable federal and state laws, rules, regulations, and HN P&Ps that pertain to the solicitation, sale, and administration of any HN Medicare product, including the prevention of fraud, waste and abuse.
7. Actively participate with HN and/or any government agency regarding all inquiries, investigations and audits resulting from member, provider, CMS, and/or regulatory agency concerns or allegations regarding any type of misconduct, fraud, or associated sales and marketing misrepresentation issues.
8. Annually complete the HN Medicare re-certification training and pass the re-certification exam(s) – **this applies to selling Producers (anybody who sells) and internal sales associates.**
9. Maintain records for 10 years.

Application Processing

Health Net requires Authorized Producers, Sales Entities, Individual Producers and Sales Associates to comply with timely application submission timelines. Health Net requires signed, dated, complete enrollment applications to be submitted to Health Net no later than the next calendar day following receipt from the beneficiary.

1. The preferred submission method is by RightFax, utilizing the appropriate fax number provided by Health Net.
2. Mailed applications must be sent by overnight mail on the same day as received from the beneficiary.
3. Hand-carried applications must be delivered to a Health Net Medicare department associate the same day as received from the beneficiary.

Authorized Producers affiliated with Sales Entities:

Authorized Producers affiliated with a Sales Entity should follow application processes as identified by their Sales Entity in order to reconcile application submissions after faxing to Health Net. Authorized Producers may submit applications to their respective Sales Entity. In such cases, the Authorized Producer and the Sales Entity are responsible for timely submission, ensuring Health Net receives the application no later than the next calendar day after receipt. The following outlines responsibilities of the Authorized Producer and/or Sales Entity representative:

1. RightFax applications to Health Net and responsible for the validity and legibility of the data and for the completeness of each application submitted prior to sending to Health Net.
2. Authorized Producers are required to date the application and provide their name and HN Medicare ID legibly in the Broker required information section on the enrollment form.
3. Submit all enrollment applications to the Health Net no later than the next calendar day of receipt from the beneficiary. The completed application can be faxed, hand-carried or sent by overnight mail to Health Net, although RightFax is the preferred method of receipt.
4. Applications received on the final marketing day of each month must be received at Health Net by 11:59 pm to ensure the requested effective date (or as it applies to a specific region).
5. Authorized Producers should use Health Net provided batch sheets.
6. The Health Net Broker Hub will send an email confirming receipt of the application if an email address was provided.
7. Failure to follow Health Net requirements for submitting applications may result in processing delays, which may then impact enrollees' requested coverage date and/or Sales Entity and Producer commission payments.

Individual Producers:

The following outlines Individual Producer responsibilities when submitting enrollment applications:

1. RightFax applications to Health Net and responsible for the validity and legibility of the data and for the completeness of each application submitted prior to sending to Health Net.
2. Submit all enrollment applications to the Health Net no later than the next calendar day of receipt from the beneficiary. The completed application can be faxed, hand-carried or sent by overnight mail to Health Net, although RightFax is the preferred method of receipt.
3. Individual Producers are required to date the application and provide their name and HN Medicare ID legibly in the Broker required information section on the enrollment form.
4. Applications received on the final marketing day of each month must be received at Health Net by 11:59 pm to ensure the requested effective date (or as it applies to a specific region).
5. The Health Net Broker Hub will send an email confirming receipt of the application if an email address was provided.
6. Failure to follow Health Net requirements for submitting applications may result in processing delays, which may then impact enrollees' requested coverage date and/or Producer commission payments.

Sales Associates:

The following outlines Sales Associate responsibilities when submitting enrollment applications:

1. Sales Associates must follow the internal Enrollment processing guidelines.

2. Forward applications to IKON/AMES, Health Net Sales Hub or the Regional Sales Assistant and are responsible for the validity and legibility of the data and for the completeness of each application submitted prior to sending to Health Net. Regardless of the method of entry, all applications must be submitted through RightFax no later than the next calendar day of receipt from the beneficiary.
3. Internal Sales Associates are required to date the application and provide their name and HN Medicare ID legibly in the HN Internal Sales Rep required information section on the enrollment form.
4. Are contacted by a Regional Sales Assistant if an incomplete application is received only if an e-mail address was provided on the application.
5. All copies of submitted applications must be filed in a secure location on Health Net premises within 5 calendar days of application submittal. All copies of submitted applications must be maintained in a secure location to ensure confidentiality of member personal health information (PHI) and personal identifiable information (PII) pursuant to HIPAA rules.
6. It is a prohibited practice for storage of member PHI and PII by Sales Associates outside of Health Net premises (e.g, home office).

The following are applicable to Sales Entities, including Field Marketing Organizations (FMO), Managing Agency (MAGY) and General Agencies (GA):

1. Responsible for all aspects of organizing training sessions for the Sales Entity producers using training materials and presentations provided by HN. HN may require that HN associates conduct such training directly or may delegate in writing the responsibility to the Sales Entity.
2. Sales Entities and/or management are responsible for training all producers about HN products, processes, etc. Sales Entity must provide ongoing training and oversight so that the Sales Entity producers remain knowledgeable about all HN Medicare related products and services, along with CMS regulations relative to the sales and marketing of Medicare Advantage and MAPD plans. Sales Entities and/or Management are also responsible for disseminating all HN communications to the Sales Entity producers throughout the course of the contract.
3. Maintain records as required by the Sales Entity HN contract, plus an individual record on each contracted Producer. This includes sales production, retention and disenrollments, sales allegations, training documentation and sign-in sheets, and other criteria as determined by HN (requirements can be found in the "Required Documentation of Sales Practices" P&P).
4. Perform quality checks of Producers' sales processes as defined by HN and report on the same.
5. Validate the accuracy and completeness of all applications sold by authorized Producers and/or Sales Entity Representative prior to submitting to HN. All application errors are the responsibility of the Sales Entity Representative and /or Producer Sales Entity to work to obtain correct information.
6. Provide ongoing communication to the Sales Entity producers as required or requested by HN. At a minimum, ensure and verify that all educational and

informational content developed by HN is distributed in the manner and timeframes prescribed by HN.

7. Provide HN with all required and/or requested reports and information. This includes, but is not limited to, contributions to any and all federal or state required reports and reports at the individual producer level within timeframes required by HN.
8. Maintain a written compliance program and provide reports to HN as requested.
9. Provide annually, or upon request to HN a list of all individual producers affiliated with the Sales Entity who solicit and/or sell HN Medicare products.
10. Sales Entities that have a call center (in-house or sub-contracted) to field prospect calls must be approved by HN and must ensure authorized Producers are not acting as a customer service representative and agent simultaneously. There should be a clear distinction within the organization as to the type of representative that will be answering calls, their precise roles and level of knowledge and training.
11. Producers and solicitors who close sales must be certified by HN and all must follow HN policies and procedures. In addition, the Sales Entity must follow state laws relative to non-licensed solicitors.

Review/Revision History

First Issued……...August 2007
Revised……September 2008
Revised……September 2009
Revised……September 2010
Revised……March 2011
Revised……July 2011
Revised……July 2012

Additional Information:

Applies to contract numbers H0351, H0562, H5439, H5520, H6815.

APPOINTMENT OF PRODUCERS BY INSURERS

11/07

The date following each state indicates the last time information for the state was reviewed/changed.

STATE	CITATIONS	APPOINTMENT FEE	PROVISION
AL (11/07)	§§ 27-4-2; 27-7-4	$30 notice of appointment; $10 annual continuation	An insurance producer shall not act on behalf of an insurer unless he is appointed by the insurer.
AK (11/07)	§ 21.27.100		Insurer must file written notice of appointment not less than 30 days after the first application is submitted.
AZ (11/07)	No provision		
AR (11/07)	§§ 23-61-401; 23-64-514; 23-64-219	$10 annual fee for resident agents, each insurer $30 annual fee for nonresident agents, each insurer $7 for limited line appointments	A producer shall not act as agent of an insurer unless producer becomes an appointed agent of the insurer. The insurer files a list with the department of all its agents whose appointment will remain in effect, with insurers being billed for appointments on June 1.
CA (11/07)	Ins. § 1704	$22 annual fee	An agent shall not act as an agent of insurer unless insurer files notice of appointment with commissioner. Authority to transact insurance by appointment shall be effective as of date notice is signed.
CO (11/07)	§ 10-2-401		No person shall act or hold himself to be an insurance producer in this state unless he is licensed. Does not specify appointment prior to solicitation.
CT (11/07)	§§ 38a-702m; 38a-782	Application fee $25 Appointment fee domestic $40 foreign $20 NY domicile $0	A producer's authority to act as an agent shall be activated on the date the insurer signs a written appointment form. The appointing insurer shall file a notice of appointment not later than 15 days after the date agency contract is executed or the first application is submitted.
DE (11/07)	tit. 18 §§ 701; 1715	$25 fee paid once	An insurance producer shall not act as agent of insurer unless appointed. Insurer shall file with commissioner notice of appointment within 15 days from execution of agency contract or submission of first insurance application. Commissioner shall verify eligibility within 30 days.

APPOINTMENT OF PRODUCERS BY INSURERS

11/07

STATE	CITATIONS	APPOINTMENT FEE	PROVISION
DC (11/07)	§ 31-1131.14	$25	An insurance producer shall not act as an agent of an insurer unless appointed. Appointing insurer shall file notice of appointment within 30 days from execution of agency contract or submission of first application to insurer. Commissioner shall verify eligibility within 10 days.
FL (11/07)	§§ 626.112; 626.341	$60	No person shall be, act as, or advertise himself to be an insurance agent unless he is currently licensed and appointed. Insurer may apply on behalf of a licensee for an additional appointment. Appointing insurer will pay penalty of $250 per appointee for appointments not submitted within 45 days of the date of appointment.
GA (11/07)	§§ 33-8-1; 33-23-5; 33-23-16	$10	Applicant for agent's license must have been appointed subject to issuance of the license. Non-resident shall not act as agent of insurer unless appointed. Insurer shall file notice of appointment of non-resident within 15 days from date of licensure or before first insurance application submitted; commissioner shall verify eligibility within 30 days.
HI (11/07)	§ 431:9A-114		An insurance producer shall not act as an agent of an insurer unless appointed. Appointing insurer shall file notice of appointment within 15 days from execution of agency contract or submission of first application to insurer. Commissioner shall verify eligibility within 30 days.
ID (11/07)	§ 41-1018		An insurance producer shall not act as an agent of an insurer unless appointed by the insurer. Appointing insurer shall file form with director within 15 days after contract is executed or first application is submitted. Director has 30 days to verify eligibility.
IL (11/07)	215 ILCS 5/500-80		Does not specify appointment prior to solicitation of business.
IN (11/07)	§ 27-1-15.6-14		An insurance producer shall not act as an agent of an insurer unless appointed by the insurer.

APPOINTMENT OF PRODUCERS BY INSURERS

11/07

STATE	CITATIONS	APPOINTMENT FEE	PROVISION
IA (11/07)	Reg. 191-10.17 § 522B.13	$5 annual fee $10 late appointments	An insurer is responsible for paying fees for its appointed agents. An individual acting as an agent of an insurer must be appointed by the insurer. The appointing insurer shall file notice with the commissioner within 30 days from the date the agency contract is executed or the first insurance application is submitted.
KS (11/07)	§§ 40-252; 40-4912	$2 if domestic company $5 if foreign company	Appoint agent on form prescribed by commissioner. Remit with fee to commissioner annually.
KY (11/07)	§ 304.9-270	$40 biennially, resident agents $50 biennially nonresident agents $100 biennially;resident business entity $120 biennially; nonresident business entity	No agent shall claim to be agent of an insurer unless appointed, and appointment approved by commissioner. Insurer shall file notice of appointment within 15 days from execution of agency contract or submission of first insurance application. May place insurance without approval of the appointment by the commissioner for a period of 15 days.
LA (11/07)	§§ 22:1078; 22:1144	$20	An insurance producer shall not act as an agent of an insurer unless appointed, except for surplus lines and workers' compensation policies placed with Louisiana Workers' Compensation Corporation. Commissioner shall verify eligibility within 30 days; notice to insurer within 15 days of that determination.
ME (11/07)	tit. 24-A §§ 601; 1420-M	$30 appointment and biennial renewal of resident producer; $70 appointment and biennial renewal of nonresident producer	An insurance producer shall not act as an agent of an insurer unless appointed. Insurer shall file notice of appointment within 15 days from execution of agency contract or submission of first insurance application.
MD (11/07)	Ins. §§ 2-112; 10-103; 10-118 Reg. 31.03.13		An insurance producer may not sell, solicit, or negotiate any insurance on behalf of an insurer for which the insurance producer does not have an appointment. Without an appointment, an insurance producer may submit an application, provided the insurer appoints the producer within 30 days. Insurers must maintain a producer register of all appointed producers.

APPOINTMENT OF PRODUCERS BY INSURERS

11/07

STATE	CITATIONS	APPOINTMENT FEE	PROVISION
MA (11/07)	§ 175:162a		An insurance producer shall not act as an agent of an insurer unless appointed. Insurer shall file notice of appointment within 15 days from execution of agency contract or submission of first insurance application. Commissioner has 30 days to verify eligibility.
MI (11/07)	§ 500.1208a.	$5 annually	A producer shall not act as an agent of an insurer unless appointed. Insurer shall file notice of appointment within 15 days after contract executed or first insurance application submitted. Commissioner shall determine eligibility within 30 days; if ineligible, commissioner shall notify insurer within 5 days.
MN (11/07)	§§ 60A.14; 60K.49	$10	A licensed insurance producer shall not engage in the business of insurance with an insurer unless either appointed by that insurer or has insurer's permission to transact business on its behalf and obtains appointment within 15 days after first application submitted to insurer. Insurer shall file notice of appointment within 15 days from execution of agency contract or submission of first application. Commissioner shall verify eligibility within 30 days.
MS (11/07)	§ 83-17-75		An insurance producer shall not act as an agent of an insurer unless he is appointed by the insurer. Submit form within 15 days after contract is executed or first application is submitted.
MO (11/07)	§ 375.022	$10	An insurer shall maintain a register of appointed producers. Name and license number of producer to be entered on company register within 30 days of authorizing a producer to transact business on its behalf.
MT (11/07)	§ 33-17-201		Does not specify appointment prior to solicitation of business.
NE (11/07)	§ 44-4061	$8 annually	An insurance producer shall not act as an agent of an insurer unless he is appointed by the insurer. Submit form within 15 days after contract is executed or first application is submitted.
NV (11/07)	§§ 680B.010; 683A.321	$15	A producer shall not act as an agent of an insurer unless appointed. Insurer shall file notice of appointment within 15 days after contract executed or first insurance application submitted. Commissioner shall determine eligibility within 30 days; if ineligible, commissioner shall notify insurer within 5 days.

APPOINTMENT OF PRODUCERS BY INSURERS

11/07

STATE	CITATIONS	APPOINTMENT FEE	PROVISION
NH (11/07)	§§ 400-A:29; 402-J:14	$25 paid once; $25 fee to cancel appointment	An insurance producer shall not act as an agent of an insurer unless he is appointed by the insurer. Submit form within 15 days after contract is executed or first application is submitted.
NJ (11/07)	§ 17:22A-42		An insurance producer shall not act as an agent of an insurer unless he is appointed by the insurer. Submit form to department after contract is executed.
NM (11/07)	§§ 59A-11-10; 59A-12-6	$23 annually	Within 60 days of obtaining an agent license, a licensee shall become appointed by an insurer; otherwise the license will expire. An insurer shall not accept insurance through any person acting as an insurance agent if the insurer knows that the person was not then licensed as an agent or was not appointed as its agent. Insurer shall file notice of appointment within 15 days.
NY (11/07)	Ins. Law § 2103	Retaliatory fee	Before an agent is issued a license, an insurer shall have filed a certificate of appointment with the superintendent.
NC (11/07)	§§ 58-33-40; 58-33-125	$20	An agent shall not place a policy with any insurer unless he has a current appointment as an agent for the insurer.
ND (11/07)	§§ 26.1-01-07; 26.1-26-13.1	$10 annually	A producer may not act as an agent of an insurer unless appointed by the insurer. Insurer shall file notice of appointment within 30 days after contract is executed or first application is submitted, whichever is later.
OH (11/07)	§ 3905.20	$20	An agent shall not act as an agent of an insurer unless appointed. Insurer shall file notice of appointment within 30 days after execution of agency contract or submission of first insurance application.
OK (11/07)	tit. 36 § 1435.15; 1435.23	$40 biennially	A producer shall not act as an agent of an insurer unless appointed. Insurer shall file notice of appointment within 45 days from execution of contract or submission of first insurance application. Commissioner shall verify eligibility for appointment within 30 days; if ineligible, commissioner shall notify insurer within 5 days.
OR (11/07)	§ 744.078		An insurance producer shall not act as an agent of an insurer unless appointed. Insurer shall file notice of appointment within 15 days from execution of agency contract or submission of first insurance application.

APPOINTMENT OF PRODUCERS BY INSURERS

11/07

STATE	CITATIONS	APPOINTMENT FEE	PROVISION
PA (11/07)	§ 40-25-1271	$12.50	An agent may not do business on behalf of an insurer without a written appointment from that insurer.
PR (11/07)	tit. 26 § 909		Proof of appointment of an applicant shall accompany the application for a license sent to the commissioner.
RI (11/07)	No provision.		
SC (11/07)	§§ 38-43-40; 38-43-50	$40 biennially	A producer shall not act as an agent of the insured unless appointed. Insurer shall file notice of appointment within 15 days after execution of agency contract or submission of first application and certify that it has investigated the character and record of the applicant. Commissioner shall determine eligibility within 30 days.
SD (11/07)	§§ 58-2-29; 58-30-176	$10 annually	An insurance producer shall not act as an agent of an insurer unless he is appointed by the insurer. Submit form within 15 days after contract is executed or first application is submitted.
TN (11/07)	§ 56-6-115	$15	A producer shall not act as agent of an insurer unless appointed. Insurer shall file notice of appointment within 15 days after execution of agency contract or submission of first insurance application. Commissioner shall determine eligibility within 30 days.
TX (11/07)	I.C. Sec. 4001.201		No person shall act as an agent unless licensed, and no insurer shall appoint agent unless licensed. General agents may appoint subagents (Sec. 4001.205).

APPOINTMENT OF PRODUCERS BY INSURERS

11/07

STATE	CITATIONS	APPOINTMENT FEE	PROVISION
UT (11/07)	§ 31A-23a-302		An insurer shall designate a natural person that has a producer, limited line producer, customer service representative, consultant, managing general agent, or reinsurance intermediary license to act on its behalf prior to doing business for the agency.
VT (11/07)	tit. 8 §§ 4800; 4813l	$60 biennially	A producer shall not act as an agent of an insurer unless appointed. Insurer shall file notice of appointment within 15 days after execution of agency contract or submission of first insurance application. Insurer shall make separate appointment for each line of insurance for which agent will be acting as agent.
VI (11/07)	Tit. 22 § 758		To qualify for any agents' license, an applicant must be appointed as its agent by one or more authorized insurers.
VA (11/07)	§ 38.2-1825	$14	An appointment issued to an agent by an insurer shall authorize the appointee to act as an agent for the insurer unless terminated, suspended, or revoked.
WA (11/07)	§§ 48.17.150 to 48.17.160	$20 biennially	To qualify for an agent's license an applicant must have been appointed by one or more insurers. Insurers shall file written notice of the appointment with the commissioner. Commissioner may adopt regulation allowing a producer to place insurance without notifying the commissioner of an appointment, as long as he does so within 30 days.
WV (11/07)	§ 33-12-18		A producer may not act as an agent of an insurer unless appointed. Insurer shall file notice of appointment within 15 days after execution of agency contract or submission of first insurance application. Commissioner shall determine eligibility within 30 days.
WI (11/07)	§ 628.11	$5 annually for residents; $15 annually for nonresidents	An insurer shall report at intervals all appointments of agents.
WY (11/07)	§ 26-9-213	$15 annually	An insurance producer shall not act as an agent of an insurer unless he is appointed by the insurer. Submit form within 15 days after contract is executed or first application is submitted.

3. Standards of Professionalism

Policy Statement:

Health Net follows the Centers for Medicare & Medicaid's (CMS) requirements contained in Chapter 3 of the Medicare Managed Care Manual and in the applicable regulations, in regard to standards of professionalism. Health Net expects that each Producer who sells Health Net Medicare Advantage (MA) and MAPD Plans conduct themselves in a professional manner when interacting with Medicare beneficiaries. Health Net expects that each Producer will assist Medicare beneficiaries to obtain Medicare coverage that best meets their needs and provides a high quality customer solution for them.

Policy Purpose:

The purpose of this policy is to ensure that contracted Producers adhere to Health Net's (HN) Standards of Professionalism and personal behavior when representing, soliciting and selling HN MA and MAPD Plan products.

In addition, the purpose is to promote the ethical representation of HN's Medicare products with the highest level of honesty, integrity, and professionalism.

Scope/Limitations:

This policy applies to all Health Net Sales Associates, external Producers contracted by Health Net, including independent Producers, Agency, General Agents (GA's), Managing Agency (MAGY) and Field Marketing Organizations (FMO's).

Related Policies:

TR920-103355	Oversight & Monitoring of Producers
TR920-113534	Disclosure Requirements
TR920-114053	Introduction to Sales
TR920-122549	Medicare Sales Materials
TR920-111825	Rapid Disenrollment -
TR920-123318	Qualification and Primary Duties for Producers
TR920-124259	Required Documentation of Sales Practices
TR920-1182	Sales Allegations - Producer
TR920-132651	Monthly Sales and Marketing Event Reporting to Medicare Compliance
TR920-11030	Sales Producer Training
TR920-11273	Standards of Professionalism
TR930-102915	Sales Practices Involving Vulnerable
TR920-124584	Scope of Appointment/48 Hr Waiting Period &
TR920-103355	Oversight & Monitoring of Producers

References:

Title 42 of the CFR 422.2268
Title 42 of the CFR 423.2268

Chapter 3 of the CMS Medicare Managed Care Manual – Update: June 7, 2012
Sections: 10 Introduction; 30.5 Submission of Materials for CMS Review; 30.6 Anti Discrimination; 70.8 Marketing /Sales Events;70.8.1 Additional Guidance for Marketing Events in the Provider Setting; 70.8.2 Plan Activities and Materials in the Health Care Setting;120 Guidance on Marketing and Sales Oversight and Responsibility

Definitions:

Medicare	The Federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End Stage Renal Disease (ESRD).
Medicare Advantage (MA)	A Medicare program that allows for more choices among Medicare health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (ESRD).
Part D Plan	A prescription drug plan (PDP), an MA-PD plan, or a PACE plan offering qualified prescription drug coverage. This includes employer- and union-sponsored plans.
Sales Entity	Field Marketing Organization (FMO), General Agency (GA), Managing Agency (MAGY) or Agency
Field Marketing Organization (FMO)	An FMO is an agency contracted to provide broad coverage for the marketing and sales of a health plan. Areas of support will include, but are not limited to, Marketing / Lead Generation, Call Center capabilities, and Administrative functions.
General Agency (GA)	A GA is an agency contracted to provide sales of a health plan. Typically its focus is on Producer recruitment and sales. Areas of support will include, but are not limited to, Producer Certification, Sales Training, Product Training and Compliance Oversight.
Agency	An agency that allows Producers to write underneath them.
Producer	Any person who is authorized to sell Health Net Medicare products, including persons who are directly contracted with Health Net (Individual Producers) and persons who are affiliated with a contracted Sales Entity (Authorized Producers).
Sales Associate	A person directly employed by Health Net or contracted as a vendor or sell Health Care Medicare products.
Managing Agency (MAGY)	A MAGY is an agency contracted to provide sales of a health plan. Typically its focus is on limited Provider recruitment and sales within a narrow territory. Areas of support include, but are not limited to, Producer Certification, Sales Training, Product training, Compliance Oversight and Application Enrollment Processing.

Third Party Marketing Organization (TMO)	An entity such as a Field Marketing Organization (FMO), General Agent (GA), or similar type of organization that has been retained to sell or promote a plan sponsor's Medicare products on the plan sponsor's behalf either directly or through sales agents or a combination of both.

