Name:	Disciplinary Guidelines – Broker Agents	**Number:**	B0001
Department:	Compliance	**Original Issue Date:**	7/16/2013

Guidance:
Medicare Managed Care Manual – Section 50.5.3 – Well-Publicized Disciplinary Standards

Policy

The Company establishes and maintains disciplinary standards that reflect clear and specific policies which encourage compliant behavior and awareness of and participation in the Compliance, Fraud, Waste and Abuse (FWA), and HIPAA training programs.

Our standards include policies that:

- Identify the Company's expectations for reporting compliance issues and assisting in the resolution of such issues;
- Identify noncompliance, FWA or HIPAA violations, including unethical or illegal behavior; and
- Provide for timely, consistent, and effective enforcement of standards and reporting when violations are determined to be founded.

Violation of the Company's Policies and/or CMS/DOI Regulations

Level I – if founded, will result in immediate termination of contract (CEO/President and/or principal of the marketing company makes the final determination in consultation with the Company's Legal/Compliance Department).

1. Dishonesty or theft.
2. Medicare Advantage door to door solicitation, improper outbound phone calls or sending unsolicited emails.
3. Misrepresentation of the product, the purpose of the sales agent's visit, or an implication that the visit is in any way connected with the government.
4. Discriminating against potential enrollees on the basis of health status, ethnicity, or personal needs.
5. Threatening, coercing, intimidating, or deceiving a member or prospective member, or the use of any other unethical sales tactics.
6. Blatant misrepresentation of plan benefits or plan premiums.
7. Marketing non-health care related products to prospective enrollees during any Medicare sales activity or presentation.
8. Negligent failure to provide full disclosure of any plan limitations and comparison to their current coverage to ensure the beneficiary understands any difference in benefits, costs and/or access to providers.
9. Forging or knowingly accepting a forged signature on an enrollment form.
10. Deliberate or negligent omission or falsification of significant information on any form, including carrier, state, and Company forms.
11. Enrollment of beneficiaries by an unlicensed individual or not licensed in a specific state.
12. Willfully enrolling an incompetent beneficiary.
13. Failure to maintain the privacy and security of all protected health information (PHI) in accordance with HIPAA guidelines and Company guidelines.
14. Offering or accepting inducements or favors to enroll.
15. Rebating or splitting commissions with another person who is not a licensed and contracted agent (i.e., payment of any kind or amount to a member or non-member as reimbursement for a referral name on the condition that the referred person purchases an insurance product).
16. Willful failure to assist a member with a disenrollment request (direct the member to call the carrier's member services division).

Level I Disciplinary Actions

Termination of contract

Level II: The following valid sales allegations are defined as egregious and subject to progressive discipline, up to and including termination of contract. (This list is a representative sample and is not all-inclusive.):

1. Requiring beneficiaries to provide any contact information as a prerequisite for attending an event.
2. Providing food/meals to potential enrollees that does not adhere to CMS Chapter 3 guidelines for Medicare Advantage and Prescription Drug Plan sales (snacks may only be provided).
3. Disparaging competitor plans, Medicare, or health care reform.
4. Incorrect enrollment paperwork/clerical error.

5. Marketing health care related products not identified or agreed upon on the telephonic or paper scope of appointment form.
6. Holding applications (when it impacts the member's effective date) or failing to submit applications within the carrier's specific time requirement.

Level II Disciplinary Actions

Valid: Level 2 Allegations – based on a rolling six (6) month period:

- First Occurrence – Coaching/Counseling
- Second Occurrence – First written warning
- Third Occurrence – Final written warning
- Fourth Occurrence – Termination of contract

Steps may be omitted at the discretion of the Company.

Invalid: Level 2 Allegations

Track and trend

Level III

Parameters of submitted vs. accreted sales (rapid disenrollment – defined as member cancellation/disenrollment during the first 90 days of enrollment) and rolling ninety (90) day cycle throughout the enrollment year. The expectation is a 5% or lower disenrollment rate.

Category 1: 0-10 enrollments
Category 2: 11-20 enrollments
Category 3: >21 enrollments

Level III

Category 1:	0-4%	disenrollment average – No Action
	5-10%	disenrollment average – Coaching
	11-20%	disenrollment average – First written warning
	> 20%	disenrollment average – Corrective action plan
Category 2:	0-4 %	disenrollment average – No Action
	5-10 %	disenrollment average – Coaching
	11-25%	disenrollment average – First written warning
	>26%	disenrollment average – Corrective action Plan
Category 3:	0-4%	disenrollment average – No Action
	5-15%	disenrollment average – First written warning
	21-25%	disenrollment average – Final Written Warning
	>26%	disenrollment average – Termination of contract

Steps may be added and/or omitted at the discretion of the Company.

POLICY

Title:	**Marketing Material Submission & Review**	Number:	B0002
Department(s):	Brokerage Companies & Legal	Original Issue Date:	11/21/2013

Guidance
Medicare Marketing Guidelines - 30.3 Plan/Part D Sponsor for Subcontractor Activities and Submission of Materials for CMS Review

Policy

Advertising and marketing material, in any form, must be approved by both the carrier, if applicable and the Company's Legal/Compliance Department prior to submission for printing and distribution. Marketing material will be reviewed for compliance and applicable laws, with a view towards ensuring materials are complete and accurate and devoid of deception or the capacity to mislead or deceive.

1. Marketing company/broker completes the advertising review checklist, attaches the marketing piece, written carrier approval of the marketing piece (if applicable), and source material, and submits these documents to the Company's Legal/Compliance Department.
2. Legal/Compliance Department evaluates the marketing piece for the following:
   a. Review of material content.
   b. Ensures all applicable guidelines and regulations are satisfied.
   c. Documents and submits changes, if any.
   d. Final review, sign off, and issuance of approval code.
   e. Approved pieces are filed in the Legal/Compliance Department.
3. Approved marketing pieces are returned to the marketing company/broker.

POLICY

Title:	Agent/Agency Website Guidelines	Number:	B0003
Department(s):	Brokerage Companies & Legal	Original Issue Date:	1/24/2014

Guidance

Medicare Marketing Guidelines – Section 100 – Websites and Social/Electronic Media and Carrier Guidelines

Policy

The Company and contracted carriers maintain requirements regarding the content on agent and agency websites. Specific compliance emphasis relating to regulations implemented by the Centers for Medicare and Medicaid Services (CMS) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) must be applied to website content regarding MA and PDP.

Standard Website Guidelines:

1. All website fonts must be coded to be equivalent to or larger than 12-point Times New Roman font for content for consumers.
2. Websites with educational information relating to Medicare or Medicaid should include a link to the official website for Medicare and Medicaid; http://www.medicare.gov.
3. Websites may not make misleading statements regarding CMS, the Medicare program, or any other government agency.
4. Websites may not use words or symbols in a manner that would give the false impression that the entity or the website is approved, endorsed, or authorized by Medicare or any government agency.
5. Websites must be up-to-date with current information.
6. Information (e.g., numbers, facts, figures) posted on a website should cite sources and include dates.
7. Agents may not use carrier brands and/or logos without the express written permission from the carrier.
8. Plan materials or proprietary plan information must not be posted to any agent or agency website.
9. Do not provide links to foreign drug sales; this includes links from advertisements that may appear on the website.

Consumer Facing Website Guidelines
The following is a list of required CMS disclaimers that must be posted within a website when providing benefits or requesting information:

- When an electronic business reply card is presented, it is recommended that one of the following disclaimers appear:
  - *"A sales agent may call as a result of completing the information."*
  - *"A licensed representative may [call/visit] you regarding this insurance-related information request."*
- When benefits are promoted, the following disclaimer is recommended:
  - *"The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information, contact the plan. Limitations, copayments and restrictions may apply."*

Agent-Facing Website Guidelines
Agent-facing websites are directed to agents for agent recruitment activities, education, and communication. These websites must contain a disclaimer similar to the following:

- *"The information on this website is for agent use only and not intended for the general public."*
- *"For agent use only. Not for use with consumers."*

Websites may not include any carrier-specific marketing tools, marketing material, and/or proprietary materials developed by the carrier. Printed information may not indicate that the agent/agency is providing objective or unbiased source information.

Social Media
Use of company/carrier logos and/or plan name affiliation announcement(s) are not permitted on social media platforms such as Facebook or Twitter.

Website Monitoring
Monitoring of agents' websites will be conducted on a routine basis. Agents are encouraged to review all proposed website content for compliance prior to displaying content on their website. Compliance issues must be promptly corrected.