General Requirements

Producers and Sales Associates are expected to adhere to the following requirements:

1. Be prompt for appointments and presentations.
2. Any unsolicited means of direct contact of beneficiaries is prohibited, including door-to-door solicitation, email or any outbound telemarketing without the beneficiary initiating the contact or giving express permission.
3. Appropriate business attire for the region of the country is required at all times.
4. If it is not possible to keep an appointment or presentation, a call must be made as early as possible to reschedule; habitual missed appointments are not acceptable.
5. Producers shall not smoke when representing, soliciting, and selling HN's Medicare products.
6. Producers shall not be under the influence of illegal drugs including medical marijuana, when representing, soliciting and selling HN's Medicare products.
7. Producers shall not drink alcohol during working hours on days when they're representing, soliciting and selling HN's Medicare products or prior to sales meetings conducted outside of normal business hours.
8. Producers shall not use inappropriate language while representing, soliciting, and selling HN Medicare products.
9. Upon request, Producers shall produce a photo ID to the prospect; driver's license is acceptable.
10. Producers shall provide and leave behind a current business card to all Medicare beneficiaries prior to all sales presentations and/or meetings In addition, Producers shall ensure the beneficiary has copies or shall leave behind the Summary of Benefits, copy of the enrollment application (if any portion is completed), enrollment instructions and forms, written notice that plan benefits and cost-sharing may change from year to year, written explanation of plan's grievance, coverage/organization determination (including exceptions) and appeals processes, including differences between the processes and when it is appropriate to use each.
11. "Hard Sell" tactics are never to be employed. The goal is to assist the Medicare beneficiary to enroll in a benefit plan that will meet their needs and provide a positive customer experience during the benefit year.
12. Producers shall follow the specific requirements for sales events that are cancelled or missed as specified in the Do & Don't Reference chart attached to this P&P.
13. The Producer or Sales Associate must acknowledge electronically the Sales Producer Code of Conduct by accessing the Health Net/AHIP website directly by entering this URL in your browser: https://healthnet.cmpsystem.com. Or you can access the link through the Broker Portal on www.healthnet.com > I'm a Broker >

select your region > Manage Accounts > Appointment & Contracting > Medicare Brokers.

14. Producers and Sales Associates must comply with the most current Medicare Marketing Guidelines when conducting all sales presentations and/or meetings. The following are prohibited marketing and sales activities and is not meant to be an all-inclusive list:
    - Distributing marketing materials and making verbal statements at all sales presentations and/or meetings that are materially inaccurate, misleading, or otherwise make material misrepresentations.
    - Misrepresenting themselves, and/or the benefit plans or services covered by the benefit plans the producer represents.
    - Claim within their marketing materials that they are recommended or endorsed by CMS, Medicare, the Department of Health & Human Services (DHHS), or any other federal, state or local government entity or organization.
    - Make statements or imply the following: "endorsed or employed by Medicare," "calling on behalf of Medicare," "calling for Medicare," "Medicare certified", or that "Medicare recommends that beneficiaries enroll in the plan."
    - Use of absolute superlatives (e.g., "the best," "highest ranked," "rated number 1") unless they are substantiated with supporting data provided to CMS as a part of the marketing review process.
    - Making comparative statements of their plan(s) to other plan(s) by name unless they have written concurrence from all plan sponsors being compared (for example, studies or statistical data) either in marketing materials or sales presentations &/or meetings. This documentation must be included when the material is submitted for review.
15. Producers and Sales Associates may be monitored to ensure compliant sales and marketing activities. All non-compliant activities reported to Health Net are investigated and appropriate enforcement actions taken in accordance with HN Policies and Procedures.

Review/Revision History

First Issued……August 2007
Revised……September 2008
Revised……September 2009
Revised……September 2010
Revised……March 2011
Revised……July 2011
Revised……June 2012

Additional Information:
Applies to contract numbers H0351, H0562, H5439, H5520, H6815.

4. Required Documentation of Sales Practices

Policy Statement:
Health Net (HN) follows the Centers for Medicare & Medicaid's (CMS) requirements contained in Chapter 3 of the Medicare Managed Care Manual and in the applicable regulations, in regard to required documentation of sales practices. Health Net maintains records on each HN sales associate, directly contracted HN Producers, and some information on Producers who are affiliated with a Sales Entity, who are selling HN's Medicare Advantage (MA) and MAPD plans. The records are a combination of hard copy files and electronic data. Agencies, General Agents (GAs), or Field Marketing Organizations (FMOs) must maintain hard copy files for all Producers who are part of their organizations. All plan sponsors must abide by CMS rules and regulations regarding record retention by retaining documents (i.e. books, records and documents etc.) for a period of ten (10) years.

Policy Purpose:
The purpose of this Policy and Procedure is to ensure that HN and/or its contractors maintain thorough and auditable records on each individual Sales Associate and Producer documenting compliance with CMS and Health Net (HN) sales practices.

Scope/Limitations:
This P&P applies to all internal sales associates and external Producers contracted by HN, including Independent Producers, Agencies, General Agencies (GAs), Managing Agency (MAGY) and Field Marketing Organizations (FMOs).

Related Policies:

TR920-113534	Disclosure Requirements
TR920-114053	Introduction to Producer Medicare Program Selling Requirements
TR920-103355	Oversight and Monitoring of Producers
TR920-122549	Medicare Sales Materials
TR920-111825	Rapid Disenrollment - Producer
TR920-123318	Qualification and Primary Duties for Producers
TR920-124259	Required Documentation of Sales Practices
TR920-1182	Sales Allegations
TR920-132651	Monthly Sales and Marketing Event Reporting to Medicare Compliance
TR920-11030	Sales Producer Training
TR920-11273	Standards of Professionalism
TR930-102915	Sales Practices Involving Vulnerable Beneficiaries
TR920-124854	Scope of Appointment/48 Ht Waiting Period and Cross Selling

References:
Title 42 of the CFR 422.2268
Title 42 of the CFR 422.2272
Title 42 of the CFR 423.2268
Title 42 of the CFR 423.2272

Chapter 3 of the CMS Medicare Managed Care Manual – Update: June 7, 2012

Definitions:

CMS	Centers for Medicare and Medicaid Services. The federal agency within the Department of Health and Human Services that administers the Medicare program.
Medicare	The Federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End Stage Renal Disease (ESRD).
Medicare Advantage (MA)	A Medicare program that allows for more choices among Medicare health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (ESRD).
Part D Plan	A prescription drug plan (PDP), an MA-PD plan, or a PACE plan offering qualified prescription drug coverage. This includes employer- and union-sponsored plans.
Rapid Disenrollment	A rapid disenrollment is considered a member disenrollment during 3 continuous months of the member's effective date, i.e., member effective 6/1, disenrolls either 6/1, 7/1, or 8/1, this is considered a rapid disenrollment.
Sales Entity	Field Marketing Organization (FMO), General Agency (GA), Managing Agency (MAGY) or Agency.
Field Marketing Organization (FMO)	An FMO is an agency contracted to provide broad coverage for the marketing and sales of a health plan. Areas of support will include, but are not limited to, Marketing/Lead Generation, Call Center capabilities, and Administrative functions.
General Agency (GA)	A GA is an agency contracted to provide sales of a health plan. Typically its focus is on Producer recruitment and sales. Areas of support will include, but are not limited to, Producer Certification, Sales Training, Product Training and Compliance Oversight.
Agency	An agency that allows Producers to write underneath them.
Producer	Any person who is authorized to sell Health Net Medicare products, including persons who are directly contracted with Health Net (Individual Producers) and persons who are affiliated with a contracted Sales Entity (Authorized Producers).
Sales Associate	A person directly employed by Health Net or contracted as a vendor to sell Health Net Medicare Products.
Managing Agency (MAGY)	A MAGY is an agency contracted to provide sales of a health plan. Typically its focus is on limited Provider recruitment and sales within a narrow territory. Areas of support include, but are not limited to, Producer Certification, Sales Training, Product training, Compliance Oversight and Application Enrollment Processing.

Third Party Marketing Organization (TMO)	An entity such as a Field Marketing Organization (FMO), General Agent (GA), or similar type of organization that has been retained to sell or promote a plan sponsor's Medicare products on the plan sponsor's behalf either directly or through sales agents or a combination of both.

General Requirements

1. HN maintains individual files for Producers who contract with HN and HN sales associates at the health plan level. Sales Entities also maintain individual files for Producers contracted or employed through those entities.
    - Note: HN maintains limited documentation for Producers who are affiliated with a Sales Entity, i.e, copy of license, certification and training documentation.

Producer:

a. CMS requires the following documentation (either hard copy or in a database, as long as the information is reproducible in hard copy form):

- Copy of state license
    - All applicable licenses or certifications must be present
    - All licenses must be current and appropriate as required by state law
- Evidence of training on products
    - Evidence that Producer participated and completed formal training (initial and annual re-training) for each state the Producer represents
    - Evidence of subsequent trainings should also be included
- Performance data
    - Any data such as volume of sales that the entity maintains on Producers
    - Information regarding salary structure, quota systems, and commissions
    - Information regarding "rapid" disenrollments that are tracked back to the Producers
    - Sales allegations and outcomes for each Producer
    - Documentation of Producer oversight, if available
- Personnel actions
    - Corrective actions from confirmed sales allegations
    - Documentation of any other complaints filed against the individual Producer
    - Management oversight/response where sales allegations or training needs have been identified
- ***Contract***
    - Must have provisions within the contract that the organization is responsible for ensuring that the Producer abides by all applicable MA and/or PDP laws, all other Federal health care laws, CMS policies including CMS marketing guidelines, and HN policies.
    - Must include a provision stating that any coordinated marketing must be done in accordance with all applicable MA and/or PDP laws, CMS policies, including CMS marketing guidelines, all Federal health care laws, and HN policies.
    - Must have compensation schedules in the written contract

b. HN requires the following acknowledgements during initial certification and re-certification:

- Required Acknowledge
  - Acknowledge that the Producer has received and abides by the HN Sales Producer Code of Conduct, Do and Don't chart, the CMS Marketing guidelines, the HN Code of Business Conduct and Ethics, the Medicare Compliance Program/Fraud Waste and Abuse (FWA Training and the HN Producer Policies & Procedures. In addition, the Producer will acknowledge that he/she must complete State specific product training prior to being able to sell HN Medicare products. The acknowledgements will be done electronically via HN AHIP website. https://healthnet.cmpsystem.com

c. HN requires that the following documentation be maintained in MACESS:

- Signed agreement coversheet
- Copy of license(s)
- W9 (directly contracted Producers or where split commissions are paid to the Producer and overrides to their affiliated organization)
- Copy of agency authorization (if applicable)
- Copy of online certification results
- Electronic Funds Transfer form (optional)
- Training Acknowledgement Forms

d. All other documentation must be maintained in the hard copy file.

Sales Associate:

a. Health Net requires the following information be maintained in the Personnel File in accordance with the internal personal file guidelines:

- Copy of State License(s)
- Evidence of Training
- Evidence of Subsequent Training
- Volume of Sales Data and Goals
- Sales Incentive Plan
- Rapid Disenrollment Data
- Sales Allegations/Corrective Action Plan
- Documentation of Management Oversight
- Other (Misc)

Health Net conducts a periodic review of Sales Associate personnel files to ensure the file has been updated to include all relevant documentation to ensure compliance with CMS rules and HN policies and procedures.

Review/Revision History

First Issued……...August 2007
Revised…….September 2008
Revised…….September 2009
Revised…….September 2010
Revised…….March 2011
Revised…….July 2011
Revised…….July 2012

Additional Information:
Applies to contract numbers H0351, H0562, H5439, H5520, H6815.

5. Sales Producer Training

Policy Statement:
Health Net follows the Centers for Medicare & Medicaid's (CMS) requirements contained in Chapter 3 of the Medicare Managed Care Manual and in the applicable regulations, in regard to Producer training.

The Centers for Medicare & Medicaid Services (CMS) requires that Medicare Advantage (MA) and MAPD plans have effective training programs for all producers and internal Health Net sales teams who sell MA and MAPD plans. Specifications for training/testing criteria and documentation requirements will be provided annually by CMS. In addition, CMS requires that all producers and Health Net sales associates who sell MA and MAPD plans pass a regulated written test and take a producer training course, for each state they will represent, to demonstrate their knowledge of the Medicare program and the plan specific Health Net products they intend to sell.

Health Net (HN) believes that each Medicare beneficiary should be able to understand the benefits of the Medicare plans they are reviewing and be able to select the Medicare plan with the right health care coverage that appropriately meets their personal needs. Health Net recognizes that Producers play a significant role in helping Medicare beneficiaries with their coverage choices. Accordingly, Health Net's policy states that each Producer selling our plans should be highly qualified and properly trained according to the company's philosophy, policies and processes.

It is Health Net's direct policy that appointed producers and the company's Sales Associates will not be authorized/certified to sell our Medicare health plans until all of Health Net's training requirements are completed and documented. It is part of Health Net's policy that initial and renewal sales commissions will not be paid on any enrollments made by a Producer or a company Sales Associate who is not appropriately certified (ie. AHIP or other HN Medicare approved certification exam, passing score, product training, and acknowledgement of all related training materials). Producers must remain in good standing annually to continue to be paid renewals for any plans sold effective 1/1/2009 and forward. If a Producer completes and submits re-contracting in subsequent years, the prior year's renewals will **not** be paid but the broker will be eligible for renewal commissions for the year in which the broker is certified. Renewals will not be paid retroactively to any year in which re-contracting was not completed. Our policies and procedures also specify that any appointed Health Net Producer and HN Sales Associates who wish to continue selling our Medicare products annually must go through recertification prior to the Annual Open Enrollment Period. In addition, Health Net may require re-training and/or re-certification of any appointed Producer and Health Net sales associate, at any time, if sales allegations are identified or there is a high volume of rapid disenrollments or late applications.

Health Net does not recognize the certification status of any other Medicare Advantage or Part D Plan organization other than AHIP or other HN Medicare approved certification exam. Health Net has contracted with AHIP to provide on-line testing for all Health Net appointed producers. Producers who have already taken the AHIP training test and passed it will not be required to take the certification exam again. However, whether a producer has taken the on-line test or not yet taken it, they must still register

on the HN AHIP site https://healthnet.cmpsystem.com to acknowledge that all required documentation related to selling Health Net plans has been read and understood. HN may accept certification trainings of other organizations on a case-by-case basis.

Health Net Sales Operations Support validates that Brokers and Sales Agents are required to create a unique non-transferable user name and ID and must provide individual attestations agreeing to the terms of service on the AHIP site. Health Net Sales Operations Support cross- references the current Chapter 3 Medicare Marketing Guidelines with the AHIP training modules to validate that the integrity of the testing meets CMS guidelines. Agents are tested with a random order of questions, sharing of test results is strictly prohibited.

Policy Purpose:
The intent of this operational policy is to document the sales training, certification requirements, and identify business owners and other participants related to training development, execution, and documentation for both internal and contracted sales Producers.

Scope/Limitations:
The intent of this operational policy is to document the sales training, certification requirements, and identify business owners and other participants related to training development, execution, and documentation for both internal and contracted sales Producers.

Related Policies:

TR920-113534	Disclosure Requirements
TR920-114053	Introduction to Producer Medicare Program Selling Requirements
TR920-103355	Oversight and Monitoring of Producers
TR920-122549	Medicare Sales Materials
TR920-111825	Rapid Disenrollment - Producer
TR920-123318	Qualification and Primary Duties for Producers
TR920-124259	Required Documentation of Sales Practices
TR920-1182	Sales Allegations
TR920-132651	Monthly Sales and Marketing Event Reporting to Medicare Compliance
TR920-11030	Sales Producer Training
TR920-11273	Standards of Professionalism
TR930-102915	Sales Practices Involving Vulnerable Beneficiaries
TR920-124854	Scope of Appointment/48 Ht Waiting Period and Cross Selling

References:
Title 42 of the CFR 422.2268
Title 42 of the CFR 422.2272
Title 42 of the CFR 423.2268
Title 42 of the CFR 423.2272

Chapter 3 of the CMS Medicare Managed Care Manual – Update: June 7, 2012 Sections 10 Introduction, 30.5 Submission of Materials for CMS Review; 30.6 Anti-

Discrimination; 120.3 Agent/Broker Training and Testing

Definitions:

AHIP	America's Health Insurance Plans. National association representing member companies providing health insurance coverage. Provides training and certification for HN producers and agents.
CMS	Centers for Medicare and Medicaid Services. The federal agency within the Department of Health and Human Services that administers the Medicare program.
Medicare	The Federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End Stage Renal Disease (ESRD).
Medicare Advantage (MA)	A Medicare program that allows for more choices among Medicare health plans. Anyone who has Medicare Parts A and/or B is eligible, except those who have End-Stage Renal Disease (ESRD).
Medicare Advantage (MA) Organization	A public or private entity organized and licensed by a state as a risk-bearing entity (with the exception of provider sponsored organization receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements.
Part D Plan	A prescription drug plan (PDP), an MA-PD plan, or a PACE plan offering qualified prescription drug coverage. This includes employer- and union-sponsored plans.
Part D Plan Sponsor	Refers to an organization offering a PDP, MA or MA-PD plan, a PACE organization offering a PACE plan including qualified prescription drug coverage, and a cost plan offering qualified prescription drug coverage. This includes employer- and union-sponsored plans.
Sales Entity	Field Marketing Organization (FMO), General Agency (GA), Managing Agency (MAGY) or Agency.
Field Marketing Organization (FMO)	An FMO is an agency contracted to provide broad coverage for the marketing and sales of a health plan. Areas of support will include, but are not limited to, Marketing / Lead Generation, Call Center capabilities, and Administrative functions.
General Agency (GA)	A GA is an agency contracted to provide sales of a health plan. Typically its focus is on Producer recruitment and sales. Areas of support will include, but are not limited to, Producer Certification, Sales Training, Product Training and Compliance Oversight.
Agency	An agency that allows Producers to write underneath them.
Producer	Any person who is authorized to sell Health Net Medicare products, including persons who are directly contracted with Health Net (Individual Producers) and persons who are affiliated with a contracted Sales Entity (Authorized Producers).
Sales Associate	A person directly employed by Health Net or contracted as a vendor to sell Health Net Medicare products.
Managing	A MAGY is an agency contracted to provide sales of a health plan.

Agency (MAGY)	Typically its focus is on limited Provider recruitment and sales within a narrow territory. Areas of support include, but are not limited to, Producer Certification, Sales Training, Product training, Compliance Oversight and Application Enrollment Processing.
Third Party Marketing Organization (TMO)	An entity such as a Field Marketing Organization (FMO), General Agent (GA), or similar type of organization that has been retained to sell or promote a plan sponsor's Medicare products on the plan sponsor's behalf either directly or through sales agents or a combination of both.

Procedure:

Sequence of Health Net's Certification Policy

Health Net's Medicare certification process means that each Producer as well as all plan Sales Associates will be required to complete the following training program annually (in addition to any other on-boarding requirements/state appointment):

1. All Producers and Health Net (HN) sales associates are required to begin the certification registration process by accessing the healthnet.com broker portal (This is a required process even if Producer took the AHIP training by going directly to the AHIP website. Producers are not required to re-take an already completed and passed exam.)
2. All Producers and HN Sales Associates are directed to the HN landing page on the AHIP Web training site.
3. On the HN landing page of the AHIP website, there is documentation that all Producers and HN Sales Associates are required to read and acknowledge before they can take the AHIP test. Producers and Health Net Sales Associates who have already taken the test must still acknowledge they have read the Health Net policy documents. The documentation includes the Producer Policies & Procedures, the Code of Conduct, the Sales & Marketing Do & Don't Chart, and the Medicare Marketing Guidelines, the HN Code of Business Conduct and Ethics and the HN Medicare Compliance Program and Fraud, Waste and Abuse training.
4. All Producers and HN sales associates must review all required AHIP training modules before taking the test
5. All Producers and HN Associates must pass the AHIP training with a score of at least 90% as required by AHIP..
6. All Producers and HN sales associates must print out a test certificate and an attestation document to confirm review of all training documents from the Health Net/AHIP web site. These documents are required to attend HN regional field-based training sessions for each state the Producer will be selling business (in person, webinar, or conference call)
7. All Producers must complete the Health Net Compliance Training for Fraud, Waste and Abuse found on the broker portal and included as part of the recertification training.
8. All Producers and HN sales associates must provide any other required documentation to HN as instructed (ie Product and Compliance Acknowledgement form).

Training Modules and the Certification Exam(s)

1. **HN National Certification Exam**: For 2013, Health Net has moved its national on-line certification exam to AHIP which means that Producers and HN sales associates must pass the AHIP exam each year with a score of 90% or greater, before they will be permitted to sell.
    a. Each Producer and plan Sales Associate is allowed three (3) attempts to successfully pass the HN AHIP certification exam. If the Producer or plan Sales Associate is unable to pass with a satisfactory score after three (3) attempts, the Producer or plan Sales Associate may re-register with HN AHIP, pay the fee and retake the exam.
    b. Agents are strongly encouraged to study all modules prior to completing all random questions for the exam.

2. **HN Certification Period:** Producers and HN plan sales associates must be certified for the plan year in which they are selling. Additionally, Producers and HN plan sales associates must be product trained for the plan year for the products they are selling.

    a. EXAMPLE: A Producer first becomes certified on February 3, 2012 to sell the current year's HN Medicare products. The certification will remain valid to sell through December 1, 2012 member effective dates.

    b. EXAMPLE: A Producer first becomes certified to sell HN Medicare products on September 20, 2012 by passing the 2012 HN AHIP online training. The certification is accepted as valid for the remainder of 2012, and to sell through January 1, 2013 member effective dates. Additionally, the Producer must take the product specific training for the 2012 selling year and for the 2013 selling year.

3. **HN Region Specific Training Modules:** Each Health Net region develops training modules for their field-based training program that provides regional specific information to Producers and plan Sales Associates about:
    - Health Net's Medicare Advantage and/or Part D Plan products offered in the region
    - Region specific processes and procedures
    - Other information that regional management wants to communicate to sales Producers and plan Sales Associates.
    - Producers and plan Sales Associates who are not able to attend one of the scheduled product specific trainings are required to attend a make-up session and do not become certified or be authorized to sell HN products until training is completed.
    - Producers and Sales Associates are regularly monitored to ensure compliant sales and marketing activities. In an effort to prevent non-compliant activities, Health Net has developed a Medicare Sales Compliance Training module to ensure compliance with the Medicare Marketing Guidelines. Additionally, Health Net will be conducting a series of electronic communications throughout the contract year intended to review topics previously covered in the Compliance Training module and bi-weekly Compliance departmental meetings to further support an effective sales and marketing compliance program.

Documentation and Record-Keeping

The Health Net Medicare Broker Contracting Unit documents the completion of the certification training requirements by using two databases:

1. AHIP: Producers register for the annual certification training and exam at the AHIP website (http://ppg6.pinpointglobal.com/HealthNet/Production/Apps/Medicare/). The AHIP registration database tracks and records that the Producer or HN Sales Associate has read all the required documentation plus verifying certification exam scores (in addition to other demographic information).

2. MACESS is a database that houses information about Producers including, but not limited to:
   - Signed agreement coversheet
   - Copy of the appropriate and current state license(s) required to solicit and sell Health Net Medicare Advantage and Part D products
   - W9 (if directly contracted)
   - Copy of agency authorization (if applicable)
   - Copy of online certification results
   - Electronic Funds Transfer form (optional)

Each Health Net region and contracted sales entity who provides product specific training maintains documentation of the training, including:

- ♦ Copies of the actual training documents
- ♦ Date and time of the training
- ♦ Topic/subject of the training
- ♦ Sign-in sheets with the Producer/plan sales associate name and signature

Contracted Sales Entities Involvement in the Training And Certification Process

Sales Entities contracted with HN assists by working with regional sales management to schedule entity specific field training seminars/webinars. HN may sit in on some training sessions to ensure quality and that accurate information is being provided. The Sales Entity also requires that all of their Producers complete the online certification training (or AHIP training), complete field training, have a writing number, and be approved by HN prior to being allowed to sell any HN MA and Part D Plan products.

Review/Revision History

First Issued……August 2007
Revised……..September 2008
Revised……..September 2009
Revised……..July 28, 2010
Revised……..September, 2010
Revised…….. March 2011
Revised……July, 2011
Revised……..June 2012

Additional Information:
Applies to contract numbers H0351, H0562, H5439, H5520, H6815.

6. Oversight & Reporting of Medicare Marketing/Sales Events

Policy Statement:

Health Net (HN) follows the Centers for Medicare & Medicaid's (CMS) requirements contained in Chapter 3 of the Medicare Managed Care Manual (MMCM) and in the applicable regulations concerning the notification of scheduled Marketing/Sales Events to CMS.HN is committed to accuracy and timeliness in reporting Marketing/Sales Events to CMS via HPMS. The HN Director, Business Compliance, Medicare Sales is responsible for implementing oversight and monitoring of Marketing/Sales Events to ensure compliance with CMS requirements and adherence to applicable HN policies and procedures.

Policy Purpose:

To ensure HN is in compliance with all CMS rules and guidance regarding the collection and submission of sales and marketing event data, the collection and reporting of the cancellation of sales and marketing events and the proper notification to beneficiaries of any cancelled events.

Scope/Limitations:

This policy and the related procedures apply to all employed Sales Associates, contracted Producers, Agencies, General Agents, Field Marketing Organizations (FMO's), Managing Agency (MAGY) or any other downstream entities representing Health Net, Inc., and its subsidiaries.