Corrective Action
Agents/agencies notified of a compliance issue should correct the issue immediately, but in no event greater than 14 days to correct the issue from the date of notice. If the issue is not corrected, the agent or agency will be subject to corrective action. CMS reserves the right to request immediate action regarding website content.

POLICY

Title:	Background and Exclusion Verification Policy	**Number:**	B0004
Department:	Legal	**Original Issue Date:**	10/31/2014

Guidance
Medicare Managed Care Manual – Chapter 21; Section 50.6.8 – OIG/GSA Exclusion

Policy

The Department of Health and Human Services ("HHS") Office of the Inspector General ("OIG") provides information to the health care industry and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs. This information is set forth in the HHS-OIG list of excluded individuals/entities ("LEIE"). The LEIE includes mandatory exclusions (e.g., conviction of Medicare fraud) and permissive exclusions (e.g., misdemeanor convictions related to health care fraud other than Medicare) for which the OIG has the discretion to exclude individuals and entities on various grounds. The General Services Administration ("GSA) Excluded Parties List System and System for Award Management debarment list include exclusions taken by various federal agencies.

The Company does not hire or contract in the health care business with individuals and entities that are identified on the HHS-OIG LEIE or GSA exclusion lists. Accordingly, and as set forth more fully in the Company's background check guidelines, the Company checks potential new hires against the HHS-OIG LEIE and GSA exclusion lists prior to hire and verifies the status of associates on a monthly basis against the HHS-OIG LEIE and GSA exclusion lists. The Company screens vendors against the HHS-OIG and GSA excluded parties list. If a finding of a potential match against the HHS-OIG list or GSA exclusion list is made, the Human Resources Department and Legal Department will review the information to determine if the name on the list is a match to the applicant or employee and conduct a further identity verification using a social security number and/or other identifying information depending on the exclusion list being checked. Agents are also checked against the HHS-OIG LEIE and GSA exclusion list by the respective insurance companies at the time of appointment and monthly thereafter and they notify the Company of any HHS-OIG and GSA findings.

If a finding is made by the Company, the Human Resources Department and Legal Department will review the information to determine if the name on the list is a match and will take appropriate action and make the required report of any findings to the contracted Field Marketing Organization ("FMO"). Thereafter, the contracted FMO will alert any and all applicable contracted carriers. The Company's records maintenance requirements must include, but are not limited to, a minimum of ten (10) years.

Policy

Title:	Effective Lines of Communication	**Number:**	L0001
Department:	Compliance	**Original Issue Date:**	11/21/2013

Guidance
Medicare Managed Care Manual 50.1- Written Policies, Procedures and Standards of Conduct

Policy

The Company has established and implemented effective lines of communication regarding compliance matters. This is designed to ensure that Company associates have open access to the Legal/Compliance Department to discuss Compliance, Fraud, Waste and Abuse (FWA), and HIPAA matters. Such open lines of communication ensure that associates have access to the Legal/Compliance Department to allow compliance issues to be reported as they are identified.

All information is conveyed by the Company in a timely manner and to all appropriate parties. The Company's written standards of conduct and policies and procedures require all associates to report compliance concerns and suspected or actual violations (e.g., Compliance, FWA, and HIPAA) through one of the available reporting methods.

The Company does not tolerate retaliation or retribution against anyone who provides a good faith report of potential or suspected violations. The Company will keep reports confidential to the extent reasonably practicable within the legitimate needs of the Company and as permitted under applicable law.

When a suspected issue is reported, the Company provides the complainant with information regarding expectations of a timely response, non-retaliation, and a certain degree of confidentiality, along with progress reports, as warranted.

On a regular basis, typically monthly, the Compliance Department will send out Compliance Bulletins relating to topics that include Compliance, HIPAA and/or FWA.

Policy

Title:	Agent/Broker Compensation	Number:	L0002
Department:	Legal/Commissions	Original Issue Date:	11/21/2013

Guidance
Medicare Marketing Guidelines Section 120.4 – Agent/Broker Compensation; 42 CFR 422.2274(a); 423.2274

Policy

All compensation requirements contained in this section apply to independent agents/brokers. Employed and captive agents/brokers who only sell for one Plan/Part D Sponsor are exempt from compensation requirements, except where noted (e.g., referral/finder fees). However, all other marketing and sales requirements must be met.

Compensation:
Compensation includes monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commissions, bonuses, gifts, prizes, awards, and referral/finder's fees.
Compensation DOES NOT include:
• The payment of fees to comply with State appointment laws;
• Training;
• Certification;
• Testing costs;
• Reimbursement for mileage to, and from, appointments with beneficiaries; or
• Reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials.

Initial Compensation:
Initial compensation may be paid at or below the fair market value (FMV) cut-off amounts published by CMS annually.

Renewal Compensation:
Renewal compensation may be paid for each enrollment in Year 2 and beyond. Renewal compensation may be paid up to fifty (50) percent of the current FMV, published by CMS annually.

Referral/Finder's Fees:
Referral/Finder's fees paid to agents and brokers, including independent, employed, and captive agents and brokers, may not exceed $100 ($25 for PDPs). This amount is not reasonably expected to provide enough financial incentive for an agent or broker to recommend or enroll a beneficiary into a plan that is not the most appropriate for the beneficiary's needs.

Additionally, referral/finder's fees paid to all agents and brokers must be part of total compensation and must not exceed FMV for that contract year.

Policy

Title:	Agent/Marketing Oversight Policy	Number:	L0003
Department:	Compliance	Original Issue Date:	11/21/2013

Guidance
50.3.1 – General Compliance Training

Policy

The Company has developed a Marketing Oversight Policy to promote adherence to standards of business conduct throughout all aspects of our marketing and sales divisions. The purpose of this policy is to ensure conformity with all applicable federal, state, and local laws, rules, and regulations by our organization that includes all associates.

The Compliance Department maintains the Marketing Oversight Policy that includes:

- The review of the agent/broker appointment governed by regulatory requirements
- The review of agent/broker training
    - New agent training
    - Supplemental agent/broker training
    - Review of generic marketing material
    - Process for overseeing and responding to agent and broker complaints
    - Implementation of corrective action

Corrective Action may include but is not limited to, the following:

- Coaching/monitoring session
- Verbal/written warning
- Retraining
- Suspension with or without commissions
- Contract termination
- Reporting to the department of insurance and insurance company

Monitoring activities may include, but are not limited to, the following:

- Cancellation rates
- Disenrollment rates
- Rapid disenrollment rates

- Submission of enrollment applications per carrier guidelines
- Scope of Appointment forms
- Third party secret shopper surveillance
- Complaints and marketing incidents
- Marketing/sales seminars cancellations and event updates

Policy

Title:	Enrollment/Disenrollment Requests	Number:	L0004
Department:	Legal	Original Issue Date:	11/21/2013

Guidance
Medicare Enrollment/Disenrollment Chapter 2 – 40.1 Eligibility, Enrollment and Disenrollment

Policy

The Medicare beneficiary is generally the only individual who may execute a valid election for an enrollment/disenrollment from a Medicare-related plan. However, another individual may be the legal representative or appropriate party to execute an enrollment request as the applicable law of the state in which the beneficiary resides may allow. The Centers for Medicare and Medicaid Services (CMS) will recognize state laws that authorize certain persons to make an election for Medicare beneficiaries.

Enrollment
Sales agents must:

- Review the enrollment information for accuracy
- Request the beneficiary to sign/notate the application, as applicable, per carrier and application type.
- Submit enrollment documentation/e-application per carrier guidelines.

Disenrollment
Requests must be made in writing and submitted to the carrier.

POLICY

Title:	Background and Exclusion Verification Policy	**Number:**	L0005
Department:	Legal	**Original Issue Date:**	11/21/2013
Originator:	Marilyn Ferreira	**Effective Date:**	1/1/2013, 7/1/2014, 7/1/2015
Last Reviewed by:	M. Ferreira	**Replaces:**	
Last Reviewed Date:	8/26/2015	**Last Revised Date:**	8/26/2015
Date of Approval:	11/21/2013		
Approved By:	Ryan Scully, Esq.	**Signature:**	

Guidance
Medicare Managed Care Manual – Chapter 21; Section 50.6.8 – OIG/GSA Exclusion

Policy

The Department of Health and Human Services ("HHS") Office of the Inspector General ("OIG") provides information to the health care industry and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs. This information is set forth in the HHS-OIG list of excluded individuals/entities ("LEIE"). The LEIE includes mandatory exclusions (e.g., conviction of Medicare fraud) and permissive exclusions (e.g., misdemeanor convictions related to health care fraud other than Medicare) for which the OIG has the discretion to exclude individuals and entities on various grounds. The General Services Administration ("GSA) Excluded Parties List System and System for Award Management debarment list include exclusions taken by various federal agencies.