Related Policies:

BT215-124424 National Medicare Broker Services – Sales Event Submission

References:

42 CFR §417.428, §422.2260, §423.2260, §422.2268, §423.2268

Medicare Managed Care Manual, Ch. 3 Medicare Marketing Guidelines -June 7, 2012

§10 Introduction,§70.10Marketing/SalesEvents; §70.10.1 Notifying CMS of Scheduled Marketing Events

Desktop Procedure: Entering Sales Events into HPMS and Reporting Events to Medicare Compliance (*HNcorp\DFS-Common\Tempe'\GovProgs\DESKTOP PROCEDURES*)

Definitions:

Agency

An agency that allows Producers to write underneath them.

CMS

Centers for Medicare and Medicaid Services. The federal agency within the Department of Health and Human Services that administers the Medicare program.

Field Marketing Organization (FMO)

An FMO is an agency contracted to provide broad coverage for the marketing and sales of a health plan. Areas of support will include, but are not limited to, Marketing / Lead Generation, Call Center capabilities, and Administrative functions.

General Agency (GA)

A GA is an agency contracted to provide sales of a health plan. Typically, its focus

is on Producer recruitment and sales. Areas of support will include, but are not limited to, Producer Certification, Sales Training, Product Training and Compliance Oversight.

HPMS

Health Plan Management System. A CMS multifunctional database used by plan sponsors to communicate various data to CMS, including but not limited to, marketing event notifications to CMS. HPMS also includes various modules such as: Bid Submission, Complaints Tracking Module, Marketing Material Review, and Part C and D Performance Metrics.

Managing Agency (MAGY)

A MAGY is an agency contracted to provide sales of a health plan. Typically, its focus is on limited Provider recruitment and sales within a narrow territory. Areas of support include, but are not limited to, Producer Certification, Sales Training, Product training, Compliance Oversight and Application Enrollment Processing.

Marketing/SalesEvent

Marketing/Sales Presentations designed to steer, or attempt to steer, potential enrollees toward a plan or a limited set of plans. There are two types of sales events, formal and informal. Formal events are sales presentations to beneficiaries in audience/presenter style providing specific plan information. Informal events are normally conducted at a table where beneficiaries receive health plan brochures, pre-enrollment materials, and plan information.

Medicare

The Federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End Stage Renal Disease (ESRD).

Medicare Advantage (MA).

A Medicare program that allows for more choices among Medicare health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (ESRD).

Medicare Advantage (MA) Organization

A public or private entity organized and licensed by a state as a risk-bearing entity (with the exception of provider sponsored organization receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements.

Producer

Any person who is authorized to sell HN Medicare products, including persons who are directly contracted with HN (Individual Producers) and persons who are affiliated with a contracted Sales Entity (Authorized Producers).

Sales Associate

A person directly employed by HN or contracted as a vendor to sell HN Medicare products.

Sales Entity

Field Marketing Organization (FMO), General Agency (GA), Managing Agency (MAGY) or Agency.

Third Party Marketing Organization (TMO)

An entity such as a Field Marketing Organization (FMO), General Agent (GA), or similar type of organization that has been retained to sell or promote a plan sponsor's Medicare products on the plan sponsor's behalf either directly or through sales agents or a combination of both.

Policy/Procedure:

Submission of Medicare Marketing/Sales Events

A. All requests to conduct Marketing/Sales Events at which Health Net Medicare Products will be presented and/or discussed must be submitted to HN for approval in advance of the event, as follows:

1. Complete all required fields of the HN Medicare Marketing/Sales Event Reporting spreadsheet for each proposed event.
2. Fax or email the completed spreadsheet to the Territory Manager, Account Executive, or Broker Services team no later than the 15th of the month before a scheduled event in the following month.
3. The HN Regional Sales Director or delegate will approve or deny all sales event requests.

B. HN reserves the right to deny an event request. If an event request is denied, the submitter will be notified within 48 hours of the denial and an explanation will be provided.

C. HN reports all formal and informal Marketing/Sales events to CMS via HPMS prior to any advertising of the event or, seven (7) calendar days prior to the event's scheduled date, whichever is earlier. See Desktop Procedure: Entering Sales Events into HPMS and Reporting Events to Medicare Compliance.

Reporting Updated, Changed, or Cancelled Events

A. Updated, changed, or cancelled Marketing/Sales events should be submitted to the Territory Manager, Account Executive, or Broker Services team on a new spreadsheet (with an explanation in the email or fax cover sheet) at least 48 hours prior to the originally scheduled date and time.

B. The Territory Manager, Account Executive, or Broker Services team will provide updated sales event data to the designated HN associate in order to modify the Marketing/Sales Event information, which was reported previously to CMS via HPMS.

C. If beneficiaries were identified through personal calls or RSVP, then a representative of the regional sales team or Producer also calls the beneficiaries to inform them of the cancellation.

D. The Sales Associate or Producer must attempt to notify beneficiaries of advertised Marketing/Sales Events by the same media if the event date, time, or venue location has been changed, updated, or cancelled.

E. If notification is not possible using the same media, then a representative must be present at the originally scheduled event start date, time ,and, location and must stay at the location for at least 15 minutes after the scheduled start in order to notify beneficiaries of the event change and /or cancellation. Note: If the Marketing/Sales Event was cancelled due to severe weather, a representative is not required to be present at the location.

F. The Sales Associate or Producer prepares the documentation of notification with an attestation that the event was cancelled; beneficiaries notified, with an explanation why the event was canceled. The documentation must include a list of beneficiary names, phone numbers, and the date/time beneficiaries were notified.

Training

A. Regional Medicare Sales teams provide training regarding the required process for Marketing/Sales Event notification, including the reporting of additional/updated or cancelled events, to all producers, sales associates, and sales entities. This training is included as part of the initial certification and the annual re-certification process and is required for all HN Medicare Sales Associates and Producers.

Conducting a Medicare Marketing/Sales Event

A. For approved HN Marketing/Sales Events, the Sales Associate or Producer must use the HN and CMS approved, market appropriate, sales presentation deck and materials during the Marketing/Sales Event.

B. Only currently contracted, licensed and HN certified Producers (or Sales Associates) are permitted to present at sales events. Seasonal/Temporary Associates licensed and certified may present at sales events with prior approval from the Sales Director.

C. Unlicensed Seasonal/Temporary Associates are permitted to provide seminar assistance, including the following: set-up, check-in, materials distribution, receive completed enrollment forms, and answering plan benefit questions from beneficiaries before and after the sales presentation. Unlicensed Associates are prohibited from, and may not, steer or provide any advice on the selection of a plan.

Compliance

A. .All Sales Associates, Producers, Sales Entities, or any other downstream entities representing HN are responsible for complying with all CMS requirements with sales events. Any costs associated with advertising event changes and/or cancellations will be the sole responsibility of the Producer and/or sales entity unless approved by written permission from the Regional Director of Sales or the Director, Business Compliance, Medicare Sales.

B. All Sales Associates, Producers, and sales entities are required to use HN approved materials to ensure compliant sales events. The materials include, but are not limited to:
    1. HN approved sales event sign-in sheet;
    2. CMS approved sales presentation in printed or electronic formats;
    3. Statement of Understanding for Sales Events (available on healthnet.com);
    4. Sales Collateral.

C. Sales Management reserves the right to attend Marketing/Sales Events to ensure compliance with CMS regulations and adherence to applicable HN policies and procedures.

D. HN contracts with an external company to conduct surveillance of sales presentations to ensure Marketing/Sales Event compliance with CMS regulations. Additionally, CMS performs surveillance ("secret shopping") activities of Marketing/Sales Events.

E. Producers or Sales Associates who fail to comply with this policy are subject to disciplinary action up to and including possible termination.

Sales Management regularly reviews agent /broker oversight activities and deficiencies in order to ensure compliance and improve the program effectiveness.

Review/Revision History

First issued…….September 2012

Addenda(s):

Applies to contract numbers H0351, H0562, H5439, H5520, and H6815

7. Scope of Appointment Documentation / 48 Hour Waiting Period and Cross Selling

Policy Statement:

Health Net (HN) follows the Centers for Medicare & Medicaid's (CMS) requirements contained in Chapter 3 of the Medicare Managed Care Manual and in the applicable regulations, in regard to Scope of Appointment (SOA) documentation. As per CMS requirements, Health Net secures SOA documentation prior to any face-to-face personal/individual Marketing appointment, including beneficiary walk-ins. The SOA documentation is obtained either in writing (and signed by the beneficiary) or obtained verbally via recorded phone conversation and is retained for 10 years. SOA documentation is not required for Marketing presentations, as the products to be discussed should be mentioned in the advertising materials for the event.

In addition, as per CMS requirements, Health Net follows guidelines regarding the 48-hour waiting period and the prohibition against cross-selling Non Health Care Related Products during any Marketing activity.

Policy Purpose:

To ensure Health Net is in compliance with all CMS rules and guidance regarding obtaining SOA documentation by Sales Associates and contracted Producers. In addition, to ensure Health Net is in compliance with all CMS rules and guidance regarding the 48-hour waiting period and the CMS prohibition on cross-selling.

Scope/Limitations:

This policy and the related procedures apply to all Sales Associates employed, contracted, or otherwise representing Health Net, Inc. and its subsidiaries, including independent Producers, Agency, General Agents (GAs), Managing Agency (MAGY), and Field Marketing Organizations (FMOs).

Related Policies:

TR920-113534	Disclosure Requirements
TR920-114053	Introduction to Producer Medicare Program Selling Requirements
TR920-103355	Oversight and Monitoring of Producers
TR920-111825	Rapid Disenrollment - Producer
TR920-123318	Qualification and Primary Duties for Producers
TR920-124259	Required Documentation of Sales Practices
TR920-1182	Sales Allegations
TR920-132651	Monthly Sales and Marketing Event Reporting to Medicare Compliance
TR920-11030	Sales Producer Training
TR920-11273	Standards of Professionalism
TR930-102915	Sales Practices Involving Vulnerable Beneficiaries
TR920-124854	Scope of Appointment/48 Ht Waiting Period and Cross Selling

References:

Title 42 of the CFR 422.2268(g) and (h)

Chapter 3 of the CMS Medicare Managed Care Manual – Update: June 7, 2012

- Chapter 3 of the CMS Medicare Managed Care Manual
  - Section 70.10.2 – Personal/Individual Marketing Appointments
  - Section 70.10.3 – Scope of Appointment

Definitions:

CMS	Centers for Medicare and Medicaid Services. The federal agency within the Department of Health and Human Services that administers the Medicare program.
Cross-Selling	Selling any non-health care related product (annuities, Life Insurance, etc.) during any Medicare Advantage or Part D sales activity or presentation. CMS prohibits cross-selling.
Marketing	Steering, or attempting to steer, an undecided Medicare beneficiary toward Health Net Medicare Advantage and Part D plans through advertising, media, and sales activities.
Medicare	The Federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End Stage Renal Disease (ESRD).
Medicare Advantage (MA)	A Medicare program that allows for more choices among Medicare health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (ESRD).
Medicare Advantage (MA) Organization	A public or private entity organized and licensed by a state as a risk-bearing entity (with the exception of provider sponsored organization receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements.
Non-Health Care Related Products	Any insurance product not involving medical/health coverage (for example, annuities and life insurance). Dental coverage is considered medical/health coverage.
Walk-In	The term used when a beneficiary walks into an establishment (Agency, Producer Office) unsolicited by a producer for the sole purpose of obtaining information to enroll into a plan or discuss plan options to assist in their decision making process.
Sales Entity	Field Marketing Organization (FMO), General Agency (GA) or Agency.
Field Marketing Organization (FMO)	An FMO is an agency contracted to provide broad coverage for the marketing and sales of a health plan. Areas of support will include, but are not limited to, Marketing / Lead Generation, Call Center capabilities, and Administrative functions.
General Agency (GA)	A GA is an agency contracted to provide sales of a health plan. Typically its focus is on Producer recruitment and sales. Areas of support will include, but are not limited to, Producer Certification,

	Sales Training, Product Training and Compliance Oversight.
Agency	An agency that allows Producers to write underneath them.
Producer	Any person who is authorized to sell Health Net Medicare products, including persons who are directly contracted with Health Net (Individual Producers) and persons who are affiliated with a contracted Sales Entity (Authorized Producers).
Sales Associate	A person directly employed by Health Net or contracted as a vendor to sell Health Net Medicare Products.
Managing Agency (MAGY)	A MAGY is an agency contracted to provide sales of a health plan. Typically its focus is on limited Provider recruitment and sales within a narrow territory. Areas of support include, but are not limited to, Producer Certification, Sales Training, Product training, Compliance Oversight and Application Enrollment Processing.
Third Party Marketing Organization	An entity such as a Field Marketing Organization (FMO), General Agent (GA), or similar type of organization that has been retained to sell or promote a plan sponsor's Medicare products on the plan sponsor's behalf either directly or through sales agents or a combination of both.

Procedure:

A. Health Net requires that each Producer and Sales Associate obtain a signed SOA form **prior to** any Marketing appointment with a beneficiary (includes existing Health Net members who wish to discuss alternative Plans). The SOA form must be signed by the beneficiary and returned prior to the appointment. If it is not feasible for the SOA form to be executed prior to the appointment, as an exception, a Producer may have the beneficiary sign the form prior to the start of the sales presentation. The Producer MUST also document why it was not feasible for the SOA to be completed prior to the appointment. This documentation should be added as a note on the SOA Form.

1. Producer may obtain an SOA form and the beneficiary may return the form in the following ways:

   - Mail
   - Fax
   - Email
   - In person (exception rule would apply)

2. **Step 1**: Producer explains to the Medicare beneficiary how to complete the CMS approved Scope of Appointment form.

   Step 2: The Medicare Beneficiary completes and signs the form and returns it to the Producer by **Mail**, **Fax** or **E-mail**.
   The Producer is required to retain the completed Scope of Appointment form, signed by the Medicare Beneficiary, for a time of no less than 10 years. The form must be retained **regardless of appointment outcome** and must be readily accessible to Health Net upon request.

B. Verbal Recording documentation of SOA

Telephonic recording of the Scope of Appointment by authorized producers is not permitted without prior approval from Health Net.

Employed HN Producers will have access to record Scope of Appointments:

- **Step 1:** Receive Medicare Beneficiaries permission to record the conversation.
- **Step 2**: While recording, confirm the Medicare Beneficiaries Name. Confirm the products, or Product lines to be discussed. Confirm the date and time of the appointment. Confirm that the Medicare Beneficiary authorizes the appointment.
- Internal Health Net associates will use vendor's recording software to verbally record documentation of the SOA. Internal Health Net sales associates will contact their Regional Sales Office to obtain these instructions.

Do not begin discussing MA or MAPD plans prior to the beneficiary signing the Scope of Appointment form.

C. SOA Form Document Maintenance

Producers are responsible for maintaining records for a minimum of 10 years and having them immediately available to provide to Health Net upon request.

D. Business Reply Cards (BRC) Used to Fulfill SOA Requirement

A BRC may be used to fulfill the SOA documentation requirement. If Health Net Marketing or a contracted Producer decides to create a BRC to document the SOA requirement, the following elements must be included on the BRC:

1. Beneficiary name, address and phone number
2. Location for the beneficiary to clearly initial the plan type (MA, or MA-PD and other Medicare plans that will be discussed). Plans do not have to specify the product type (HMO, PPO, etc.).
3. Identify the plan type (MA, or MA-PD) – description not required.
4. A beneficiary signature line (for the recorded script, a clear "Yes" oral agreement)
5. Plan Marketing ID#, as required for all Marketing pieces
6. The following 3 disclaimer sentences:
    a. By signing this you are agreeing to a Sales telephone call from a sales agent to discuss the specific types of products you initialed above.
    b. The person that will be discussing plan options with you is either employed or contracted by a Medicare Health Plan or prescription drug plan that is not the Federal government, and they may be compensated based on your enrollment in a plan.
    c. Signing this does NOT affect your current enrollment, nor will it enroll you in a Medicare

Advantage Plan, Prescription Drug Plan, or other Medicare plan.

E. Scope of Appointment Form and Waiting Period

Producers must document the scope of a marketing appointment prior to any face-to-face sales meeting (48 hours in advance when practicable). When the Scope of Appointment (SOA) form is used for documentation, the beneficiary (or their authorized representative) must initial the product types to be discussed and must sign and date the form.

If the SOA form is signed by the beneficiary at the time of the appointment or was signed by the beneficiary less than two (2) days in advance of the appointment date, then the Producer must provide an explanation for the exception on the SOA form.

Examples of exceptions to the two day (or 48 hour) waiting period include:

1. an individual marketing appointment that follows a marketing/sales event at which a completed and signed SOA was obtained;
2. beneficiary walk-ins (unplanned visit from the beneficiary at a Plan or Producer office);
3. when, at the request of the beneficiary, additional product types – not in scope on the initial SOA – need to be discussed during a current appointment. Note: a second scope of appointment form must be completed prior to discussion of additional product types;
4. when a beneficiary receives the SOA two days prior to the appointment, but does not have access to fax, email, or another mechanism which would allow him/her to return the SOA form 48 hours prior to the appointment

During a marketing appointment, Producers can only discuss health care products which have been agreed upon by the beneficiary in the Scope of Appointment.

Review/Revision History

Revised……September 2009
Revised……September 2010
Revised……March 2011
Revised……July 2011
Revised……July 2012

Additional Information:
Applies to contract numbers H0351, H0562, H5439, H5520, H6815

health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

Health Net
MEDICARE PROGRAMS

SCOPE OF SALES APPOINTMENT CONFIRMATION FORM

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

☐	**Stand-alone Medicare Prescription Drug Plans (Part D)**
	Medicare Prescription Drug Plan (PDP) – A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.
☐	**Medicare Advantage Plans (Part C) and Cost Plans**
	Medicare Health Maintenance Organization (HMO) – A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
	Medicare Preferred Provider Organization (PPO) Plan – A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.
	Medicare Private Fee-For-Service (PFFS) Plan – A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.
	Medicare Special Needs Plan (SNP) – A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.
	Medicare Medical Savings Account (MSA) Plan – MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

Material ID# Y0035_2012_0031 (H0351,H0562, H5439, H5520, H6815, S5678) File & Use 08022011

Medicare Cost Plan – In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

_____

Signature:

_____

Signature Date:

If you are the authorized representative, please sign above and print below:

Representative's Name: _____

Your Relationship to the Beneficiary: _____

To be completed by Agent:

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	
Date Appointment Completed:	
Plan Use Only: 6025431 CA82678 (7/11)	

Scope of Appointment documentation is subject to CMS record retention requirements

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:

Health Net A Medicare Advantage organization with a Medicare contract. A stand-alone prescription drug plan with a Medicare contract.

A Coordinated Care plan with a Medicare Advantage contract but without a contract with the state Medicaid program.

SCOPE OF APPOINTMENT – 48 HOUR WAITING PERIOD RULE CHART

Health Net® MEDICARE PROGRAMS

According to Centers for Medicare and Medicaid Services (CMS), a beneficiary must agree to the scope of products that will be discussed with an agent *prior to* any face-to-face personal/individual marketing appointment. The agreement can be documented telephonically by the Plan (only) or by the agent using a Scope of Appointment (SOA) form. In either case, the beneficiary must agree to the products that can be discussed (i.e. the scope) at a face-to-face personal/individual marketing appointment.

Initial Scope of Appointment Product Discussion Agreement	Secondary Product Discussion	SOA Req'd	Schedule secondary appt	48 Hour Waiting Period Req'd	Medicare Marketing Guideline Reference	Agent Documentation
Initial Stand-alone Prescription Drug Plans (Part D) or Medicare Advantage Plans (Part C)	N/A	Yes	N/A	No	70.5.1, 70.9.1	If unable to obtain SOA **before** the appt, agent must document the reason given by beneficiary on the form
Stand-alone Prescription Drug Plans (Part D)	**Agent** initiates Medicare Advantage Plans discussion	Yes	Yes (when practicable)	Yes (when practicable)	70.5.1, 70.9.1	If not practicable to wait 48 hrs, agent must document reason on the form and proceed with discussion
Stand-alone Prescription Drug Plans (Part D)	**Beneficiary** initiates Medicare Advantage Plan discussion	Yes	No	No	70.5.1, 70.9.1	Agent must document beneficiary request on the form and proceed with discussion
Medicare Supplement	**Agent or beneficiary** initiates Medicare Advantage &/or Prescription Drug Plan discussion	Yes	Yes (when practicable)	Yes (when practicable)	70.5.1, 70.9.1	If not practicable to wait 48 hrs, agent must document reason on the form and proceed with discussion.
Non-healthcare product (life, annuities, etc.) appointment NOTE: CROSS-SELLING OF NON-HEALTH PRODUCTS DURING MA OR PART D SALES OR MARKETING ACTIVITY IS PROHIBITED	**Agent or beneficiary** initiates Medicare Advantage &/or Prescription Drug plan discussion	Yes	Yes	No	70.8, 70.9.1	If agent returns for appt at beneficiary request on same day, must document the reason given by beneficiary on the form
Stand-alone Prescription Drug Plans (Part D) or Medicare Advantage Plans (Part C) **initiated by the beneficiary immediately after a public sales presentation**	N/A	Yes	No	No	70.9.1	Agent must indicate "beneficiary requested appt immediately following public sales presentation" on the form
Stand-alone Prescription Drug Plans (Part D) or Medicare Advantage Plans (Part C) **initiated by the beneficiary after walking into office**	N/A	Yes	No	No	70.9.2	Agent must indicate "walk-in" on the form

SCOPE OF APPOINTMENT FREQUENTLY ASKED QUESTIONS (FAQs)

Question 1: A Producer has a pre-scheduled appointment at a beneficiary's home to discuss Medicare Supplement plans. No Scope of Appointment was obtained. During the meeting, the beneficiary asks about Medicare Advantage (MA) and/or PDP plans. Can the Producer discuss MA or Part D plans?

- **Answer**: Yes, if the beneficiary initiates discussion about MA or Part D plans, the Producer may have the beneficiary complete a Scope of Appointment form and continue with the discussion about MA or Part D plans.

Question 2: A Producer has an appointment with a beneficiary to discuss a PDP product and Scope of Appointment documentation was obtained as required. During the appointment, the beneficiary requests to discuss an MA product. Can the Producer discuss an MA product with the beneficiary?

Answer: Yes, since an SOA form was completed for the initial appointment, the Producer must have the beneficiary sign a new Scope of Appointment form to discuss MA products and then may continue the marketing appointment. A new separate appointment is not required.

Question 3: A Producer has a pre-scheduled sales appointment at a beneficiary's home. At the end of the meeting, the beneficiary invites the Producer to his next-door neighbors house because he mentioned the meeting to his friend, who is also interested in meeting with the Producer regarding Medicare Advantage and/or PDP plans. Can the Producer meet with the neighbor?

Answer: No. The Producer does not have an appointment with the neighbor. The neighbor must schedule an appointment with the Producer and the specific lines of business to be discussed must be identified and documented on the Scope of Appointment form or via a recorded telephone conversation when the appointment is scheduled. In addition, the Producer cannot go next door to meet the neighbor, as this would be considered door-to-door solicitation.

Question 4: A Producer arrives at the beneficiary's home to find several of the beneficiarie's friends there, who are interested in hearing the sales presentation. Can the Producer proceed with the sales presentation in the presence of the beneficiary's friends?
Answer: Yes. The Producer can still give his/her presentation in the presence of friends, as long as the additional beneficiaries complete the Scope of Appointment form prior to conducting the sales discussion (indicate on the form "beneficiary-initiated contact"). The Producer may also enroll the friends. Note: the Producer must have been unaware that the additional beneficiaries
or friends would be there prior to the appointment.

Question 5: Is a 2nd SOA form required when the Producer returns a second time to close the sale, complete paperwork, etc.

Answer: As long as the same products are being discussed, the SOA would still apply. The SOA form doesn't include a date, so the scope isn't tied to a specific appointment.

It applies to the products that will be discussed. So, the SOA would still be valid unless there is change in the products to be discussed.

Question 6: If a prospect needs to reschedule an appointment (same plan discussions), do we need a new SOA or voice recording?

Answer: No, a new SOA form is not required for rescheduled appointments.

Question 7: Do we need a scope of appointment form for a non-sales appointment? Example, a member requests a buy up option form or a directory or mail order prescription from, etc.

Answer: No. The Scope of Appointment documentation is only required for Sales related appointments. Producers meeting with their current clients for purposes unrelated to sales would not require this documentation.

Question 8: Can a beneficiary sign an SOA form at a marketing presentation? If so, can a Producer meet with the beneficiary immediately, or do they have to wait 48 hours?

Answer: A beneficiary can sign an SOA form at a marketing/sales presentation and the Producer can arrange to meet individually with that beneficiary immediately after the marketing/sales presentation. The 48-hour waiting period does not apply.

Question 9: Can Health Net accept an SOA form from another Organization?

Answer: Yes, a Producer who contracts with multiple organizations will sometimes use an SOA form from one Organization but enroll the beneficiary into another Organization.

CMS encourages Plans to use the Model SOA form, which is not Organization specific.

8. Disclosure Requirements

Policy Statement:
Health Net follows the Centers for Medicare & Medicaid's (CMS) requirements contained in Chapter 3 of the Medicare Managed Care Manual and in the applicable regulations, in regard to disclosure requirements. CMS requires Medicare Advantage (MA) organizations and MAPD Plan sponsors to provide certain disclosures to beneficiaries while conducting sales activities. Producers who sell Health Net (HN) MA and MAPD products are required to provide these disclosures to beneficiaries, in writing and/or verbal, in accordance with CMS guidelines.

Policy Purpose:
The purpose of this policy is to ensure that point of sale disclosures are made in Compliance with CMS Marketing guidelines and that consistent language is used to represent Health Net's status as a contracted Medicare Advantage (MA) Plan and MAPD sponsor.

Scope/Limitations:
This policy applies to all Health Net Sales Associates, external sales Producers contracted by Health Net, including independent Producers, Agency, General Agents (GA's), Managing Agency (MAGY) and Field Marketing Organizations (FMO's).

Related Policies:

TR920-113534	Disclosure Requirements
TR920-114053	Introduction to Producer Medicare Program Selling Requirements
TR920-103355	Oversight and Monitoring of Producers
TR920-122549	Medicare Sales Materials
TR920-111825	Rapid Disenrollment - Producer
TR920-123318	Qualification and Primary Duties for Producers
TR920-124259	Required Documentation of Sales Practices
TR920-1182	Sales Allegations
TR920-132651	Monthly Sales and Marketing Event Reporting to Medicare Compliance
TR920-11030	Sales Producer Training
TR920-11273	Standards of Professionalism
TR930-102915	Sales Practices Involving Vulnerable Beneficiaries
TR920-124854	Scope of Appointment/48 Ht Waiting Period and Cross Selling

References:
Title 42 of the CFR 422.2268
Title 42 of the CFR 423.2268

Chapter 3 of the CMS Medicare Managed Care Manual – Update: June 7, 2012
Sections: 10 Introduction; 30.5 Plan Sponsor Responsibility for Subcontractor Activities and

Submission of Materials for CMS Review; 30.6 Anti Discrimination; 30.9 Required Materials in Enrollment Kit; 70.8 Marketing /Sales Events; 120 Guidance on Marketing and Sales Oversight and Responsibility.

Definitions:

CMS	Centers for Medicare and Medicaid Services. The federal agency within the Department of Health and Human Services that administers the Medicare program.
Medicare	The Federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End Stage Renal Disease (ESRD).
Medicare Advantage (MA)	A Medicare program that allows for more choices among Medicare health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (ESRD).
Medicare Advantage Organization (MAO)	A public or private entity organized and licensed by a state as a risk- bearing entity (with the exception of provider sponsored organization receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements.
Medicare Advantage Prescription Drug	An MA plan that provides qualified prescription drug coverage.
Part D Plan	A prescription drug plan (PDP), an MA-PD plan, or a PACE plan offering qualified prescription drug coverage. This includes employer- and union-sponsored plans.
Part D Plan Sponsor	Refers to an organization offering a PDP, MA or MA-PD plan, a PACE organization offering a PACE plan including qualified prescription drug coverage, and a cost plan offering qualified prescription drug coverage. This includes employer- and union-sponsored plans.
Prescription Drug Plan (PDP)	Prescription drug coverage that is offered under a policy, contract, or plan that has been approved as specified in 42 C.F.R. 423.272 to offer qualified prescription drug coverage.
Sales Entity	Field Marketing Organization (FMO), General Agency (GA), Managing Agency (MAGY) or Agency.
Field Marketing Organization (FMO)	An FMO is an agency contracted to provide broad coverage for the marketing and sales of a health plan. Areas of support will include, but are not limited to, Marketing/Lead Generation, Call Center capabilities, and Administrative functions.
General Agency (GA)	A GA is an agency contracted to provide sales of a health plan. Typically its focus is on Producer recruitment and sales. Areas of support will include, but are not limited to, Producer Certification, Sales Training, Product Training and Compliance Oversight.
Agency	An agency that allows Producers to write underneath them.

Producer	Any person who is authorized to sell Health Net Medicare products, including persons who are directly contracted with Health Net (Individual Producers) and persons who are affiliated with a contracted Sales Entity (Authorized Producers).
Sales Associate	A person directly employed by Health Net or contracted as a vendor or sell Health Care Medicare products.
Managing Agency (MAGY)	A MAGY is an agency contracted to provide sales of a health plan. A MAGY is an agency contracted to provide sales of a health plan. Typically its focus is on limited Provider recruitment and sales within a narrow territory. Areas of support include, but are not limited to, Producer Certification, Sales Training, Product training, Compliance Oversight and Application Enrollment Processing.
Third Party Marketing Organization (TMO)	An entity such as a Field Marketing Organization (FMO), General Agent (GA), or similar type of organization that has been retained to sell or promote a plan sponsor's Medicare products on the plan sponsor's behalf either directly or through sales agents or a combination of both

Procedure:

General Requirements

1. All Producers and Sales Associates must comply with the Medicare Marketing Guidelines. These rules require Producers and Sales Associates to make specific verbal disclosures and distribute written disclosures at all public sales presentations &/or meetings.
2. At the beginning and during the sales presentation, Producers and Sales Associates must provide adequate written descriptions of plan information (made available by HN) per CMS regulations, which require certain disclosures by using the entire HN pre-enrollment kit during all sales presentations.
3. Producers and Sales Associates are regularly monitored to ensure compliant sales and marketing activities. All non-compliant activities reported to Health Net are investigated and appropriate enforcement and corrective actions are taken in accordance with HN Policies and Procedures.
4. In order to detect, prevent, and help resolve non-compliant Producer and Sales Associate marketing and sales activities, Health Net contracts with an external surveillance agency to secret shop public sales presentations for compliance with the Medicare Marketing Guidelines.

Special Needs Plan (SNP) Enrollment Disclosure

1. Producers and Sales Associates must provide the entire HN SNP pre-enrollment kit, which includes the Comprehensive Written Statement (CWS) contained in the Summary of Benefits (SB) packet to all prospective SNP enrollees.
2. The CWS must be provided to the beneficiary to compare the benefit package of the SNP for an informed benefit plan choice.
3. Prospective SNP enrollees, regardless of their enrollment method, are required to sign and acknowledge receipt of the Dual SNP SB (which includes the CWS)

prior to the enrollment effective date.

Producer Disclosure Responsibilities – Sales Meetings

The following is a list of disclosure items that must be communicated during sales meetings and is not meant to be an all-inclusive list:

1. Producers and Sales Associates must verbally mention the types of products (ie. HMO, PPO, etc.) to be discussed at the beginning of the sales presentation.
    - Producers must also use this language in the introduction of a sales presentation/seminar or an inbound phone call.
2. Producers must use a sign-in sheet that clearly indicates completion of any contact information is optional and by providing the information, a Sales Representative may call. Sales Associates are required to use the Health Net approved sign-in sheet.
3. Producers and Sales Associates must verbally mention the prescription drug information including copayments, costs, coverage gap or "donut hole" and formulary.
4. During SNP presentations/events, Producers and Sales Associates must clearly explain the following during SNP presentations/events:
    - Eligibility limitations (e.g., required special needs status)
    - Special enrollment period (SEP) to enroll in, change or leave SNPs
    - Process for in-voluntary disenrollment if the beneficiary loses his/her Medicaid or institutional status (or becomes ineligible for the C-SNP).
    - A description of how drug coverage works with the plan.
5. Sales Associates are required to use the Health Net/CMS approved sales presentation for 2013.

Producer Disclosure Responsibilities – Sales Appointments

The following is a list of disclosure items that must be communicated during sales meetings and is not meant to be an all-inclusive list:

1. Producers and Sales Associates must clearly and accurately disclose or provide:
    - a business card or contact information;
    - at the beginning of the sales presentation the type of plan (ie. HMO, PPO, Medicare Supplement, etc.) to be discussed at the beginning of the sales presentation;
    - other coverage (employer group, Med Supp, Medicare Advantage) disenrollment process;
    - all current doctor(s), medical group, hospital contractual status with HN;
    - power of attorney (POA) if any, to be present to discuss plan information;
    - special needs plan (SNP) eligibility, HMO plan network and referral requirements, and auto–disenrollment in current stand-alone drug coverage.

Review/Revision History

First issued……August 2007
Revised……September 2008
Revised……October 2008
Revised……November 21, 2008
Revised……September 2009
Revised……August 2010
Revised……March 2011
Revised……July 2011
Revised……July 2012

Additional Information:

Applies to contract numbers H0351, H0562, H5439, H5520, H6815.

9. Medicare Sales Materials

Policy Statement:
Health Net follows the Centers for Medicare & Medicaid's (CMS) requirements contained in Chapter 3 of the Medicare Managed Care Manual and in the applicable regulations, in regard to the use of sales materials in the selling of all CMS-contracted products.

Policy Purpose:
The purpose of this policy is to provide guidance to help ensure that Producers understand Health Net and CMS approval requirements regarding Medicare Advantage and MAPD advertising and sales materials in order to prevent misrepresentations or violations of CMS regulations and marketing guidelines.

Scope/Limitations:
This P&P applies to all Sales Producers employed or contracted by HN, including full time Health Net Sales Associates, seasonal Health Net Sales Associates, independent Producers, Agency, General Agencies (GAs), Managing Agency (MAGY) and Field Marketing Organizations (FMOs).

Related Policies:

TR920-113534	Disclosure Requirements
TR920-114053	Introduction to Producer Medicare Program Selling Requirements
TR920-103355	Oversight and Monitoring of Producers
TR920-111825	Rapid Disenrollment - Producer
TR920-123318	Qualification and Primary Duties for Producers
TR920-124259	Required Documentation of Sales Practices
TR920-1182	Sales Allegations
TR920-132651	Monthly Sales and Marketing Event Reporting to Medicare Compliance
TR920-11030	Sales Producer Training
TR920-11273	Standards of Professionalism
TR930-102915	Sales Practices Involving Vulnerable Beneficiaries
TR920-124854	Scope of Appointment/48 Ht Waiting Period and Cross Selling
HG-MKTG-001	Medicare Advantage (MA) and Part D Marketing Material Development
HG-MKTG-002	Medicare Advantage (MA) and Part D Marketing Material Pre-Production Quality review
HG-MKTG-003	Medicare Advantage (MA) and Part D Marketing Material Post Production Quality Maintenance
HG-MKTG-004	Medicare Advantage (MA) and Part D Marketing Material Obsolescence
	Health Net Government Programs Transition of Medicare Sales Materials

References:

Title 42 of the CFR 422.2268
Title 42 of the CFR 423.2268

Chapter 3 of the CMS Medicare Managed Care Manual – Update: June 7, 2012
Sections: 10 Introduction; 30.5 Submission of Materials for CMS Review; 30.6 Anti Discrimination; 120.4 Agent/Broker Use of Marketing Materials

Definitions:

Alfresco	A content management tool that allows the user to create, share and retain content, enabling users to version control, search and review content.
CMS	Centers for Medicare and Medicaid Services. The federal agency within the Department of Health and Human Services that administers the Medicare program.
Creative Services	Health Net in-house creative team responsible for the writing, design, and production of advertising, pre-enrollment and some post-enrollment Marketing Material.
Health Net Medicare Compliance	Internal Health Net department that acts as a liaison between CMS and Health Net to provide oversight of Health Net's Medicare Programs and its functions.
Health Net Medicare Compliance Team	Health Net Medicare Compliance staff members who act as a subject matter experts relating to the CMS Marketing Guidelines. These associates work with the appropriate functional areas to implement marketing regulations, perform Marketing Material reviews, Marketing Material submissions, and performs general oversight functions concerning Marketing Materials.
Health Net Medicare Marketing Lead	A Health Net associate, designated by the Marketing department Vice President or Director, that has responsibilities for Producer and Provider Marketing Materials as well as other assigned Marketing responsibilities.
Marketing	Steering, or attempting to steer, an undecided potential enrollee towards a plan, or limited number of plans, and for which the individual or entity performing marketing activities expects compensation directly or indirectly from the plan for such marketing activities. "Assisting in enrollment" and "education" does not constitute marketing.
Marketing Creative Services Database	Software program used to initiate and house marketing job requests produced through the Creative Services team (i.e., advertising, pre-enrollment and some post-enrollment marketing material).
Marketing Materials	Marketing materials include any informational materials that perform one or more of the following actions: Promote an organization; provide enrollment information for an organization; explain the benefits of enrollment in an organization; describe the rules that apply to enrollees in an organization; explain how Medicare services are covered under an organization, including conditions that apply to such coverage; communicate with the individual on various

	membership operational policies, rules, and procedures.
Medicare	The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End Stage Renal Disease (ESRD).
Medicare Advantage (MA)	A Medicare program that allows for more choices among Medicare health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (ESRD).
Medicare Advantage (MA) Organization	A public or private entity organized and licensed by a state as a risk-bearing entity (with the exception of provider sponsored organization receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements.
Medicare Materials Review Team	(MMRT) Dedicated team of Health Net Quality Auditors that review all mass Medicare member mailing (EGHP and Individual) document templates before submitting to Compliance and/or CMS where required. Additionally, the team reviews data files, member universe, mailing list, and post production samples for all mass mailings and outbound call script and approves for use before distribution.
Part D Plan	A prescription drug plan (PDP), an MA-PD plan, or a PACE plan offering qualified prescription drug coverage. This includes employer- and union-sponsored plans.
Part D Plan Sponsor	Refers to an organization offering a PDP, MA or MA-PD plan, a PACE organization offering a PACE plan including qualified prescription drug coverage, and a cost plan offering qualified prescription drug coverage. This includes employer- and union-sponsored plans.
Sales Entity	Field Marketing Organization (FMO), General Agency (GA), Managing Agency (MAGY) or Agency.
Field Marketing Organization (FMO)	An FMO is an agency contracted to provide broad coverage for the marketing and sales of a health plan. Areas of support will include, but are not limited to, Marketing / Lead Generation, Call Center capabilities, and Administrative functions.
General Agency (GA)	A GA is an agency contracted to provide sales of a health plan. Typically its focus is on Producer recruitment and sales. Areas of support will include, but are not limited to, Producer Certification, Sales Training, Product Training and Compliance Oversight.
Agency	An agency that allows Producers to write underneath them.
Producer	Any person who is authorized to sell Health Net Medicare products, including persons who are directly contracted with Health Net and persons who are affiliated with a contracted Sales Entity.
Managing Agency (MAGY)	A MAGY is an agency contracted to provide sales of a health plan. Typically its focus is on limited Provider recruitment and sales within a narrow territory. Areas of support include, but are not limited to, Producer Certification, Sales Training, Product training, Compliance Oversight and Application Enrollment Processing.

Third Party Marketing Organization (TMO)	An entity such as a Field Marketing Organization (FMO), General Agent (GA), or similar type of organization that has been retained to sell or promote a plan sponsor's Medicare products on the plan sponsor's behalf either directly or through sales agents or a combination of both.

Procedure:

Producer Generated Materials:

Marketing materials cannot be submitted directly by a third party to CMS. All Producer marketing materials that include the Health Net name, logo or specific plan information, including multiple plan marketing materials and translated materials must be submitted to HN for approval prior to use by the Producer. Producers who wish to submit a translation of a Marketing Material must first have their material filed in English and CMS accepted. All Producers with marketing materials that support multiple plan sponsors must maintain documentation of approval by the plan sponsor that reviewed, submitted and received approval from CMS. Attachment A provides more specific detail on this requirement.

1. The Producer submits marketing Material to HN via e-mail to MedicareMktgReview@healthnet.com along with the a completed checklist (see Attachment B):
2. The Health Net Medicare Marketing Lead retrieves the submission from the above referenced e-mail inbox within 3 business days.

3. The Health Net Medicare Marketing Lead assigns the submitted Marketing Material a Health Net job number and enters it into the Health Net Marketing Creative Services database.

4. The Health Net Medicare Marketing Lead forwards the proposed Marketing Material to the Medicare Marketing Review Team and Health Net's Compliance Team via Alfresco, along with a description as provided by the Producer.

5. After a review by the Medicare Materials Review Team, (within 3 business days of receiving the document), the Health Net Medicare Compliance Team begins reviewing the submitted material to ensure material compliance based on CMS requirements. It is the responsibility of the Medicare Compliance team to determine if the submitted Marketing Material needs to be filed with CMS as File and Use Certification, 45-day CMS filing review, or Compliance Approval Only. The Health Net Compliance team responds to initial reviews within 5 to 7 business days of receiving the request in Alfresco.

    a. If the Marketing Material does not need to be submitted to CMS for approval, the Health Net Medicare Compliance Team notifies the Health Net Medicare Marketing Lead of the decision via Alfresco.

    b. If the Marketing Material needs to be submitted to CMS for approval, the Health Net Medicare Compliance Team notifies the Health Net Medicare

Marketing Lead if the piece qualifies for File and Use status or must be submitted for a 45-day review process via Alfresco.

6. If any mandatory content (as provided in the Medicare Marketing Guidelines) has been omitted, the Health Net Medicare Compliance Team returns the material back to the Health Net Medicare Marketing Lead via Alfresco, requesting more information, mandatory CMS and Compliance edits, and suggestions. Medicare Compliance also informs the Medicare Marketing Lead of the filing status and material ID at this time.

7. The Health Net Medicare Marketing Lead notifies the Producer using a Medicare Material Status History Form (see Attachment C) via email of the required edits.

8. The process described above repeats until the Health Net Medicare Compliance Marketing Lead deems the Marketing Material suitable for submission to CMS or Compliance approval. Subsequent reviews by the Health Net Medicare Compliance Team is completed within 3 business days of receiving the request in Alfresco.

9. Once the edits have been added by the Producer, submitted through Alfresco and approved for use by CMS or Compliance, the Health Net Medicare Compliance Team notifies the Health Net Medicare Marketing Lead of the date that the Marketing Material may be distributed, or is approved.

10. Upon approval of the marketing material, one additional edit is made to include the Approval or Distribution date to the Marketing Material. Medicare Compliance team requests that the final Marketing Material be submitted for final Compliance approval.

11. Upon final approval, the Health Net Medicare Marketing Lead notifies the Producer using a Medicare Material Status History Form (see Attachment C) via email that they may proceed with use of the Marketing Material including the first date of approved distribution.

12. The Health Net Medicare Marketing Lead uploads approved Marketing Material into the Creative Services Marketing database, for tracking purposes.

Producer Websites

Producers are responsible for the following when using their own website to market to beneficiaries:

The Producer website must be maintained and updated with the most current HN and CMS approved materials and other information for Annual Enrollment, Medicare Advantage Disenrollment Period (MADP), and Lock-in periods.

CMS and HN Approved Marketing Materials

1. Producers may access HN/CMS approved marketing materials on the Broker portal section of Healthnet.com.
2. Within the Broker portal, the Producer access the “Brochures & Forms” section.
3. A list of HN/CMS approved materials display in PDF format on the screen. The Producer can access any of the approved materials and make edits to the bracketed sections of the PDF only. Non-bracketed areas of the material are locked to prevent unauthorized edits to the material.
4. Producers who mail marketing materials to beneficiaries are required to include one of three statements on any envelope or the mailing itself (if no envelope is being sent) regardless of the material inside of the envelope.
   - Advertising pieces – “This is an advertisement”
   - Plan Information – “Important plan information about your enrollment”
   - Health – “Health or wellness or prevention information”
   - Other – non health or non plan related information

Marketing Material Obsolescence

Materials that have been marked as obsolete can no longer be used in marketing to Medicare beneficiaries. Producers are notified via email when materials become obsolete. Producers can also view obsolete materials in the HN broker portal website. Follow this path to view Obsolescence documents: www.healthnet.com >I'm A Broker >Quick Links > Forms and Brochures >Medicare Plans > Other Medicare Materials/ Obsolescence Documents.

Auditing

1. Health Net may periodically request copies of Producer marketing materials that have been used to ensure only CMS approved materials are being used and that the CMS approved content was not modified by the Producer. Additionally, a random audit of Producer and Sales Entity websites may be conducted to ensure the most current HN and CMS approved materials are being used in accordance with HN policies and procedures.

Review/Revision History
Revised……September 2009
Revised……September 2010
Revised……March 2011
Revised……July 2011
Revised……..July 2012

Additional Information:
Applies to contract numbers H0351, H0562, H5439, H5520, H6815.

Health Net Medicare Marketing Materials Submission, Approval, & Audit Requirements
Applies to Policy TR920-122549
Final as of July 14, 2011

Procedure Ref.	Item and/or Content	Approval Submission Requirements	Producer Documentation & Retention Requirements	Health Net Audit
Producer Generated Materials – 1	**Producer developed Health Net marketing item** (company logo, plan names, benefits, premiums, etc)	Must be submitted to Health Net for review and CMS approval. Producer may not use until Health Net returns the final approved version and the first date of approved distribution.	Producer must retain a copy for not less than 10 years.	Health Net may audit Producer documents to ensure that the distributed copy matches the final HN/CMS approved copy.
Producer Generated Materials – 2	**Multiple MAOs marketing item - Full Generic item** that references only that the producers offers MA, MA-PD, and/or PDP plans. No MAO names, Part D sponsor names, plan names, premiums, plan services, or benefits may be part of the item	No Health Net submission or approval requirements. NOTE: there may be state law approval requirements regarding the advertisement of insurance products. Such compliance is the full responsibility of the Producer.	None	None
Producer Generated Materials – 3	**Multiple MAOs marketing item - Partial Generic item** that references no MA, MA-PD, and/or PDP plans, no MAO names, no Part D sponsor names; **however**, the item does reference a premium (such as "$0 premium plans available") or benefit ("$0 copay for office visits") that is a benefit or service offered by a Health Net plan	Producer must submit either to Health Net or another MAO for approval: 1. If submitted to HN, HN will review and submit for CMS approval. Producer may not use until Health Net returns the final approved version and the first date of approved distribution. 2. If submitted to another MAO for approval, Producer must maintain a copy of the finished item and the approval documentation, including the approval code provided by the MAO. Submission	Producer must retain a copy for not less than 10 years.	Health Net may audit Producer documents to ensure that the distributed copy matches the final approved copy.

Health Net Medicare Marketing Materials Submission, Approval, & Audit Requirements
Applies to Policy TR920-122549
Final as of July 14, 2011

Procedure Ref.	Item and/or Content	Approval Submission Requirements	Producer Documentation & Retention Requirements	Health Net Audit
		to Health Net is not required.		
Producer Websites	Producer website content	None	Producer must follow all CMS guidelines and include appropriate disclosures.	Health Net may audit Producer websites to ensure that the CMS guidelines are being met.
CMS and HN Approved Marketing Materials	**Health Net developed** marketing item (company logo, plan names, benefits, premiums, etc)	Producer may use as is (with no content alterations other than in "unlocked" fields: producer name, phone number, etc)	Producer must retain a copy for not less than 10 years.	Health Net may audit Producer documents to ensure that the distributed copy matches the final HN/CMS approved copy.

Broker Medicare Advertising Material Submission Process

Objective of this document is to provide you with a tool to help ensure that 1) your Medicare advertising materials meet the CMS guidelines, and 2) help ensure a smooth material approval process.

1. **Material Submission**
   1.1. First, determine if your advertising material needs to be submitted to Health Net for further review/approval prior to being used in the marketplace.

   1.1.1. Submission is required if material satisfies one or more of the following criteria:
   - Health Net name, logo, plan name or benefits are mentioned in the material
   - No reference to Health Net or any other plan sponsor is made (including name, logo, plan name or benefits), but material explains the benefits of enrollment in an MA plan or MA-PD plan, or rules that apply to enrollees.
   - No reference to Health Net or any other plan sponsor is made (including name, logo, plan name or benefits), but material explains how Medicare services are covered under an MA plan or MA-PD plan, including conditions that apply to such coverage.

   NOTE: Material referencing Medicare Annual Enrollment Period and timeframe alone does not require submission, provided no additional information set forth in 1.1.1 is included.

   1.1.2. Submission is not required if material satisfies one or both of the following criteria:
   - Material does not satisfy any of the criteria outlined in section 1.1.1
   - Material was developed and provided by Health Net as part of the "broker toolkit"

   NOTE: Advertising materials not requiring Health Net's review must still comply with CMS minimum requirements and are subject to audit. These minimum requirements are as follows: "*Materials should not mislead or confuse beneficiaries by words, symbols, logos or terminology that would imply or give the false impression they are endorsed/approved/authorized by Medicare or any other federal agency or program. In addition, the materials should include accurate terminology and timelines set forth by CMS or any other federal agency referenced.*"

   1.2. If further review is required per section 1.1 above, please review your advertising material against the attached checklist to make sure CMS requirements are met.

   1.3. Complete and enclose checklist along with your advertising material and email both to MedicareMktgReview@Healthnet.com

2. **Material Review Timing**
   2.1. Due to the regulatory nature of our business, please allow a minimum of **45 calendar days*** for review from the date your completed checklist and advertising material are submitted to Health Net.
   *Estimated time is based on: a) material qualifying for 5-day File & Use status, and b) 3 rounds of revisions (3 business days for each round). NOTE: Materials requiring CMS review will take an additional 45 days.

   2.2. AEP (Annual Enrollment Period) materials to be used Oct 1 – Dec 7 must be submitted no later than **October 15**. AEP materials submitted after October 15 cannot be processed as there won't be sufficient time left to have material approved prior to the end of AEP.

(continued)

2.3. To help expedite the review process, please ensure:
   2.3.1. Completed checklist is enclosed with your submission, and
   2.3.2. Your material meets the requirements outlined in the checklist material attestation section

3. Resources/Help

3.1. For questions regarding this process or checklist, please email Health Net at MedicareMktgReview@HealthNet.com

3.2. CMS marketing guidelines can be found at:

http://www.cms.hhs.gov/managedcaremarketing/03_finalpartcmarketingguidelines.asp

Health Net

Broker Medicare Advertising Material Review Checklist

Section 1: GENERAL INFORMATION			
A. Material Title:		**B. Submission Date:**	
C. Material Purpose: (Provide detailed explanation of how this material will be used)			
D. Will this material be mailed?	☐ Yes ☐ No Note: If you answered "Yes" and will be using an envelope for your mailing, you must use a CMS-approved envelope (see Health Net broker toolkit for CMS-approved envelope template), or provide envelope for approval along with your material. Envelopes may require 45-day CMS review in addition to Health Net's review timing. See required legal disclaimers in section 3 for applicable legal language.		
E. Plan Type Promoted: (Check all that apply)	☐ HMO Plans ☐ PPO Plans ☐ SNP Plans ☐ N/A		
F. Distribution Period:	☐ AEP ☐ MADP ☐ SEP ☐ Year Round ☐ Other (explain in Material Purpose)		
G. Distribution Year:	☐ 2012 ☐ 2013		
H. Geography: (Check all that apply and include counties material will be distributed in)	☐ California; County(ies): ☐ Oregon; County(ies): ☐ Arizona; County(ies):		
I. Are health plans, other than Health Net listed?	☐ No If "No," skip to section K. ☐ Yes If "Yes," you must designate one of the health plans listed in your material as 'Lead Plan Sponsor'. The rest of health plans will be considered 'Non-Lead Plan Sponsors'. All health plans must review/approve the material. Lead Plan Sponsor will then do initial filing with CMS. All Non-Lead Plan Sponsors will also have to file the material as an Auxiliary Material with CMS after Lead Plan Sponsor filing.		
J. Is Health Net a Lead Plan Sponsor?	☐ No If "No," skip to section K. ☐ Yes If "Yes," you must provide written material approval from each of the health plans listed before this material can be filed with CMS. This written approval can be provided separately from the initial material submission. However, if written approvals from all the Non-Lead Plan Sponsors are not provided within 10 business days of initial submission, review timing may extend beyond 45 calendar days.		
K. Submitter Name:			

(continued)

Section 2: MATERIAL ATESTATION		
REVIEWED FOR:	**ORIGINATOR**	**Applicable CMS Marketing Guidelines Section #**
Material has been proofread.	☐	40.5
Did not use "seniors" to describe Medicare beneficiaries.	☐	40.5
Did not use "traditional Medicare" to describe Original Medicare.	☐	40.5
Did not use "free" when describing benefits. (Alternatively something like "included at no additional cost" may be used, if applicable.)	☐	40.5
Did not use absolute superlatives. (If absolute superlatives are used, supporting documentation validating the claim must be provided.)	☐	40.5
All font, including legal disclaimers = minimum 12 point Times New Roman in height & width or the equivalent.	☐	40.2
Correct benefit information (if applicable)	☐	40.5
Material contains phone number	☐	40.12
Material contains TTY/TDD number (state relay may be used as follows: TTY/TDD 711)	☐	40.12
Phone number and TTY/TDD number are the same font, size and style	☐	40.12
Hours of operation are included	☐	40.11
Correct Variable Data Indicators **<Carets> = variable text (use carets to indicate variable data. Only phone numbers, hours of operations and seminar information may be submitted as variable text)** **[Brackets] = information can stay as is or be removed**	☐	90.10
Material does not mislead or confuse beneficiaries by words, symbols, logos or terminology that would imply or give the false impression they are endorsed/approved/authorized by Medicare or any other federal agency or program. In addition, the materials should include accurate terminology and timelines set forth by CMS or any other federal agency referenced.	☐	30.6
Applicable legal disclaimers included (see the chart below with legal disclaimers and when to include them)	☐	30.18, 40, 50, 60 & 90.2.1

Section 3: REQUIRED LEGAL DISCLAIMERS	
SITUATION:	**APPLICABLE CMS-REQUIRED LEGAL:**
If seminar(s) are promoted, add the following: (Note: "Special Needs" could range from ensuring facility is wheelchair accessible, a sign language interpreter is available for those hard of hearing, and/or materials available in Braille for those who cannot see. If you're not able to accommodate the request, please direct the beneficiary to Health Net's Customer Service 1-877-885-6501 (TTY/TDD 1-800-929-9955).	A sales person will be present with information and applications. For accommodation of persons with special needs at sales meetings call <*insert your phone number*> (TTY/TDD 711), <*insert your hours of operation*>. HMO and/or PPO products will be discussed.

(continued)

Section 3: REQUIRED LEGAL DISCLAIMERS	
SITUATION:	**APPLICABLE CMS-REQUIRED LEGAL:**
If plan benefits are mentioned in the material, add the following:	The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information, contact the plan. Benefits, formulary, pharmacy network, premium and copayments may change on <January 1, 2013>.
If Health Net is mentioned on a material to be used from **February 15 thru October 14,** add the following: (Note: if more then one health plan is mentioned in an advertising material, call center hours of operation and Medicare contracting statement must be included for each health plan listed.)	Calling the number above will direct you to a licensed insurance agent/broker, or call Health Net Customer Service at <1-877-885-6501 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., Mon.–Fri., except holidays>, to receive plan information and enroll in the plan if you choose. Health Net. A Medicare Advantage organization with a Medicare contract.
If Health Net is mentioned on the material to be used from **October 15 thru February 14**, add the following: (Note: if more then one health plan is mentioned in an advertising material, call center hours of operation and Medicare contracting statement must be included for each health plan listed.)	Calling the number above will direct you to a licensed insurance agent/broker, or call Health Net Customer Service at <1-877-885-6501 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week>, to receive plan information and enroll in the plan if you choose. Health Net. A Medicare Advantage organization with a Medicare contract.
If Health Net Jade (HMO SNP) plan is mentioned in the material (Arizona only), add the following:	Health Net. A coordinated care plan with a Medicare Advantage contract. You can enroll in the Health Net Jade (HMO SNP) plan at any time during the year if you meet the eligibility requirements for this Medicare Advantage Special Needs Plan. This plan is available to persons who are eligible for Medicare (Parts A and B) and have been diagnosed with congestive heart failure and/or diabetes.
If Health Net Amber II (HMO SNP) plan is mentioned in the material (California only), add the following:	Health Net. A coordinated care plan with a Medicare Advantage contract but without a contract with the California Medicaid program. You can enroll in the Health Net Amber II (HMO SNP) plan at any time during the year if you meet the eligibility requirements for this Medicare Advantage Special Needs Plan. This plan is available to persons who are eligible for Medicare (Parts A and B) and Medi-Cal (this is the name for Medicaid in California).
If a promotional item/gift is offered, add the following:	Free gift provided without obligation to enroll, while supplies last.
If your advertising material is being mailed, the following statement must be present on the mail panel (same side where receipent's address will appear).	This is an advertisement.

10. Sales Allegations

Policy Statement:
Health Net (HN) follows the Centers for Medicare & Medicaid's (CMS) requirements contained in Chapter 3 of the Medicare Managed Care Manual and in the applicable regulations, in regard to the activities of Producers, to ensure that they do not mislead, confuse, or misrepresent the organization.

HN is committed to ensuring that all HN sales Producers and HN plan Sales Associates follow the guidelines set forth by the Centers for Medicare and Medicaid Services (CMS) and in HN policies when representing HN plans and products. When HN is informed of a possible allegation of inaccurate or improper sales activity or inappropriate conduct by a sales Producer or HN plan Sales Associates, the issue is investigated thoroughly and reviewed through the Grievance process with oversight on each case through the Sales Allegation Committee.

CMS considers sales allegations to be Plan grievances. Therefore, all sales allegations are handled in the HN Appeals & Grievances (A&G) departments, and are forwarded for further review to outside departments, such as for Sales investigation and/or the Special Investigations Unit (SIU) for issues concerning possible fraud.

Producers may NOT engage in any of the following activities when conducting marketing activities *(please see the "Do and Don't Chart" located on the Health Net producer web portal, at www.healthnet.com, the Health Net AHIP web site (https://healthnet.cmpsystem.com/) for a complete list as well as detailed information on the below activities):*

- Engage in activities which mislead, confuse or misrepresent the plan
- Engage in discriminatory marketing practices
- Offer gifts or payments as an inducement to enroll or solicit referrals
- Solicit door-to-door for Medicare beneficiaries or through other unsolicited means of direct contact, including calling a beneficiary without the beneficiary initiating the contact or giving express permission.
- May not claim recommendation or endorsement by CMS or that CMS recommends that the person enroll in HN
- May not make erroneous written or oral statements including any statement, claim, or promise that conflict with, materially alters, or erroneously expands upon the information contained in CMS approved materials
- May not use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have concurrence of all Medicare Advantage (MA) plans involved and the materials have received prior approval from HN Compliance.

- May not cross-sell any non-health care related products (such as annuities, life insurance, etc) during any sales or marketing activity or presentation conducted with respect to an MA plan or Part D plan

- May not provide meals of any sort, regardless of value, at any event at which plan benefits are being discussed and/or plan materials are being distributed

- May not conduct sales or marketing activities at educational events

- May not conduct sales or marketing activities in areas where patients primarily intend to receive health care services or where health care is delivered

- May not use absolute statements, for example; “the plan you are marketing/selling is the best plan; “the best”, “highest ranked”, “rated number one” (can only use if substantiated with supporting data).

Policy Purpose:
To ensure HN is in compliance with all CMS rules and guidance regarding all sales allegations filed against HN Medicare Sales Producers (Company Sales Associates and contracted Producers, GAs, FMOs and Agencies) are properly investigated and corrective action taken as warranted.

Scope/Limitations:
This policy and the related procedures apply to all Associates employed, contracted, or otherwise representing Health Net, Inc. and its subsidiaries who represent and are authorized to sell Medicare Health Net products. This includes, but is not limited to all internal Sales Associates and external sales Producers contracted by HN, including independent Producers and Sales Entity (Agency, General Agency (GA) or Field Marketing Organization (FMO)).

Related Policies:

TR920-113534	Disclosure Requirements
TR920-114053	Introduction to Producer Medicare Program Selling Requirements
TR920-122549	Medicare Sales Materials
TR920-103355	Oversight and Monitoring of Producers
TR920-111825	Rapid Disenrollment - Producer
TR920-123318	Qualification and Primary Duties for Producers
TR920-124259	Required Documentation of Sales Practices
TR920-132651	Monthly Sales and Marketing Event Reporting to Medicare Compliance
TR920-11030	Sales Producer Training
TR920-11273	Standards of Professionalism
TR930-102915	Sales Practices Involving Vulnerable Beneficiaries
TR920-124584	Scope of Appointment/48Hr Waiting Period & Cross Selling

References:

Title 42 of the CFR 422.2268
Title 42 of the CFR 422.2272
Title 42 of the CFR 422.2274
Title 42 of the CFR 423.2268
Title 42 of the CFR 423.2272
Title 42 of the CFR 423.2274

Chapter 3 of the CMS Medicare Managed Care Manual – Update: June 7, 2012

- Sections 10- Introduction; 30.5 Submission of materials for CMS Review; 30.6 Anti-discrimination; 70 – Rewards and incentives, Promotional Activities, Events, and Outreach

Definitions:

AT Fault	An "At Fault" result occurs when an allegation is validated based on the results of the investigation. Corrective action is required for all At Fault determinations.
CMS	Centers for Medicare and Medicaid Services. The federal agency within the Department of Health and Human Services that administers the Medicare program.
Education Events	Educational events are designed to inform Medicare beneficiaries about Medicare Advantage, Prescription Drug or other Medicare programs and do not include marketing, (i.e., the event sponsor does not steer, or attempt to steer, potential enrollees toward a specific plan or limited number of plans).
No Determination	A "No Determination" result is made when a determination cannot be made due to not having enough information to review the complaint, i.e., the researcher was unable to contact the member.
No Fault	A "No Fault" result is made when it is determined that the Producer or HN plan sales staff is found not at fault for the allegation
Sales Allegation	A beneficiary complaint of a potential marketing problem. A beneficiary, family beneficiary, advocate, Power of Attorney, provider, CMS, or the Health Insurance Counseling Advocacy Program (HICAP) may initiate sales allegations either verbally or in writing. Sales allegations may originate from communication obtained during an outbound verification call, inbound telephone calls, as well as outbound quality control calls.
Sales Allegation Committee	A Committee comprised of various associates within Sales, Compliance, Appeals & Grievances, the Special Investigations Unit (SIU), and other attendees as necessary. The Committee meets on a regular basis to review sales allegations and recommend corrective actions.
Sales Entity	Field Marketing Organization (FMO), General Agency (GA), Managing Agency (MAGY) or Agency.
Field Marketing Organization	An FMO is an agency contracted to provide broad coverage for the marketing and sales of a health plan. Areas of support will include, but are not limited to, Marketing / Lead Generation, Call Center

(FMO)	capabilities, and Administrative functions.
General Agency (GA)	A GA is an agency contracted to provide sales of a health plan. Typically its focus is on Producer recruitment and sales. Areas of support will include, but are not limited to, Producer Certification, Sales Training, Product Training and Compliance Oversight.
Agency	An agency that allows Producers to write underneath them.
Producer	Any person who is authorized to sell Health Net Medicare products, including persons who are directly contracted with Health Net (Individual Producers) and persons who are affiliated with a contracted Sales Entity (Authorized Producers).
Sales Associate	A person directly employed by Health Net or contracted as a vendor to sell Health Net Medicare products.
Managing Agency (MAGY)	A MAGY is an agency contracted to provide sales of a health plan. Typically its focus is on limited Provider recruitment and sales within a narrow territory. Areas of support include, but are not limited to, Producer Certification, Sales Training, Product training, Compliance Oversight and Application Enrollment Processing.
Third Party Marketing Organization (TMO)	An entity such as a Field Marketing Organization (FMO), General Agent (GA), or similar type of organization that has been retained to sell or promote a plan sponsor's Medicare products on the plan sponsor's behalf either directly or through sales agents or a combination of both.

Procedure:

A. Beneficiary sales allegations are received by HN via the member call centers, member correspondence, CMS correspondence, state Departments of Insurance, or other communication to anyone within HN.

B. When a beneficiary sales allegation is received, HN conducts a thorough investigation of the issue.

C. The Producer or Sales Associate is asked to complete the Sales Allegation Form (attached). The form must be completed and returned within **5** (five) calendar days. It is critical that Producers and Sales Associates respond timely.

D. HN reviews the sales allegation and the Producers response and makes a determination of "at fault", "no fault" or "no determination".

E. Corrective actions are implemented as needed and could include but are not limited to:

1. Coaching/counseling
2. Additional training
3. Ride-alongs
4. Verbal warning
5. Documented verbal warnings
6. Written warning
7. Suspension
8. Termination

In the event a sales allegation is not responded to by the Producer or Sales Associate as required, Health Net has a right to take any of the above actions. Note: It is part of all Producer agreements/Sales Entity contracts that all sales allegations require a response.

CORRECTIVE ACTION PLANS:

Fraud

- Any documented incidence(s) of Producer or Sales Associate fraud will result in immediate termination.

At Fault Determinations

- Immediate termination occurs if a Producer or Sales Associate has an At Fault determination that substantiates a direct violation of the CMS marketing guidelines, such as:
  - Door to Door sales
  - Unsolicited outbound telemarketing, which violates the CMS regulations
  - For serious allegations, failure to respond to Health Net regarding sales and marketing allegations.

Other At Fault Determinations

- If a Producer or Sales Associate has an At Fault determination, documented corrective action must take place.
- If a Producer or Sales Associate has three At Fault determinations in a rolling 12-month period with the same issue post-CAP notification, the Producer or Sales Associate is subject to termination.
- If there is a pattern of At Fault issues with a Sales Entity, Health Net develops corrective action steps and/or pursues termination.

No Determinations

- If a Producer or Sales Associate has a pattern of No determinations related to the same issue in a rolling 12-month period, HN may conduct outbound calls to a sampling of members enrolled through that Producer or Sales Associate for the current selling period (AEP, MADP, lock-in) to document and ensure understanding of HN program. Any additional issues discovered from these calls results in further actions as deemed appropriate by the Sales Allegation Committee. Additionally, HN or a HN Sales Entity develops a CAP with the Producer or Sales Associate.

Review/Revision History

First Issued……..August 2007
Revised……..September 2008
Revised……..October 2008
Revised……..January 2009
Revised……..March 5, 2009
Revised……..March 13, 2009
Revised……..April 20, 2009
Revised……..September 2009
Revised……..September 2010
Revised……..July 2011
Revised……..July 2012

Additional Information:

Applies to contract numbers H0351, H0562, H5439, H5520, H6815.

Sales Allegations Form

Agent Statement

Member/Prospect Name:
Agent Name:
Allegation Date:

When was your initial contact with the member?	
Did you have an appointment?	
Did you provide a complete enrollment packet?	
Was it explained that the prospect was joining a Medicare Advantage Plan?	
Was the Lock-In provision explained?	
Were the new member expectations reviewed	
Did you provide valid contact information?	
Was the referral process explained?	
Do you feel you thoroughly answered all questions during the presentation?	
Did you provide a timely response to any issues with the prospect?	
Were there any outstanding issues that needed to be resolved?	
Do you have a record of this in your contact management system?	
Comments:	[redacted]

GA/FMO/RSM Determination

Fault Determination:

None	☐
Coaching/Counseling	☐
Additional Training	☐
Ride Along(s)	☐
Verbal Warning	☐
Documented Verbal Warning	☐
Written Warning	☐
Suspension	☐
Termination	☐

Comments:	[redacted]

11. Rapid Disenrollment - Producer

Policy Statement:
Health Net follows the Centers for Medicare & Medicaid's (CMS) requirements contained in Chapter 3 of the Medicare Managed Care Manual and in the applicable regulations, in regard to appropriate sales practices. Health Net (HN) invests considerable resources to identify, educate, enroll, and retain members who have selected our Medicare plans. The company relies on and appropriately compensates contracted Producers to help with membership growth and retention. Accordingly, HN has a justifiable expectation that no contracted sales Producer or Sales Entity will engage in activities known as "churning" or "flipping" their clients (who are HN members) to other health care carriers, if the products offered by HN are competitive and continue to meet the member's needs. When the primary goal of the Producer or Sales Entity is to generate additional commissions from other companies, this practice is not acceptable to HN and is typically not in the best interests of members. This policy does not diminish the appropriate purpose of a Producer, which is to help clients evaluate their needs and make sound choices about their Medicare coverage.

Health Net complies with the Centers for Medicare & Medicaid (CMS) compensation requirements contained in Chapter 3 - Medicare Marketing Guidelines, section 120.4 Agent/Broker Compensation and 120.4.6 Recovering Compensation Payments (Charge-backs). Health Net will recover compensation when a member disenrolls from the plan within the first three months of enrollment (rapid disenrollment) and any other time a beneficiary is not enrolled in a HN plan.

> NOTE: When a member enrolls in a plan effective October 1, November 1, or December 1, and subsequently changes plans effective January 1 of the following year, this is not considered a rapid disenrollment. Therefore, plan sponsors cannot recover (charge-back) agent compensation payments. If, however, a beneficiary enrolls in October and disenrolls in December, then the plan sponsor should charge back because of a rapid disenrollment.

Exceptions may apply in accordance with CMS requirements.

HN will not recover funds if the beneficiary qualifies for one of the following special election periods (SEP):

- Disenrollment from Part D due to other creditable coverage; or institutionalization

- Under the following exceptional circumstances:
  - Gains/drops employer/union sponsored coverage;
  - Because of a CMS sanction against the plan;
  - Because of plan terminations;
  - Because of a non-renewing section 1876 cost plan
  - During the Medigap trial period;
  - In order to coordinate with Part D enrollment periods; or
  - In order to coordinate with an SPAP

- Due to following changes in status:
  - Becoming dually eligible for both Medicare and Medicaid;
  - Qualifying for another plan based on special needs;

- Becoming LIS eligible;
- Qualifying for another plan based on a chronic condition; or
- Moves into or out of institution;
- Due to an auto– or facilitated enrollment

- When moving to a plan with a 5-star rating

The beneficiary is involuntarily disenrolled for one of the following reasons:

- Death;
- Moves out of the service area;
- Non-payment of premium;
- Loss of entitlement;
- Retroactive notice of Medicare entitlement;
- Contract violation; or
- Plan non-renewal or termination

Policy Purpose:
The purpose of this policy is to establish a procedure for overseeing Producers and Sales Entities in order to identify and prevent churning of clients.

Scope/Limitations:
This P&P applies to all external Producers contracted by HN, including independent Producers, Agency, General Agents (GA's), Managing Agency (MAGY) and Field Marketing Organizations (FMO's).

Related Policies:

TR109-132413	Disclosure Requirements
TR920-114053	Introduction to Producer Medicare Program Requirements
TR109-14215	Medicare Sales Materials
TR109-154346	Oversight and Monitoring of Producers
TR109-143217	Qualification and Primary Duties for Producers
TR109-145024	Required Documentation of Sales Practices
TR109-10546	Sales Allegations
TR109-114713	Monthly Sales and Marketing Event Reporting to Medicare Compliance
TR109-94830	Sales Producer Training
TR109-11319	Standards of Professionalism
TR920-102915	Sales Practices Involving Vulnerable Beneficiaries

References:
Title 42 of the CFR 422.2274
Title 42 of the CFR 423.2274

Chapter 3 of the CMS Medicare Managed Care Manual – Update: June 7, 2012

Sections: 10 Introduction; 30.5 Submission of Materials for CMS Review; 30.6 Anti Discrimination;70 Rewards and Incentives, Promotional Activities, Events and Outreach; 120.4.4 Developing and Implementing a Compensation Strategy

Definitions:

Churning	The practice of soliciting a current Client to change health care plans for the sole purpose of receiving compensation.
CMS	Centers for Medicare and Medicaid Services. The federal agency within the Department of Health and Human Services that administers the Medicare program.
Compensation	Compensation includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commissions, bonuses, gifts, prizes, awards, and finder's fees.
Medicare	The Federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End Stage Renal Disease (ESRD).
Rapid Disenrollment	A rapid disenrollment is considered a member disenrollment during the first 3 continuous months of the member's effective date, i.e., member effective 6/1/2010, disenrolls either 6/1, 7/1, or 8/1, this is considered a rapid disenrollment.
Sales Entity	Field Marketing Organization (FMO), General Agency (GA), Managing Agency (MAGY) or Agency.
Field Marketing Organization (FMO)	An FMO is an agency contracted to provide broad coverage for the marketing and sales of a health plan. Areas of support will include, but are not limited to, Marketing / Lead Generation, Call Center capabilities, and Administrative functions.
General Agency (GA)	A GA is an agency contracted to provide sales of a health plan. Typically its focus is on Producer recruitment and sales. Areas of support will include, but are not limited to, Producer Certification, Sales Training, Product Training and Compliance Oversight.
Agency	An agency that allows Producers to write underneath them.
Producer	Any person who is authorized to sell Health Net Medicare products, including persons who are directly contracted with Health Net (Individual Producers) and persons who are affiliated with a contracted Sales Entity (Authorized Producers).
Sales Associate	A person directly employed by Health Net or contracted as a vendor to sell Health Net Medicare Products
Managing Agency (MAGY)	A MAGY is an agency contracted to provide sales of a health plan. Typically its focus is on limited Provider recruitment and sales within a narrow territory. Areas of support include, but are not limited to, Producer Certification, Sales Training, Product training, Compliance Oversight and Application Enrollment Processing.
Third Party	An entity such as a Field Marketing Organization (FMO), General

Marketing Organization (TMO)	Agent (GA), or similar type of organization that has been retained to sell or promote a plan sponsor's Medicare products on the plan sponsor's behalf either directly or through sales agents or a combination of both.

Procedures:

A. Oversight

1. HN Sales Leaders evaluate on a monthly basis Producers and/or Sales Entities to determine the membership retention rate of their overall HN book-of-business (BOB) and to identify any adverse trends.

2. Indicators for specific actions include the following:
    a. High percentage of rapid disenrollment rates
    b. Other member- or Producer-specific evaluations, including member complaints.

3. When unacceptable member termination trends are apparent from the data, the Producer or Sales Entity are flagged. HN management takes action to identify why members have left HN, which include:
    a. Calling or otherwise surveying former members to determine why they terminated their HN coverage,
    b. Evaluating the new plan they selected
    c. Determining what the member was told about changing coverage

B. Actions

1. Rapid Disenrollments: Compensation is adjusted according to CMS regulations.
2. When adverse trends are documented, HN's goal is to work with the Producer or Sales Entity to understand the high termination rates and/or why recommendations to leave HN are being made.
3. Depending on the severity and nature of the disenrollment trends, HN may take corrective action up to, and including, Producer contract termination.

All corrective actions are tracked to completion.

Review/Revision History

First Issued……August 2007
Revised……September 2008
Revised……November 10, 2008
Revised……September 2009
Revised……August 2010
Revised……July 2011
Revised……July 2012

Additional Information:

Applies to contract numbers H0351, H0562, H5439, H5520, H6815.

12. Oversight and Monitoring of Producers

Policy Statement:
Health Net (HN) follows the Centers for Medicare & Medicaid's (CMS) requirements contained in Chapter 3 of the Medicare Managed Care Manual (MMCM) and in the applicable regulations in regard to the oversight and monitoring of Producers.

The HN Regional VPs of Medicare Programs are responsible for implementing oversight and monitoring of sales Producers, sales training, and other processes to ensure that sales activities in their Regions are compliant with CMS requirements and consistent with HN Policies and Procedures.

Policy Purpose:
To ensure Health Net is in compliance with all CMS rules and guidance regarding the oversight and monitoring of Producers.

Scope/Limitations:
This policy and the related procedures apply to all Associates employed, contracted, or otherwise representing Health Net, Inc. and its subsidiaries who represent and are authorized to sell Medicare Health Net products. This includes, but is not limited to all internal sales associates and external sales Producers contracted by HN, including independent Producers, Agency, General Agencies (GA's), Managing Agency (MAGY) and Field Marketing Organizations (FMO's).

Related Policies:

TR920-113534	Disclosure Requirements
Tr920-114053	Introduction to Producer Medicare selling Requirements
TR920-103355	Oversight and Monitoring of Producers
TR920-122549	Medicare Sales Materials
TR920-111825	Rapid Disenrollment - Producer
TR920-123318	Qualification and Primary Duties for Producers
TR920-124259	Required Documentation of Sales Practices
TR920-1182	Sales Allegations
TR920-132651	Monthly Sales and Marketing Event Reporting to Medicare Compliance
TR920-11030	Sales Producer Training
TR920-11273	Standards of Professionalism
TR930-102915	Sales Practices Involving Vulnerable Beneficiaries
TR920-124854	Scope of Appointment/48 Ht Waiting Period and Cross Selling
BA627-113035	Medicare Record Retention

References:
Title 42 of the CFR 422.2268
Title 42 of the CFR 423.2268

Sections: 10 Introduction; 30.5 Submission of Materials for CMS Review; 30.6 Anti Discrimination; 120 Marketing and Sales Oversight and Responsibilities

Definitions:

CMS	Centers for Medicare and Medicaid Services. The federal agency within the Department of Health and Human Services that administers the Medicare program.
Medicare	The Federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End Stage Renal Disease (ESRD).
Medicare Advantage (MA)	A Medicare program that allows for more choices among Medicare health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (ESRD).
Medicare Advantage (MA) Organization	A public or private entity organized and licensed by a state as a risk- bearing entity (with the exception of provider sponsored organization receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract
Part D Plan	A prescription drug plan (PDP), an MA-PD plan, or a PACE plan offering qualified prescription drug coverage. This includes employer- and union- sponsored plans.
Part D Plan Sponsor	Refers to an organization offering a PDP, MA or MA-PD plan, a PACE organization offering a PACE plan including qualified prescription drug coverage, and a cost plan offering qualified prescription drug coverage. This includes employer- and union-sponsored plans.
Sales Entity	Field Marketing Organization (FMO), General Agency (GA), Managing Agency (MAGY or Agency.
Field Marketing Organization (FMO)	An FMO is an agency contracted to provide broad coverage for the marketing and sales of a health plan. Areas of support will include, but are not limited to, Marketing / Lead Generation, Call Center capabilities, and Administrative functions.
General Agency (GA)	A GA is an agency contracted to provide sales of a health plan. Typically its focus is on Producer recruitment and sales. Areas of support will include, but are not limited to, Producer Certification, Sales Training, Product Training and Compliance Oversight.
Agency	An agency that allows Producers to write underneath them.
Producer	Any person who is authorized to sell Health Net Medicare products, including persons who are directly contracted with Health Net (Individual Producers) and persons who are affiliated with a contracted Sales Entity (Authorized Producers).
Sales Associate	A person directly employed by Health Net or contracted as a vendor to sell Health Net Medicare products.

Managing Agency (MAGY)	A MAGY is an agency contracted to provide sales of a health plan. Typically its focus is on limited Provider recruitment and sales within a narrow territory. Areas of support include, but are not limited to, Producer Certification, Sales Training, Product training, Compliance Oversight and Application Enrollment Processing.
Third Party Marketing Organization (TMO)	An entity such as a Field Marketing Organization (FMO), General Agent (GA), or similar type of organization that has been retained to sell or promote a plan sponsor's Medicare products on the plan sponsor's behalf either directly or through sales agents or a combination of both.

Procedure:

General Requirements

Producers are expected to adhere to standards of professionalism at all times (see attached "Standards of Professionalism" Policy and Procedure.

1. Producers and Sales Associates are regularly monitored to ensure compliant sales and marketing activities. All non-compliant activities reported to Health Net are investigated and appropriate enforcement actions taken in accordance with HN Policies and Procedures.

Individual Producers and Agencies

- HN provides the same or similar oversight activities for contracted Producers or authorized agents, as it would for HN employed or captive field agents.
- Producers/Sales Associates; this could include such sales monitoring activities as ride-a-longs, attending sales seminars, secret shopper/surveillance findings and other activities as determined appropriate by local market sales leaders. Oversight activities are conducted on either scheduled or random basis and include general and compliance issues related monitoring.

Producers Authorized with a Sales Entity

Per HN policies, each Sales Entity has the responsibility to conduct oversight of their contracted Producers and maintain Producer records. Appropriate HN sales management audits each Sales Entity. Corrective actions are implemented when requirements have not been met. Areas to be audited include (but are not limited to):

- Compliance with the Sales Entity's own internal policies and procedures
- Compliance with CMS and HN policies and the applicable HN contract
- Training and re-training
- Complaint tracking, actions, and outcomes
- License status changes
- Advertising and marketing materials used
- Compliance with CMS required disclosures at sales events &/or meetings
- Sales Entity and independent Producer websites for updated CMS and HN approved materials

- Scope of Appointment documentation
- Producer record maintenance
- Secret Shopper surveillance
- Sales Entities are responsible to cooperate with HN's investigation of sales allegations that involve their Producers. They must comply with all corrective or disciplinary actions against a Producer that are deemed appropriate by the responsible HN VP of Medicare Programs or HN Sales Leader. Failure to cooperate with HN's investigation or to implement corrective actions timely may result in corrective action against the GA, MAGY, or FMO.

Actions related to single significant incident or continued non-compliance

Any Producer or Sales Entity that has either a documented single significant incident of non-compliance, continual non-compliance, or a combination of single significant incidents and continual non-compliance is subject to disciplinary action. The HN Vice President of Medicare Programs, in conjunction with the Regional Sales Allegation Committee, is responsible for determining the corrective action to be taken, which includes counseling, retraining, warnings, suspension, contract termination, withholding commissions, and reporting to CMS and the states Department Of Insurance (as required). Producer-specific corrective action plans are developed to appropriately address the non-compliance issues and tracked to completion.

Record Keeping

Records are maintained pursuant to HN's record keeping policy and are a combination of HN maintained hard copy files and electronic data (maintained on a HN data base) for HN Sales Associates and direct contracting Producers of all types. All records must be kept for 10 years and are subject to audit as required by Medicare regulations.

HN and each Sales Entity must maintain at least the following information in each Producer sales file:

- Copy of state license
- Copy of HN AHIP annual certification exam results
- Training documents, sign in sheets
- Documentation of sales allegations, investigation outcomes, and all corrective actions
- Performance data, i.e., sales volume, commissions paid, commission chargebacks, etc. (At Regional Sales Director's discretion).

HN may conduct scheduled or random audits of Sales Entities record-keeping. In the event deficiencies are discovered, HN reserves the right to develop corrective action plans and re-audit the Sales Entities as necessary until the deficiencies are fully corrected. Failure of a Sales Entity to cooperate in such audits may be grounds for contract termination including the potential loss of sales commissions.

Reporting Unlicensed Producers

Sales Producers must be licensed as required by state law, trained, and tested annually on Medicare rules and regulations and on details specific to the plan products in order to sell Medicare Advantage and/or a Part D plan. CMS requires HN to report incidences of submission of applications by unlicensed producers and brokers to the authority in the State where the application was submitted. Additionally, HN must notify any

beneficiaries that were enrolled in their plan by an unqualified (unlicensed or failure to comply with training or testing requirements), and advise those beneficiaries of the agent's status. Upon notification, the beneficiaries may request to make a plan change (special election period). Producers acting as customer service representatives are not required to hold a license and cannot engage in marketing activities. Unlicensed producers/customer service representatives may discuss plan benefits, however they are prohibited from comparing plan benefits for the beneficiary and advising or counseling the beneficiary on the appropriate plan selection. All producer types, including licensed and unlicensed, must follow applicable state laws.

Review/Revision History

First Issued……August 2007
Revised……..September 2008
Revised……..September 2009
Revised……..August 2010
Revised……..March 2011
Revised……..July 2011
Revised……July 2012

Additional Information:
Applies to contract numbers H0351, H0562, H5439,H5520, H6815.

13. Sales Practices Involving Medicare Beneficiaries, Including Vulnerable Beneficiaries

Policy Statement:
Health Net follows the Centers for Medicare & Medicaid's (CMS) requirements contained in Chapter 3 of the Medicare Managed Care manual. Health Net (HN) is committed to ensuring that all HN Sales Producers and HN plan Sales staff follow the guidelines set forth by the Centers for Medicare and Medicaid Services (CMS) and in HN policies when representing HN plans and products. This is particularly important when conducting sales activities to beneficiaries with special needs, e.g. vision or hearing impaired beneficiaries, beneficiaries who have other disabilities, beneficiaries residing in Long Term Care Facilities or group homes, Special Needs Plan (SNP) members, and beneficiaries with limited English proficiency.

Policy Purpose:
To ensure all sales Producers follow CMS guidelines when marketing HN Medicare products and to ensure that vulnerable beneficiaries are not targets of unscrupulous and aggressive marketing tactics. Health Net does not tolerate inappropriate conduct or aggressive marketing techniques targeted at any Medicare beneficiaries. When HN is informed of such behavior, the issue is investigated thoroughly and corrective actions are taken as necessary up to and including termination of the Producers ability to sell HN Medicare products.

Scope/Limitations:
This policy and the related procedures apply to all Associates employed, contracted, or otherwise representing Health Net, Inc. and its subsidiaries who represent and are authorized to sell Medicare Health Net products. This includes, but is not limited to all external Sales Producers contracted by HN, including independent Producers, Agency, General Agencies (GA's), Managing Agency (MAGY) and Field Marketing Organizations (FMO's).

Related Policies:

TR920-113534	Disclosure Requirements
TR920-114053	Introduction to Producer Medicare Program Selling Requirements
TR920-103355	Oversight and Monitoring of Producers
TR920-122549	Medicare Sales Materials
TR920-111825	Rapid Disenrollment - Producer
TR920-123318	Qualification and Primary Duties for Producers
TR920-124259	Required Documentation of Sales Practices
TR920-1182	Sales Allegations
TR920-132651	Monthly Sales and Marketing Event Reporting to Medicare Compliance
TR920-11030	Sales Producer Training
TR920-11273	Standards of Professionalism
TR930-102915	Sales Practices Involving Vulnerable Beneficiaries
TR920-124854	Scope of Appointment/48 Ht Waiting Period and Cross Selling

References:
Title 42 of the CFR 422.2268

Title 42 of the CFR 423.2268

Chapter 3 of the CMS Medicare Managed Care Manual – Update: June 7, 2012
Sections: 10 Introduction; 30.5 Submission of Materials for CMS Review; 30.6 Anti Discrimination; 30.7, Requirements Pertaining to Non English Speaking Populations;120. Marketing and Sales Oversight and Responsibilities

Definitions:

Agency	An agency that allows Producers to write underneath them.
CMS	Centers for Medicare and Medicaid Services. The federal agency within the Department of Health and Human Services that administers the Medicare program.
General Agency (GA)	A GA is an agency contracted to provide sales of a health plan. Typically its focus is on Producer recruitment and sales. Areas of support will include, but are not limited to, Producer Certification, Sales Training, Product Training and Compliance Oversight.
Field Marketing Organization (FMO)	An FMO is an agency contracted to provide broad coverage for the marketing and sales of a health plan. Areas of support will include, but are not limited to, Marketing / Lead Generation, Call Center capabilities, and Administrative functions.
Medicare	The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End Stage Renal Disease (ESRD).
Medicare Advantage (MA)	A Medicare program that allows for more choices among Medicare health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (ESRD).
Medicare Advantage (MA) Organization	A public or private entity organized and licensed by a state as a risk-bearing entity (with the exception of provider sponsored organization receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements.
Sales Allegation	A member complaint of a potential marketing problem. A member, family member, advocate, Power of Attorney, provider, CMS, or the Health Insurance Counseling Advocacy Program (HICAP) may initiate sales allegations either verbally or in writing. Sales allegations may originate from communication obtained during an outbound verification call, inbound telephone calls, as well as outbound quality control calls.
Sales Entity	Field Marketing Organization (FMO), General Agency (GA). Managing Agency (MAGY) or Agency.
Sales Producer	Any person who is authorized to sell Health Net Medicare products, including persons who are directly contracted with Health Net (Individual Producers) and persons who are affiliated with a contracted Sales Entity (Authorized Producers).
Special Needs Plan	Includes dual-eligible beneficiaries (Medicare-Medicaid) and /or Chronic conditions.

(SNP)	
Vulnerable Beneficiary	Includes beneficiaries with special needs, e.g. blind or deaf beneficiaries, beneficiaries who are legally incompetent, beneficiaries residing in Long Term Care Facilities or group homes, Dual-Eligible Special Needs Plan (SNP) members, and beneficiaries with limited English proficiency.
Managing Agency (MAGY)	A MAGY is an agency contracted to provide sales of a health plan. Typically its focus is on limited Provider recruitment and sales within a narrow territory. Areas of support include, but are not limited to, Producer Certification, Sales Training, Product training, Compliance Oversight and Application Enrollment Processing.
Third Party Marketing Organization (TMO)	An entity such as a Field Marketing Organization (FMO), General Agent (GA), or similar type of organization that has been retained to sell or promote a plan sponsor's Medicare products on the plan sponsor's behalf either directly or through sales agents or a combination of both.

Procedure:

A. In order to prevent aggressive marketing techniques, Health Net (HN) requires each Producer to do the following:

1. Producer Training: Producers must complete 2 training requirements before they can actively sell HN products;

   (1) Annual AHIP online training with a passing score of 90% or better, Successful completion of other training and certification programs as required and approved by the Vice President of Medicare Programs.

   (2) Field-based or online product training for Compliance and HN Products that includes CMS Marketing and Sales guidelines including the Do & Don't Chart (see Attachment 1 under Addenda(s), page 6 in this policy). Separate product training must be completed for each HN market in which a producers wishes to sell.

2. Each Producer who is currently contracted to sell HN Medicare products, or to receive renewal sales commissions, must successfully complete the annual certification training prior to marketing and/or selling HN Products during the intended product year. New producers who contract with HN can market and sell HN's Medicare products once they complete and pass the certification and product training. All producers are required to complete re/certification and product training. Producers submit the appropriate documents and wait until they receive their HN verification letter and/or HN identification number prior to marketing and selling HN's Medicare products.

3. Complete the HN Acknowledgement Form. (See Attachment 2 under Addenda(s) on page 6)

4. Has and maintains the appropriate insurance license(s) in each state in which the producer intends to sell HN Medicare products.

B. When someone other than the Medicare beneficiary completes a Producer effectuated enrollment or disenrollment request, the Producer must ensure that the individual completing the enrollment:

1. Attests to having the authority under State law to do so;
2. Confirms that proof of authorization, if any, required by State law that empowers the individual to make the enrollment or disenrollment request on behalf of the individual is available and can be provided upon request by CMS;
3. Signs and dates the enrollment request form;
4. Indicates his/her relationship to the beneficiary, and;
5. Provides contact information.

Note: MA organizations *cannot* require documentation showing proof of authorization as a condition of enrollment or disenrollment.

A Medicare beneficiary is generally the only individual who may execute a valid request to enroll in or disenroll from an MA plan. However, CMS recognizes State laws that authorize persons to make such requests for Medicare beneficiaries. Another individual could be the legal representative or appropriate party to execute an enrollment or disenrollment request (e.g. court-appointed legal guardian, durable power of attorney, etc.).

If a beneficiary is unable to sign an enrollment form or disenrollment request or complete an enrollment request mechanism due to reasons such as physical limitations or illiteracy, State law governs whether another individual may execute the enrollment request on behalf of the beneficiary. Agents must follow state laws in these circumstances. If there is uncertainty regarding whether another person may sign for a beneficiary, the Agent should contact Health Net Sales (management).

Note: Representative payee status alone is not sufficient to enroll a Medicare beneficiary.

Additionally, the Agent should inquire regarding the preference for the delivery of required notifications and other plan materials (i.e. sending mail to the beneficiary directly or to the representative, or both). Health Net will make reasonable accommodations to satisfy these wishes.

C. When conducting marketing and sales activities to all Medicare Beneficiaries, including vulnerable beneficiaries or beneficiaries with special needs, Producers ensure that the beneficiaries' needs are taken into account by:

1. Providing marketing materials in the preferred language of the beneficiary.
2. If requested by a Medicare beneficiary or their legal representative, arranging for a translator to be present, either in person or by telephone. If a sales producer is not proficient in the language spoken by the Medicare beneficiary, they must have/use a translator who is proficient in the language of the Medicare beneficiary.
3. Ensuring sales meeting locations include accommodations for people with special needs in accordance with applicable law.
4. As appropriate, invite caretakers, family members, and/or authorized representatives to attend the marketing session.

D. Health Net takes appropriate action to detect and prevent aggressive marketing techniques targeted at all Medicare beneficiaries, including vulnerable beneficiaries. These include:

1. **Outbound Education & Verification Call:** (to occur during the first 15 calendar days of obtaining the members enrollment form. The first two attempts are made within the first ten days). Calls will be placed to all individual Medicare members including SNP members (Dual & Chronic) with the specific purposes of:
   - Verifying enrollment
   - Ensuring the members' understanding of the benefit plan
   - Identify any issues or concerns which Health Net needs to address or provide assistance to the member.

   Health Net makes 3 attempts to contact the member to verify enrollment. If HN is unable to get in touch with the member after the first attempt, HN sends the Member Education Letter (see at the end of this section. HN then makes 2 more attempts to contact the member and complete the verification.

   If any sales irregularities or questionable practices are uncovered during the call, the issues will be documented in the member contact system and an investigation will be started through the HN Sales Allegation process. This process will also provide the necessary steps needed by each Sales Allegation Committee to capture the appropriate data for sales allegation tracking and trending at the sales producer level.
2. **Acknowledgement Letter:** HN uses the acknowledgement letter sent to new enrollees to include important information about the selected plan and instructions of what to do if the enrollee needs more information or does not want to be enrolled. (see at the end of this section)
3. **Complete a Statement of Understanding:** The Agent Statement of Understanding must be fully completed and submitted with each enrollment application, where applicable (see at the end of this section).
4. **Regional Sales Allegation Committee oversight** of the compliant tracking module (CTM), sales allegations, formal grievances, rapid disenrollment data, and other sales and marketing complaints in regard to activities of Producers, to ensure that they do not mislead, confuse, or misrepresent HN.

E. Any Producer who is found to be in violation of the marketing guidelines or HN policies and procedures will be subject to corrective actions, which can include:

1. Coaching/counseling
2. Additional training/ride-alongs
3. Verbal warning
4. Written warning
5. Suspension
6. Termination
7. Reporting to a local, State, or Federal agency (Police, CMS, DOI, etc.) for further investigation
8. or a combination of the above

F. Health Net makes marketing materials available in any language that is the primary

language of more than **5 percent** of the plan's geographic service area.

Review/Revision History
First Issued……December 2008
Revised…… January 2009
Revised…… April 20, 2009
Revised……..February 18, 2010
Revised……..May 21, 2010
Revised……..June 3, 2010
Revised……..September 23, 2010
Revised……...July 2011
Revised……..July 2012

Additional Information:
Applies to contract numbers H0351, H0562, H5439, H5520, H6815.

<July 8, 2012>

<TITLE> <FIRST_NAME> <LAST_NAME>
<ADDRESS1>
<ADDRESS2>
<CITY>, <STATE> <ZIP>

<Subscriber ID #: <Ref ID>>

<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <TITLE> <LAST_NAME>:

Thank you for enrolling in <Plan name>. Beginning <effective date>, you must see your <plan name> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <plan name> doctor(s). You will need to pay your plan co-payments and coinsurance at the time you get health care services as described in your member materials. **[*Optional language*:** This letter is proof of insurance that you should show at your doctor appointments until you get your member card from us.] [***Optional language for MA-PD*:** This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

[***MA PPO plans use the following paragraph in place of 1st paragraph above:*** Thank you for enrolling in <Plan name>. Beginning <effective date>, you must get your health care as provided in your <*insert either Member handbook or Evidence of Coverage*>. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as described in your member materials. **[*Optional language*:** This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.]

What should I do now?
Medicare must review all enrollments. We will send your enrollment to Medicare, and they will do a final review. When Medicare finishes its review, we will send you a letter to confirm your enrollment with <plan name>. But, you shouldn't wait to get this letter before you begin using<plan name> doctors on <effective date>. Also, don't cancel any

Material ID # Y0035_2012_0284 (H0351, H0562, H5439, H5520, H6815) File & Use 09032011
WEL

Medigap/Medicare Select or supplemental insurance that you have until we send you the confirmation letter.

[*MA-PD plans with a premium include the following:* If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.]

[*Plans with a premium include the following:*
How do I pay my premium?
Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you choose to have your monthly premium automatically deducted from your Social Security/Railroad Retirement Board benefit check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <1-800-275-4737>. TTY users should call <1-800-929-9955>. [MAOs that disenroll for non-payment of plan premiums include the following sentence: Members who fail to pay the monthly plan premium may be disenrolled from <plan name>.]

What do I need to know about getting health care services?
You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <Plan>. If you don't have Medicare Parts A and B, we will bill you for any health care you receive from us, and neither Medicare nor <plan name> will pay for those services. Also, if you have end stage renal disease (ESRD), you may not be able to be a member of <plan name>, and we may have to send you a bill for any health care you've received.

[*MA PPO plans do not use the following paragraph:* Please remember that, except for emergency or out-of-area urgent care, or out-of-area dialysis services, if you get health care services from a non-<plan name> doctor without prior authorization, you will have to pay for these services yourself.]

When can I make changes to my coverage?
Once enrolled in our plan, you can make changes only during certain times of the year. From October 15th through December 7th each year, anyone can make any type of change. From January 1 through February 14, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. [Plans with drug benefit: If you join a Medicare Prescription drug plan, you will be automatically disenrolled from our plan and returned to Original Medicare.] Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help with your prescription drug costs. If you qualify, you may enroll in or disenroll from a plan at any time. If you lose this extra help during

the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help. If you have more questions about this, please feel free to call <plan name> at <1-800-275-4737>.

**[*MA-PD plans with a premium include the following two paragraphs:*
*[Dual-eligible SNPs may omit the following paragraph]***
Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.]

[*Optional*: **What else do I need to know about my coverage?**
If applicable, insert information instructing member in simple terms on how to select a primary care provider/site (PCP); how to obtain Medicare Advantage Plan services, e.g., provide the name, phone number, and location of the PCP, include the membership identification card when possible, explain unique POS and/or PPO procedures (when applicable), explain which services do not need PCP approval (when applicable), etc.]

If you have any questions, please call <plan name> at <1-800-275-4737>. TTY users should call <1-800-929-9955 >. We are open <8:00 a.m. to 8:00 p.m., 7 days a week>.

Thank you.

<Membership Accounting and Eligibility Department>

Health Net®
MEDICARE PROGRAMS

Model Letter to Beneficiaries Who Could Not be Reached for Verification by Phone

[Date]
[Member #]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear [first and last name of applicant]:

We have received your application to enroll in [plan name and type of plan (all but HMOs spell out the type of plan in addition to giving the acronym, e.g., "Private Fee-For-Service (PFFS)], which is a [insert whichever is applicable: Medicare Advantage Plan or Medicare Prescription Drug Plan or Medicare Cost Plan]. [For Medicare health plans: Enrolling in [plan name] means that you will be getting your Medicare coverage through [plan name]. [Plan name] is not Original Medicare and it is not a Medigap or Medicare supplemental insurance plan.]

Please review this letter carefully – it has important information about how our plan works and how you can [For Medicare health plans: get care or Medicare Prescription Drug Plan: get prescription drugs]. Because [plan name] is a [insert type of plan; all but HMOs spell out the type of plan in addition to giving the acronym, e.g., "Private Fee-For-Service (PFFS)], it has some special rules that you will need to follow. We want to make sure you understand these rules before your enrollment becomes final.

At the end of this letter, we tell you:

- How to contact us by telephone if you have questions.
- What happens next in processing your enrollment in our plan.
- What to do if you change your mind about enrolling in our plan (the deadline for cancelling your enrollment is [insert date (date must be either 7 calendar days from the date of this letter or the last day of the month in which the enrollment request was received, whichever comes later)].

It's a good idea to share this letter with people who help you make important decisions, such as your spouse, children, trusted friends, or your doctor.

Important things to know about getting your Medicare as a member of our plan

Below are some important things to know about getting the care and services you need while you are a member of our plan: Make sure you understand and accept the rules explained below.

[All plans must include the language that follows for showing the membership card, cost sharing, and providers to use]

Show your [plan name] membership card before you get any [Insert *health care services* or *prescription drugs*]

Enrolling in [plan name] means that you will be getting your [Insert *Medicare coverage* or *Medicare prescription drug coverage*] through [plan name]. Once you are enrolled in our plan, we will send you a [plan name] membership card. You must use this card whenever you get [Insert *health care services or prescription drugs]*. Otherwise, your care might not be covered and you'll have to pay the full cost yourself.

During the time you are a member of our plan, you must not use your red, white and blue Medicare card (unless you are receiving hospice services or getting care in a clinical research study). The red, white and blue Medicare card is used by people getting their Medicare coverage through Original Medicare, and our plan is different from Original Medicare.

You should keep your red, white and blue Medicare card in a safe place because you will need it later on if you return to Original Medicare. But during the time you are a member of [plan name], be sure to use only your [plan name] membership card. Otherwise, your [health care services or prescription drugs] might not be covered and you'll have to pay the full cost yourself.

Know what you will have to pay as your share of the costs for [health care services or prescription drugs] you receive

As with any Medicare coverage, you will need to pay your share of the cost for services you receive. When you filled out the enrollment form, you should have received written information that tells what you must pay for services you receive as a member of [plan name]. If you need this information, please call us at [Member Services/Customer Service] [insert number and calling days and hours] or visit our website at [insert website information].

Understand which [providers, pharmacies] you can use

[All **HMO** plan types must include the following language:

[Plan name], the plan you are enrolling in, is a [type of plan]. It has a network of doctors, specialists, hospitals, and other providers that provide healthcare services to members of our plan. You need to know which providers are part of our network because you [insert whichever is applicable: must use *or* may be required to use] the providers who are in our network to get your healthcare services.

There are only four situations when [plan name] will cover healthcare services you get from providers who are not part of the plan's network. These are:

- If you are having an emergency.

- If you have an urgent need for care and network providers are not available to give you this care.
- If you need kidney dialysis that is not available from the plan's network.
- If you have asked for and received permission from [plan name] to use a provider who is not in the plan's network.

[SNPs with arrangement with the State may revise this language to reflect, when applicable, that the organization is providing both Medicaid and Medicare covered benefits].

The health care providers in the plan's network can change at any time. For the most up-to-date information on the network of providers, check our website or call [Member Services/Customer Service.]

[All **Cost Plans and PPOs** must include the following language:

[Plan name], the plan you are enrolling in, is a [type of plan]. It has a network of doctors, specialists, hospitals, and other health care providers you can use to get your covered services. You can also use health care providers who are not in [plan name]'s network – however, your share of the costs for your covered services may be higher if you do.

The health care providers in the plan's network can change at any time. For the most up-to-date information on the network of providers, check our website or call [Member Services/Customer Service.]

[All **PDPs** and all other plan types offering Part D coverage must include the following:

[Plan name] has a network of pharmacies. In most situations, we will pay for your prescriptions only if you use a pharmacy in our network. To get more information, including the most up-to-date list of pharmacies in the plan's network, you can either check our website or call [Member Services/Customer Service.]

If you have limited income and resources, you may be able to get extra help to pay for your prescription drug premiums and costs. To learn more and find out if you qualify for getting extra help, you can call any of these places:

- Medicare at 1-800-Medicare (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778.
- Your State Medicaid Office at [insert contact information.]

If you want to, you can cancel your enrollment in our plan

If you do not want us to finish enrolling you as a new member, you can cancel your enrollment. If you do not want to become a new member of [plan name], you must call [plan name] [Member

Services/Customer Service] at [phone number]. You can call [insert calling hours and days of operation]. Tell the person who answers that you want to cancel your enrollment in [plan name].

The deadline for cancelling your enrollment is [insert date (date must be either 7 calendar days from the date of this letter or the last day of the month in which the enrollment request was received, whichever comes later)]. If you decide you want to cancel your enrollment request and you don't call us before [insert date], we will not be able to cancel your enrollment. You may also call 1-800-Medicare for assistance in exploring other enrollment options.

Otherwise, welcome to our plan!

Unless you call to cancel your enrollment, you will be enrolled in our plan. You will receive a letter shortly confirming with more information about your enrollment.

Sincerely,

Health Net Medicare Programs

<July 8, 2012>

<TITLE> <FIRST_NAME> <LAST_NAME>
<ADDRESS1>
<ADDRESS2>
<CITY>, <STATE> <ZIP>

<Subscriber ID #: <Ref ID>>

<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <TITLE> <LAST_NAME>:

Thank you for enrolling in <Plan name>. Beginning <effective date>, you must see your <plan name> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <plan name> doctor(s). You will need to pay your plan co-payments and coinsurance at the time you get health care services as described in your member materials. **[*Optional language*:** This letter is proof of insurance that you should show at your doctor appointments until you get your member card from us.] [***Optional language for MA-PD*:** This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

[***MA PPO plans use the following paragraph in place of 1st paragraph above:*** Thank you for enrolling in <Plan name>. Beginning <effective date>, you must get your health care as provided in your <*insert either Member handbook or Evidence of Coverage*>. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as described in your member materials. **[*Optional language*:** This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.]

What should I do now?
Medicare must review all enrollments. We will send your enrollment to Medicare, and they will do a final review. When Medicare finishes its review, we will send you a letter to confirm your enrollment with <plan name>. But, you shouldn't wait to get this letter before you begin using<plan name> doctors on <effective date>. Also, don't cancel any

Material ID # Y0035_2012_0284 (H0351, H0562, H5439, H5520, H6815) File & Use 09032011
WEL

Health Net
MEDICARE PROGRAMS

Health Net Medicare Advantage 2013 Statement *of* Understanding *for Sales Appointments*

Medicare beneficiary should initial each box confirming that the sales agent has reviewed each item listed below, and that the beneficiary understands this important enrollment information.

Initial each box after reviewing	
	Health Net Representative/Agent 1. The person that is discussing Medicare health plan options with me does not represent Medicare, the Social Security Administration or any branch of the federal or state government.
	Medicare Advantage vs. Medicare Supplement 2. I understand that the Health Net Medicare Advantage (HMO/PPO/SNP) health plan _____ (print plan name) I have selected is not a Medicare Supplemental plan. Health Net will be responsible for my covered medical services and, if applicable, prescription drugs. I will use my Health Net ID card rather than my white, red and blue Medicare card to access my coverage. Should I decide to leave my Medicare Advantage plan in the future, I will retain my eligibility for Original Medicare.
	Medicare Advantage Plan Change 3. When enrolling in a Health Net Medicare Advantage Plan, I understand that I will be automatically disenrolled from any other Medicare Advantage or Part D plan. I understand that I can only be enrolled in one Medicare Advantage Prescription Drug Plan or Part D plan at a time.
	Plan Premiums 4. If my plan has a monthly premium, I understand that I must pay this premium or Health Net reserves the right to disenroll me from the plan after appropriate advance notice. I understand that I am responsible for continuing to pay the Medicare Part B premium in addition to any plan premium if applicable.
	Plan Effective Date 5. I understand that the proposed effective date on the application is not guaranteed and enrollment is not effective until my eligibility has been verified by the Centers for Medicare & Medicaid Services (CMS).
	Plan Changes 6. I have been informed by the sales agent that I may not change MA plans after December 7, 2012, unless I qualify for a Special Election Period (SEP). From January 1 through February 14, 2013, I can only disenroll from my MA plan and return to Original Medicare. I may enroll in a prescription-only drug plan at that time (subject to eligibility requirements).
	Service Area Requirements 7. I must be a resident in the Health Net Medicare Advantage service area to enroll. I cannot remain outside the plan service area for more than 6 consecutive months. I am aware that certain plans utilize only certain contracted providers within a specific service area. If I move from the plan service area, I must inform Health Net's Customer Contact Center immediately. If I receive an out-of-area letter from Health Net, I must respond to the letter within the required time frame, or I will be disenrolled from the plan.

CA89795 (7/12)
Material ID # Y0035_2013_0043 (H0351, H0562, H5439, H5520, H6815, EG) CMS Accepted 07232012

White – Health Net Pink – Writing Agent Yellow Enrollee

Health Net is a Medicare Advantage organization with a Medicare contract. Health Net is a Coordinated Care plan with a Medicare contract and a contract with the California, Arizona and Oregon Medicaid programs. Health Net is a Coordinated Care plan with a Medicare contract. These contracts are renewed annually, and availability of coverage beyond the end of the contract year is not guaranteed. These plans may not be available to Medicare beneficiaries in the following contract year because by law, plan sponsors, like Health Net, can choose not to renew their contract with CMS, or they can reduce their service area, and CMS may also refuse to renew the contract, thus resulting in a termination or non-renewal. Individuals must have both Part A and Part B to enroll. You must reside in the plan service area in order to apply for Health Net's Medicare Advantage (MA) plans. Medicare beneficiaries can only enroll in these plans during certain times of the year and must continue to pay their Medicare Part B premiums. Eligible beneficiaries must use network pharmacies to access their prescription drug benefit, except under non-routine circumstances, and quantity limitations and restrictions may apply. Limitations, copayments and restrictions may apply. Plan benefits and cost-sharing may vary by plan, county and region. Contact Health Net for more information. ARIZONA: For (Amber) Dual Eligible SNP enrollees: Premiums, copayments, coinsurance and deductibles may vary based on the level of extra help received. Please contact the plan for further details. This plan is available to anyone who has both Medical Assistance from the State and Medicare. For (Jade) Chronic SNP enrollees: This plan is available to all people with Medicare who have been diagnosed with congestive heart failure (CHF) and/or diabetes. CALIFORNIA: For (Amber I & II) Dual Eligible SNP enrollees: Premiums, copayments, coinsurance and deductibles may vary based on the level of extra help received. Please contact the plan for further details. This plan is available to anyone who has both Medical Assistance from the State and Medicare. For (Jade) SNP enrollees: This plan is available to all people with Medicare who have been diagnosed with cardiovascular disorders, chronic heart failure (CHF) and/or diabetes. OREGON: For (Jade) SNP enrollees: This plan is available to all people with Medicare who have been diagnosed with cardiovascular disorders, chronic heart failure (CHF) and/or diabetes.

In-network providers are those providers who contract with Health Net. Out-of-network providers are those who do not have a contract with Health Net but who do accept Medicare. You must use plan providers except in emergency or urgent care situations or for out-of-area renal dialysis. If you obtain routine care from out-of-network providers, you may be required to get prior authorization or referred by your primary care physician for services outside medical group or from another doctor. If a referral or a prior authorization is required and has not been obtained, you may have to pay for these services yourself.

Medicare beneficiaries may enroll in Health Net's MA plans through the Centers for Medicare & Medicaid Services Online Enrollment Center, located at www.Medicare.gov. For full information on this plan's benefits, including information on premium withholding or direct billing options, and other exclusions, limitations or restrictions to services not already identified in this document, please contact Health Net at 1-800-333-3930 in Arizona, 1-800-977-6738 in California and 1-800-949-6192 in Oregon (TTY /TDD 1-800-977-6757 in Arizona and 1-800-929-9955 in California and Oregon for the hearing and speech impaired), 8:00 a.m. to 8:00 p.m., seven days a week.

This information is available for free in other languages. Please contact our customer service number at Arizona: 1-800-333-3930; California: 1-800-977-6738; Oregon: 1-800-949-6192. Our hours of operation are 8:00 a.m. to 8:00 p.m., seven days a week. TTY/TDD users call Arizona: 1-800-977-6757; California/Oregon: 1-800-929-9955.

Esta información está disponible en forma gratuita en otros idiomas. Comuníquese con el número de nuestro servicio al cliente al Arizona: 1-800-333-3930; California: 1-800-977-6738; Oregon: 1-800-949-6192. Nuestro horario de atención es de 8:00 a.m. a 8:00 p.m., los siete días de la semana. Los usuarios de TTY/TDD deben llamar al Arizona: 1-800-977-6757; California/Oregon: 1-800-929-9955.

本資訊備有其他語言版本，可免費提供。請致電我們的客戶服務號碼 Arizona：1-800-333-3930；California：1-800-977-6738；Oregon：1-800-949-6192。我們的服務時間爲每週七天，每天上午 8:00 至下午 8:00。聽障人士請致電 Arizona：1-800-977-6757；California/Oregon：1-800-929-9955。

CA89795 (7/12)

White – Health Net Pink – Writing Agent Yellow Enrollee

Scope of Understanding Questions:

(If at anytime you receive the incorrect answer, please reconfirm that the Medicare Recipient (or POA) understands the question and gave the appropriate answer. If the Medicare Recipient (or POA) states that they understand the question and affirm their original answer, than advise them: *(Name) it would be best for you to gather more information about Health Net's Special Needs Plan prior to making a final decision for enrollment. We would ask that you speak to your Agent in more detail and after a thorough review of our Plan call us back if you determine that you would like to enroll. Thank you for your time today and we look forward to speaking with you again.*

1) As a matter of record, Health Net records all Scope of Understanding calls. Do we have your permission to record this call?

2) Thank you for calling the Health Nets Medicare Programs Enrollment Confirmation Center. My name is (HN Representative Name) and I will be assisting you today. This call is to confirm your request to enroll into Health Net's Special Needs Plan. The call will take approximately 5 – 10 minutes and you will be asked questions that confirm your understanding of how this plan works. This call may end early if at anytime it is apparent that you have not been completely informed regarding Health Net's Special Needs Plan.

3) May I ask your full name, as it appears on your Medicare Card.

4) Can you please state your Phone Number with area code? *(for recording archive identification)*

5) Is it your intention to request enrollment into Health Net's Special Needs Plan? **"YES"**

6) Do you require that a Power of Attorney, Family Member or Caregiver be present in order to make a decision to join Health Net's Special Needs plan. **"NO"**

- If "Yes"- Are they present today?
- If "NO" – conclude call.
- If "YES" - and have them come to the phone.
- If Power of Attorney – take them through call questions from start.
- If a Family Member or Caregiver, get permission to record the conversation and get their Name and Phone Number for records than ask for Medicare recipient to return to phone.)

7) Did you have a pre-authorized appointment with the Agent to review the health plan product information you have just concluded? **"YES"**

8) Did the Agent provide you with a Business card that provides his/her name and Telephone Number? **"YES"**

9) Did the Agent utilize and review Health Net materials while conducting his/her presentation?
"YES"

10) Did the Agent thoroughly cover all of the topics and answer all of your questions to your satisfaction? **"YES"**

- **(Medicare recipients name), we are about half way through the call. Do you have any questions so far or can we move forward?**

11) Were you informed that Health Net's Special Needs Plan is an HMO and utilizes contracted Physicians to provide most standard care. **"YES"**

12) Were you informed that you will need to utilize a Health Net contracted Primary Care Physician to access your physician needs? **"YES"**

13) What is the name of the Primary Care Physician and Health Net Physician ID that you have chosen?

- **Confirm Physician is on Health Net's online Directory**
- **If not, inform the caller that their requested Physician is not available and suggest that they speak to their Agent about choosing a different Primary Care Physician. End Call**

14) Were you informed that you will need to utilize your assigned Health Net contracted Primary Care Physician to receive access to services such as Physical Therapy, Preventative Services and Physician Specialists – such as, but not limited to, Cardiologists, Podiatrists, Rheumatologists, etc. **"YES"**

15) Were you informed, that in most cases not including Emergency Care, all of your physicians of choice, including your Primary Care Physician and Physician Specialist, will need to belong to the same contracted Medical Group, or Physicians Association? **"YES"**

16) Were you informed that you will be required to utilize only Health Net contracted Pharmacies, or Health Net's Pharmacy mail order program, to fill your prescription needs? **"YES"**

17) Did you understand all of the questions we have asked today? **"YES"**

(Name) I want to thank you for your time today. Do you have any questions that I may answer for you? **"NO"**

If you should have any questions that we can answer for you prior to the start of your Health Net Membership, please call me at 800. ###-####

At this time I would like to ask to speak with the Agent so that I can get their Health Net contact information and provide them with a Confirmation Number that they will need.

Agent comes to phone: Hi, my name is (HN Representative). Can I get your first and last name and Health Net Producer ID number:

Thank you (Producers name), the Scope of Understanding ID # for (Medicare Recipients name) is: #####, please place this number (give location – for example, "On the top right

hand corner") of the application.

Please know that an application will need to be submitted. If you have any questions you may call our Broker Services Department by dialing ###. ###-####.
This concludes our call today. Thank you. Goodbye.

14. Medicare late Application - Producer

Policy Statement:

Health Net (HN) is committed to ensuring that all HN Producers follow the guidelines set forth by the Centers for Medicare and Medicaid Services (CMS) and in HN policies in regards to the timely handling and processing of Medicare beneficiary enrollment applications.

When delays occur resulting in a late application submission, it is Health Net's policy to immediately address these issues, identify the underlying root cause and take actionable steps to minimize or eliminate repeated occurrences of the issue.

Policy Purpose:

The purpose of this policy is to document the process that ensures Health Net is in compliance with all CMS rules and guidance regarding the handling of late beneficiary enrollment applications.

This policy defines what is considered a late application, proactive actions Health Net takes with the HN Producers to prevent late application submissions and outlines the process HN Medicare Sales Support associates follow to properly handle beneficiary enrollment applications that are received late.

Scope/Limitations:

This policy and the related procedures apply to all HN Producers, HN Medicare Sales Support staff and encompass all Medicare products. HN Sales Associates should refer to P&P DY61-113620 (Medicare Late Application Policy and Procedure – Sales Associates).

References:

Chapter 2 of the CMS Medicare Managed Care Manual – Updated August 19, 2011

Definitions:

Agency	An agency that allows Producers to write underneath them.
AMES	Automated Membership Enrollment System (AMES) is an interface that has been developed to streamline the Medicare enrollment and document handling process for California, Oregon and Arizona Medicare MA/MAPD product lines. All documents are received electronically via Right Fax, USPS, CMS.gov online, Extend Health FTP and HN.com online.
Broker HUB	The Broker HUB is a national department responsible for verifying the Broker/Sales information reflected on enrollment application is captured accurately in AMES. All applications are processed in AMES by the Enrollment Department.
CMS	Centers for Medicare and Medicaid Services. The federal agency within the Department of Health and Human

	Services that administers the Medicare program.
Field Marketing Organization (FMO)	An FMO is an agency contracted to provide broad coverage for the marketing and sales of a health plan. Areas of support will include, but are not limited to, Marketing / Lead Generation, Call Center capabilities, and Administrative functions.
General Agency (GA)	A GA is an agency contracted to provide sales of a health plan. Typically its focus is on Producer recruitment and sales. Areas of support include, but are not limited to, Producer Certification, Sales Training, Product Training and Compliance Oversight.
Managing Agency (MAGY)	A MAGY is an agency contracted to provide sales of a health plan. Typically its focus is on limited Producer recruitment and sales within a narrow territory. Areas of support include, but are not limited to, Producer Certification, Sales Training, Product Training, Compliance Oversight and Application Enrollment Processing.
Medicare	The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End Stage Renal Disease (ESRD).
Medicare Advantage (MA)	A Medicare program that allows for more choices among Medicare health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (ESRD).
Medicare Advantage Organization (MAO)	A public or private entity organized and licensed by a state as a risk-bearing entity (with the exception of provider sponsored organization receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements.
Offenses (Incidents)	Submission of one or more late applications within a designated timeframe within a rolling 12-month period. Example, if ten (10) enrollment applications are submitted to HN late on the same day, the Producer would incur one offense/incident rather than ten (10) separate offenses/incidents.
Producer	Any person who is authorized to sell Health Net Medicare products, including persons who are directly contracted with Health Net and persons who are affiliated with a contracted Sales Entity.
Sales Entity	Field Marketing Organization (FMO), General Agency (GA) or Agency.

Procedure:

Medicare Advantage Organizations (MAOs) are responsible for the processing of beneficiary enrollment applications received in a timely manner. Health Net has well

established policies and procedures in place that ensure beneficiary enrollment applications received are processed within CMS' required processing timeframes.

1. Application Timelines

Health Net is required to transmit completed enrollment requests promptly to CMS within 7 calendar days of receipt and issue an acknowledgement letter within 10 calendar days. HN Producers are required to document the date of receipt on all applications received from beneficiaries. The Medicare timeline begins on the date the HN Producer receives a completed enrollment application. Dating an application is an acknowledgement that the completed application was received and will be forwarded to Health Net no later than the next calendar day of receipt from the beneficiary. The completed application can be faxed, hand-carried or mailed to Health Net; faxing is the preferred method of receipt.

HN Producers are required to submit enrollment applications within one (1) calendar day of receipt from the beneficiary. An application is considered to be 'late' if the application is not submitted to Health Net within three (3) calendar days of receipt from the beneficiary. Corrective action will be initiated for HN Producers who submit applications that are determined to be late (refer to Section 6).

2. Sales Entity and Producer Training/Education

According to CMS, the 7-day turnaround time begins when the HN Producer receives an enrollment application. Timely submission of enrollment applications to Health Net is a key component to timely processing and submission of enrollment data to CMS.

Annually, HN Producers are educated on the importance of timely submission of enrollment applications with optional training offered throughout the year. Training and educational material, including Producer Training P&P's, inform HN Producers of Health Net's expectation. A Health Net Sales and Compliance Presentation is updated annually and includes an Enrollment Eligibility section that stresses the importance of:

1. Completing the **For Office & Agent Use Only** section, which includes documenting the receipt date.
2. Submitting enrollment applications no later than the next calendar day of receipt from the beneficiary.
3. Avoid holding onto enrollment applications

HN Producers receive in person training, email notifications, as well as documentation stressing the importance of submitting applications accurately and in a timely manner.

3. Late Application Processing

All Medicare enrollment applications received by HN Producers are sent thru the AMES system for processing.

In situations where Health Net receives the application after the monthly plan cut-off, if proof is documented that the HN Producer received the application prior to the monthly plan cut-off, the application is processed under the late application process. Some examples of this proof include:

- A fax complete confirmation
- A fax header showing that the application was faxed before or on the cut off date.

4. Coaching and Counseling

A national cross-functional committee has been established that provides oversight on instances where late enrollment applications are received. Monthly meetings are held to discuss the current late enrollment activity.

Within the regions, reports on late application submissions are generated which identify Producers that are consistently submitting applications late. Coaching and counseling is facilitated with the HN Producer identified, with the goal of preventing any continued occurrences of late enrollment application submissions.

5. Corrective Action Process

A Corrective Action Plan (CAP) is initiated when continued late application submissions occur despite coaching and counseling of the HN Producer. The criteria established to initiate a CAP is 3 or more late application incidences within a rolling 12-month period. The CAP is completed on the third (3rd) offense within a rolling 12-month period. Corrective Actions will be implemented as follows:

- 3rd Offense will result in coaching/training
- 4th Offense will result in written warning
- Greater than 4 offenses will result in suspension and termination

HN Producers are notified via email when an enrollment application is received late. HN Sales Support will report on Producer late application activity during monthly Medicare Application Timeliness Oversight Committee (ATOC) meetings.

The Medicare Application Timeliness Oversight Committee (ATOC) meets monthly, or more frequently as needed, to review CAP forms and discuss the appropriate action to be taken against the HN Producer. The Medicare ATOC participants include Sales Directors, Sales Support Representatives, Membership Representatives, Sales Compliance Managers and a Compliance Representative. CAPs for HN Associates are not reviewed during Medicare ATOC meetings but are sent to the appropriate Sales Manager and Director for determination of any action needed.

Review/Revision History

Revised……..March 31, 2011
Revised……..May 25, 2011
Revised……..October 26, 2011
Revised……..April 4, 2012
Revised……..August 14, 2012

Additional Information:

Applies to contract numbers H0351, H0562, H5439, H5520, and H6815.

Appendix A:

Sales Producer Code of Conduct

As a Health Net (HN) sales producer, I agree to abide by all of the following while representing HN Medicare products to Medicare beneficiaries and/or their representatives, family members, friends, and in the communities in which I solicit. I will:

1. Treat each individual with whom I work representing HN Medicare products with respect, courtesy, understanding, professionalism, and empathy.
2. Accurately represent my professional designations, qualifications, professional licenses, and other such endorsements or criteria. I will not provide advice or guidance beyond my professional capabilities or qualifications, nor under any circumstance will I represent or infer that I work for or am endorsed by Medicare, Centers for Medicare and Medicaid Services (CMS) or any other governmental agency.
3. Represent HN Medicare products with complete accuracy, thoroughness, and honesty.
   Under no circumstance will I exaggerate, lie about or knowingly misrepresent the benefits, premiums, member cost-sharing, administrative rules, or any other feature about any HN Medicare product. If I don't know the answer to a question, I will find the correct answer and will not simply guess or make-up an answer. I will not make any promises on behalf of HN that I have not been specifically authorized in writing to make.
4. Confirm that each Medicare beneficiary comprehends the fundamentals of the HN products in which they are enrolling, that each understands the impacts of enrolling in a HN product and terminating any other Medicare coverage, and that all required materials have been provided before enrollment occurs. I will refrain from using technical or industry jargon to describe HN products unless law or regulation requires such specific terminology.
5. Abide by all applicable federal and state laws, regulations, and HN policies and procedures governing the solicitation and sale of Medicare products and the associated confidentiality provisions Health Insurance Portability and Accountability Act (HIPAA).
6. Use my professional skills and ethical judgment to always provide proper guidance and act in the best interest of each Medicare beneficiary with whom I work. This means that I will place my client's and prospective client's needs ahead of my own considerations in all situations.
7. Use only advertising, marketing, sales presentation, enrollment and other materials which have been provided to me by HN or that have been approved in writing by HN for my usage. I will also obtain prior written approval from HN for any advertising medium, except for generic marketing material as defined by CMS and require review and approval, I would like to use to solicit prospective HN members.
8. Abide by professional courtesy. Under no circumstance will I put any Medicare beneficiary in the "middle" of any type of dispute or debate relative to compensation or client relationship.

9. Continue to learn about the Medicare Program, HN Medicare products, and other government programs that may impact my clients and potential clients.
10. Provide timely service to my clients with professionalism, competence, and sincerity.
11. Ensure the Medicare beneficiary understands the person discussing plan options with them is either employed, contracted or authorized through a contracted entity with Health Net and may be compensated based on the beneficiary's enrollment in a plan.

Appendix B:

Do and Don't Chart

MEDICARE SALES & MARKETING ACTIVITIES DO AND DON'T REFERENCE CHART FOR HEALTH NET PLANS

GENERAL MARKETING PRACTICES	
CMS defines Marketing as activities meant "to steer, or attempt to steer potential enrollees toward a plan or a limited set of plans."	
DO	**DON'T**
Market MA and Part D plans to all eligible Medicare beneficiaries. Accept and perform enrollments.	Your selling activities must not discriminate against: • race, ethnicity, gender, age, national origin, religion • mental or physical disability • high or low income areas • health status/cherry picking (except chronic care SNPs) • newly eligible Medicare beneficiaries over other beneficiaries • claims experience, genetic information or evidence of insurability.
Distribute health plan brochures and pre-enrollment materials that have been provided by the plan and approved by CMS.	Use materials that have not been approved by CMS and Health Net Alter anything outside the bracketed areas of template material. Use materials containing a reproduction or copy of the Medicare blue, white, red card. Use words or symbols including "Medicare", "Centers for Medicare and Medicaid Services", "Department of Health and Human Services" or "Health and Human Services" in a manner that would convey the false impression that you, the business or product is approved or endorsed by Medicare or any other government agency
State that the plan is approved for participation in Medicare programs and/or that it is contracted to administer Medicare benefits	Engage in activities that mislead or confuse Medicare beneficiaries or provide false or misleading information about the plan and the benefits
Use qualified superlatives. **EXAMPLE:** "One of the best", "among the highest ranked."	Refer to the plan you are marketing/selling as "the best, the highest ranked", "rated number one", etc. Compare HN to another Plan by name unless you have written concurrence from all plan sponsors being compared, or using CMS Star rating documents
	Imply that any of Health Net's MA plans are Medicare Supplement plans.

This chart reflects the regulations of the June, 2012 release of the CMS Managed Care Guidelines.

MEDICARE SALES & MARKETING ACTIVITIES DO AND DON'T REFERENCE CHART FOR HEALTH NET PLANS

Obtain the beneficiary HICN number ONLY if the beneficiary initiates contact and asks the plan contact to verify Medicaid eligibility for a SNP plan	Request beneficiary identification numbers (e.g. Social Security Numbers, bank account numbers, credit card numbers, HICN).
Solicit and collect enrollment applications after the start of the AEP, 10/15.	
Solicit and collect enrollment applications for beneficiaries who are aging-in throughout the year.	

SALES EVENT PRACTICES	
There are two types of sales events, formal, informal. "At Marketing/Sales Events, plan representatives may discuss plan specific information like premium, cost-sharing, or benefits and/or distribute or collect applications." Formal marketing/sales events are structured events of an audience/presenter style with a sales person providing specific plan information via a specific CMS approved sales presentation. Informal marketing/sales events are conducted with a less structured presentation or in a less formal environment. They typically utilize a table, kiosk or a recreational vehicle (RV) that is manned by a plan sponsor representative who can discuss the merits of the plan's products. Note: Events in which Plans are discussed with existing Health Net members are considered informal Sales Events and must be reported to CMS. Health Fairs can be either Educational Events or Sales events.	
DO	**DON'T**
Discuss **ONLY** those products (HMO, PPO) that are advertised.	Discuss products that are not included in the advertisement
At a formal event, present benefit information found in the Summary of Benefits, Benefit Highlights or CMS approved Sales Presentation.	Use a sales script, presentation, or materials that have not been approved for use by Health Net and/or CMS.
Provide light snacks at promotional or sales activities where plan benefits are being discussed and/or plan materials are being distributed such as, coffee, soft drinks, fruit, raw vegetables, pastries, cookies etc.	Market any MA or Part D plans where meals are being provided, even if the meal is not sponsored by HN and is the normal activity in that location such as soup kitchens, senior centers, etc. Conduct sales presentations and require a Scope of Appointment form. A Scope of Appointment is only required for personal/individual sales appointments, not sales events.

This chart reflects the regulations of the June, 2012 release of the CMS Managed Care Guidelines.

MEDICARE SALES & MARKETING ACTIVITIES DO AND DON'T REFERENCE CHART FOR HEALTH NET PLANS

If only one person is at an event, it is permissible to a.)continue the presentation, b.) ask the beneficiary if they would like to do an individual appointment instead of the presentation or schedule an in home for a later date. An SOA is required for individual appointments.	
Contribute cash towards gift money to a foundation or another entity if the event is jointly sponsored. The plan cannot claim to be the sole donor of the gift and it must be clear that the gift is attached to the event and not the individual organization	Ask beneficiaries to provide personal contact information in order to participate in a raffle or drawing. Use other mechanisms (e.g., raffle tickets, random numbers) for conducting drawings.
Announce all products/plan types that will be covered during the sales event at the beginning of that sales event (e.g., HMO, PPO, etc).	Omit introducing yourself or the plans that you will be discussing at the beginning of the sales event.
Submit all formal and informal sales events to so they can be reported to CMS within established timelines. Be present at the site, at the time that the event is scheduled to occur and remain on site at least 15 minutes after the scheduled start of the event, even if the event is cancelled. Exception: If the event was cancelled due to inclement weather; a representative is not required to be present at the site. Notify beneficiaries of a cancellation by the same means that was used to advertise the event if you cancelled an event more than 48 hours before the scheduled date and time.	Conduct a Sales event that has not been reported to CMS. **EXAMPLE:** You cannot simply cancel an event if you advertise an event using flyers or the web or other media. If you cancel the event, you must ALSO notify prospective attendees in the same manner that you advertised to them.
EDUCATIONAL EVENT PRACTICES	
Educational events are events designed to inform Medicare beneficiaries about MA, Prescription Drug or other Medicare programs, do not discuss plan benefits and do not steer, or attempt to steer potential enrollees toward a specific plan or limited number of plans. Educational events are submissable to CMS.	

This chart reflects the regulations of the June, 2012 release of the CMS Managed Care Guidelines.

MEDICARE SALES & MARKETING ACTIVITIES DO AND DON'T REFERENCE CHART FOR HEALTH NET PLANS

DO	DON'T
Respond to questions asked at an educational event. (A response to questions does not render the event as a sales event provided that the scope of the response does not go beyond the question asked.)	Conduct sales or marketing activities at educational events
Participate in educational health fairs and health promotional events as either a sole sponsor or co-sponsor of an event hosted by multiple organizations as long as the event does not include a sales presentation and is billed as educational.	Distribute or accept enrollment forms
Distribute Medicare and/or health education materials that meet the CMS definition of education, i.e., informing a potential enrollee about MA or other Medicare programs, but not steering a potential enrollee towards a specific plan.	Set-up of personal sales appointments or attempts to get permission for an outbound call to the beneficiary
Distribute business cards, upon beneficiary request or if the beneficiary requests information on how to contact the agent for additional information, as long as they do not contain any plan marketing or benefit information.	Discuss or distribute materials that include plan specific information, such as premiums, copayments, or other benefit information
May use a promotional item (pen, magnets, etc); including those with plan name, logo, and toll-free customer service number and/or website. Promotional items must be free of benefit information.	Distribute or display and/or accept Scope of Appointment forms, or sign-up sheets
Meals are allowed at educational events only and the cost must comply with nominal gift requirements.	Distribute business cards that include marketing information
	Attach business cards or plan/agent contact information to marketing materials
	Collect member contact information: (names, addresses, phone numbers)
	Advertise an educational event and then have a marketing event immediately following in the same general location
	Ask if they want information about a specific plan or limited number of plans.
	Refer to an event as "educational" if you plan on marketing/selling/ passing out enrollment forms, collecting leads, etc., at the event

This chart reflects the regulations of the June, 2012 release of the CMS Managed Care Guidelines.

MEDICARE SALES & MARKETING ACTIVITIES DO AND DON'T REFERENCE CHART FOR HEALTH NET PLANS

SPECIAL NEEDS EVENT PRACTICES	
DO	**DON'T**
Clearly explain the following during SNP presentations/events: • Eligibility limitations (e.g., required special needs status) • Special enrollment period (SEP) to enroll in, change or leave SNPs • Process for involuntary disenrollment if the beneficiary loses his/her Medicaid or institutional status (or becomes ineligible for the C-SNP). • A description of how drug coverage works.	

GIFTS/PROMOTIONAL ITEMS	
DO	**DON'T**
Offer promotional items to potential enrollees: • whether or not the individual enrolls in the plan • the gift is worth $15 or less, based on the retail value of the item. • the combined value of all items offered cannot exceed $15, at a time. **EXAMPLE:** The plan would like to offer gifts (less than $15) to people who call for more information about our plan. The plan would then like to offer additional gifts if they come to a separate marketing event. Each of these gifts is less than $15 Is this permissible? Answer: Yes, because it does not go over the $50 annual limit.	Intentionally provide gifts equal to more than $50.00 a year to one person. Offer a gift over $15 based on the retail value of the item Offer gifts as an inducement to enroll. Provide cash gifts or gift certificates and gift cards that can be converted to cash, regardless of dollar amount. **EXAMPLE:** Can a plan send a $1 lottery ticket as a gift to prospective members? Offering a $1 lottery ticket to prospective members violates the "no cash or equivalent" rule, since the unscratched ticket has a cash value of $1. Note: raffle cards cannot be used to initiate contact, unless the raffle card specifically says the beneficiary is giving the plan and/or Producer permission to call them.
Offer a door prize or contribute to a pool for gifts for a door prize that is identified with a list of contributors. **EXAMPLE:** A radio station, along with many sponsors organizes a	Contribute to a community door prize and claim to be the sole donor of the gift.

This chart reflects the regulations of the June, 2012 release of the CMS Managed Care Guidelines.

senior health fair. Anyone who attends may register for the door prize. The organization may contribute to the door prize, and permit attendees to register for the door prize at Plan's booth.	

MAILING AND EMAILING PRACTICES	
DO	**DON'T**
Email a beneficiary if the beneficiary agrees to receive e-mails from HN or a Producer. Provide an opt-out process for beneficiaries who no longer wish to receive e-mail communications.	Email using: Purchased lists or addresses obtained through any type of directory, or e-mail addresses obtained through friends or referrals. Email a beneficiary if the beneficiary has not agreed to receive emails. Email a beneficiary if the permission to receive an email was received by an unaffiliated third party. Require an email address or any other contact information as a condition to RSVP for an event online or through mail.
Mailings, e.g., advertising, marketing materials, etc, IF the material has been approved for use by Health Net and CMS.	Call beneficiaries to confirm receipt of mailed information
Include one of four statements on the outside of the envelope or mailing itself (ONLY if no envelope is used) that best fits the information being sent to the Medicare beneficiary: • Advertising pieces – "This is an advertisement" • Plan information – "Important plan information" • Health and wellness information – "Health or wellness or prevention information" • Non-health or non-plan information - "Non-health or non-plan related information"	Mail information to Medicare beneficiaries or current HN members if one of the four statements is not included on the envelope or mailing itself if no envelope is used (e.g., a postcard)

This chart reflects the regulations of the June, 2012 release of the CMS Managed Care Guidelines.

MEDICARE SALES & MARKETING ACTIVITIES DO AND DON'T REFERENCE CHART FOR HEALTH NET PLANS

CROSS SELLING OF NON-HEALTH RELATED PRODUCTS	
CMS defines "non-health care related products" as any insurance product not involving medical/health coverage.	
DO	**DON'T**
	Cross-sell any non-health care related products (annuities, life insurance, etc) during any Health Net sales event. (Dental coverage is considered health care coverage.) Leave brochures on non-health care related products at any Health Net sales activity.
SOLICITED verses UNSOLICITED CONTACTS	
"Health Plan, assigned Producers, and Third Party Marketing Organizations (TMO) utilized to generate sales leads and/or appointments are prohibited from engaging in direct unsolicited contact with potential enrollees, including outbound calls."	
DO	**DON'T**
Call a beneficiary when the beneficiary has given express permission to contact them. Call members you have enrolled in a plan to discuss plan issues and market other plan options. Call to confirm an appointment that has already been agreed to by the beneficiary via a completed SOA form. Return a beneficiary's phone calls or messages as these are not unsolicited. A person responding to Business reply card should be contacted within a reasonable period of time. Enroll a beneficiary if the beneficiary makes a request to enroll via an inbound phone call. NOTE: Agents/brokers who have a pre-scheduled appointment which becomes a "no-show" may leave	Participate in door to door solicitation of Medicare beneficiaries. Leave information such as a leaflet, flyer, or door hanger at a residence or on someone's car. Participate in telephonic or electronic solicitation including leaving voicemail messages on answering machines, text messages, or sending unsolicited emails. Approach individuals in common areas such as parking lots, sidewalks, hallways, lobbies, etc. Call or approach a beneficiary without the beneficiary initiating the contact. Use old lists or old consent forms to contact beneficiaries. Initiate any unsolicited outbound calls to beneficiaries. Call/visit beneficiaries after attendance at a sales event, unless the beneficiary gives express permission at the event for a follow-up or visit

This chart reflects the regulations of the June, 2012 release of the CMS Managed Care Guidelines.

MEDICARE SALES & MARKETING ACTIVITIES DO AND DON'T REFERENCE CHART FOR HEALTH NET PLANS

information at the no-show beneficiary's residence. Comply to the extent applicable with the following: • Federal Trade Commission's Requirements for Sellers and Telemarketers • Federal Communications Commission rules and applicable State law • National-Do-Not-Call Registry • Honor "Do not call again" requests • Abide by Federal and State calling hours. Get consent for future contact that is limited in scope, and event specific. The consent to contact may not be treated as open-ended permission for future contacts. **EXAMPLE:** A person asks for you to contact them during the next AEP. On the Scope of Appointment form you request the person to specify a date within the AEP on the SOA.	and has completed an SOA form. Conduct unsolicited phone calls to beneficiaries (other than to current plan members or to an agent's existing clientele). Conduct or allow unsolicited marketing calls to beneficiaries for other business (for example, a "benefits compare" meeting) and then provide those contacts to other plans for ultimate use in a MA or PDP sales appointment. Begin by selling a Medicare Supplement plan and then turn the conversation to MA or PDP products without the beneficiaries expressed request. **EXAMPLE:** If, during the course of an outbound call by a Medigap plan issuer for a Medicare Supplement product, the beneficiary initiates interest in an MA or PDP product, then that MA or PDP product may be discussed, as long as the call is recorded
Generate leads through mailings, websites, and advertising and public sales events.	Accept an MA or PDP appointment from a third party lead that resulted from an unsolicited contact with a beneficiary. Use Unsolicited third party leads. Make unsolicited calls to beneficiaries for non-MA and PDP products and provide those contacts to plans for ultimate use as an MA or PDP sales appointment
Discuss only the product(s) referenced on the business reply card, lead card, and/or in the advertisement. All business reply cards and lead cards used for documenting beneficiary agreement for a contact must be current and CMS approved. Call a beneficiary in response to a Business reply card or a lead card.	Discuss any product(s) that were not referenced on the business reply card, lead card and/or in the advertisement. Call a beneficiary in response to a business reply card or a lead card if the card does not expressly state that the beneficiary is giving the plan and/or Producer permission to call. **EXAMPLE:** Permission to call applies only to the entity from which the beneficiary requested contact, for the duration of that transaction, for the scope of product (e.g., MA-PD plan or PDP) previously discussed or indicated in

This chart reflects the regulations of the June, 2012 release of the CMS Managed Care Guidelines.

EXAMPLE: The beneficiary returns a business reply card that includes a phone number, and specifically says the beneficiary is giving the plan and/or Producer permission to call.	the reply card.
SCOPE OF APPOINTMENTS (SOA) and Individual Appointments Practices	
CMS expects SOAs to be collected 48 hours prior to the appointment, when practicable. If it is not practicable, document on the SOA why it was not feasible to obtain the scope of appointment prior to the appointment. The beneficiary must agree to the purpose and products to be discussed in the appointment and that agreement must be documented, in writing by using the SOA.	
DO	**DON'T**
Have a pre-set appointment with an individual to market MA and/or Part D plans	Return uninvited to an earlier "no show" appointment
Have a SOA form for any face-to-face personal/individual marketing appointment that is signed & dated by the beneficiary prior to the appointment.	Obtain the SOA immediately prior to the Sales appointment unless otherwise unavoidable.
Request that the beneficiary signs a new SOA if the beneficiary wants to discuss another product not agreed upon for the initial appointment. **EXAMPLE:** A Producer has obtained an SOA for a pre-scheduled appointment with a beneficiary to discuss MA products. During the appointment, the beneficiary wants to discuss a PDP product. The beneficiary must sign a new SOA and then the Producer may continue the marketing appointment. A new separate appointment is not required.	Discuss plan products not agreed upon by the beneficiary prior to the appointment. **EXAMPLE:** A Producer meets with a beneficiary to discuss a Med Supp product. An SOA Form was not completed. During the meeting, the beneficiary wants to discuss MA products. The Producer would obtain a signed SOA .
Obtain a SOA for existing clients/members as well as new members if the beneficiary is interested in changing plans. **EXAMPLE:** A Producer meets with a current HN member to discuss switching from the HN Ruby to HN Violet plan. An SOA would need to be obtained for this appointment.	Conduct an appointment with another beneficiary if the other individual has not a done a separate SOA. **EXAMPLE:** A Producer has a pre-scheduled sales appointment at a beneficiary's home. Upon arrival, the Producer discovers that the beneficiary has invited their neighbor, who is also interested in meeting with the Producer. The Producer will need to have the neighbor complete a SOA, with a note explaining the reason that the SOA is completed at the time of appointment. The Producer can then proceed with the appointment with the beneficiary and neighbor.

This chart reflects the regulations of the June, 2012 release of the CMS Managed Care Guidelines.

MEDICARE SALES & MARKETING ACTIVITIES DO AND DON'T REFERENCE CHART FOR HEALTH NET PLANS

	Call or visit a beneficiary who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call or visit via a SOA. Make a personal appointment with a beneficiary to discuss MA and/or Part D products over the phone if you cannot obtain an SOA.
Leave materials/brochures for health care products the beneficiary did not agree to discuss when the appointment was set up.	Do not leave an enrollment form for products the beneficiary did not agree to discuss when the appointment was set up.
Keep records of all your appointments for 10 years including Scope of Appointment (SOA) regardless of outcome, i.e., retain all appointment books, calendars, etc.	Discard SOA Forms or phone recordings for at least 10 years.
For beneficiary walk-ins to a Plan or Producers office or other similar beneficiary-initiated face-to-face sales event, complete the SOA Form and obtain the beneficiaries signature prior to discussing MA or PDP plans. Indicate on the form that the beneficiary was a walk-in. There is no 48 hour waiting period; you may discuss the plans agreed upon at that time.	Begin discussing MA or PDP plans prior to the beneficiary signing the SOA Form.
MARKETING IN HEALTHCARE SETTINGS	
DO	**DON'T**
Conduct sales or marketing activities in common areas of health care settings. **Examples:** Hospital cafeteria Nursing home cafeteria Community/recreational rooms Senior Center multi-purpose rooms Conference rooms Space outside of where patients wait for services or interact with providers and obtain medications	Conduct sales or marketing activities in areas where patients primarily receive health care services or where health care is delivered. **Examples:** Physician Offices Pharmacies Waiting rooms/examination rooms Hospital patient rooms Pharmacy counter areas
Schedule an appointment with a beneficiary residing in a long term care facility, or nursing home if requested to do so by the beneficiary.	Conduct promotional activities (collect enrollment forms, go door-to-door) in resident rooms of long term care facilities or nursing homes without a prior appointment.

This chart reflects the regulations of the June, 2012 release of the CMS Managed Care Guidelines.

MEDICARE SALES & MARKETING ACTIVITIES DO AND DON'T REFERENCE CHART FOR HEALTH NET PLANS

REFERRAL PROGRAMS	
DO	**DON'T**
Request referrals names and addresses from current MA or Part D plan members. Use member provided referral names and addresses to solicit potential new members by mail only. You may give a post-sale thank you gift for a referral provided it is individually worth $15 or less and in the aggregate for the year, worth $50 or less based on the retail value.	Request referrals during an in home appointment. Request a referral phone number. Offer a gift (cash or other) to a current MA or Part D plan member in return for a lead or referral. Use cash promotions as part of a referral program. Announce in a mailing that a gift will be offered for a referral. Email prospective members at email addresses obtained through friends or referrals.
ONLINE & TELEPHONE ENROLLMENTS	
DO	**DON'T**
Accept enrollments via a link to the plan sponsor's secure internet website using CMS approved materials and web pages. Accept telephonic and plan sponsor website enrollment requests that are effectuated entirely by the beneficiary or the authorized representative.	Accept enrollments via an agent/broker website. Use a third party comparison available from an agent/broker website to assist a beneficiary with telephonic enrollments. Be physically present with a beneficiary at the time of a telephonic enrollment.

PROVIDER PRACTICES If a provider agrees to make available and /or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plan sponsors with which it participates.	
DO	**DON'T**
Display plan-marketing materials for all plans with which the Provider participates. If a particular plan fails to provide materials, the provider may display the materials for only those plans that have provided them.	Steer patients to particular plan(s) and may not limit distribution of plan materials to a sub-set of the plans that they contract with.

This chart reflects the regulations of the June, 2012 release of the CMS Managed Care Guidelines.

MEDICARE SALES & MARKETING ACTIVITIES DO AND DON'T REFERENCE CHART FOR HEALTH NET PLANS

Expect providers to remain neutral parties in assisting plans to market to beneficiaries or assisting in enrollment decisions Providers may: • Provide the names of plan sponsors with which they contract • Provide information & assistance in applying for the low income subsidy • Provide objective information on ALL plan sponsors specific plan formularies, based on the patients medications & health care needs • Provide objective information regarding ALL plan sponsors specific plans being offered, such as covered benefits, cost sharing, and utilization management tools • Refer patients to other sources of information, such SHIPS, plan marketing representatives, State Medicaid office, local SS office, CMS website. • Print out and share information with patients from CMS's website	Expect providers to: • Offer sales/appointment forms • Accept enrollment applications • Mail marketing materials on behalf of plans • Make phone calls or steer beneficiaries, in any way, to a limited number of plans • Offer anything of value to induce plan enrollees to select them as their provider • Offer inducements to persuade beneficiaries to enroll in a particular plan or organization • Conduct health screening when distributing information to patients • Accept compensation directly or indirectly from the plan for beneficiary enrollment activities

This chart reflects the regulations of the June, 2012 release of the CMS Managed Care Guidelines.