The Company does not hire or contract in the health care business with individuals and entities that are identified on the HHS-OIG LEIE or GSA exclusion lists. Accordingly, and as set forth more fully in the Company's background check guidelines, the Company checks potential new hires against the HHS-OIG LEIE and GSA exclusion lists prior to hire and verifies the status of associates on a monthly basis against the HHS-OIG LEIE and GSA exclusion lists.

The Company screens vendors against the HHS-OIG and GSA excluded parties list. If a finding of a potential match against the HHS-OIG list or GSA exclusion list is made, the Human Resources Department and Legal Department will review the information to determine if the name on the list is a match to the applicant or employee and conduct a further identity verification using a social security number and/or other identifying information depending on the exclusion list being checked. Contracted "Career"Agents are also checked against the HHS-OIG LEIE and GSA exclusion list by the respective insurance companies at the time of appointment and monthly thereafter and they notify the Company of any HHS-OIG and GSA findings.

If a finding is made by the Company, the Human Resources Department and Legal Department will review the information to determine if the name on the list is a match and will take appropriate action and make the required report of any findings including, but not limited to, all contracted carriers. The Company's records maintenance requirements must include, but are not limited to, a minimum of ten (10) years.

Policy

Title:	Charge Backs- Rapid Disenrollment and Unearned Commission	Number:	L0006
Department:	Commissions/Career/ Broker/Legal	Original Issue Date:	3/24/2014

Guidance
Medicare Marketing Guidelines 120.4.6 – Recovering Compensation Payments (Charge-backs)

Policy

Plans/Part D Sponsors must recover compensation payments from agents/brokers under two circumstances: 1) when a beneficiary disenrolls from a plan within the first three months of enrollment (rapid disenrollment), and 2) any other time a beneficiary is not enrolled in a plan.

Rapid Disenrollment

• Rapid disenrollment applies when an enrollee moves from one Parent Organization to another Parent Organization, or when an enrollee moves from one plan to another plan within the same Parent Organization.

• Rapid disenrollment compensation recovery does not apply when a beneficiary enrolls in a plan effective October 1, November 1, or December 1, and subsequently changes plans effective January 1 of the following year during the Annual Election Period. If, however, a beneficiary enrolls in October and disenrolls in December, the Plan/Part D Sponsor should recover compensation based on the rapid disenrollment.

• Rapid disenrollment compensation recovery does not apply when CMS determines that recoupment is not in the best interests of the Medicare program.

Other Compensation Recovery.

• Plans/Part D Sponsors must recover a pro-rated amount of initial compensation when an enrollee disenrolls from a plan. The amount recovered must be equal to the number of months not enrolled. For example, an enrollee ages in effective April 1. The enrollee disenrolls effective September 30 of the same year. The plan initially paid a full initial compensation. Since the enrollee disenrolled (not a rapid disenrollment), the Plan/Part D Sponsor must recover from the agent or broker 6/12ths of the initial compensation (January through March and October through December).

Plans/Part D Sponsors must recover a pro-rated amount of renewal compensation when an enrollee disenrolls from a plan. This amount must be equal to the number of months not enrolled. For example, a renewal enrollee disenrolls effective February 28. The Plan/Part D Sponsor must recover from the agent or broker 10/12ths of the renewal payment if the renewal payment had been paid for the entire 12-month period.

• Plans/Part D Sponsors have the option to pay the agent or broker either full or pro-rated compensation for initial enrollments that are effective later than January 1 and the enrollees have no prior plan history. However, if the Plan/Part D Sponsor pays a full initial compensation and the enrollee disenrolls during the contract year,

the Plan/Part D Sponsor must recoup a pro-rated amount for all months the beneficiary is not enrolled. This would include months prior to the enrollment. For example, a beneficiary ages into Medicare and elects an MA-PD plan (Plan A), effective April 1. The beneficiary moves and is eligible for a special enrollment period. The beneficiary elects a new MA-PD (Plan B), effective November 1. Plan A must recoup 5/12ths of the initial compensation (January through March and November through December) to account for the months the beneficiary was not enrolled in Plan A. Since the beneficiary had prior plan history when enrolled in Plan B, Plan B may only pay a pro-rated initial compensation equal to 2/12ths (November through December).

Policy

Title:	Compliance Committee	Number:	L0007
		Original Issue Date:	11/21/2013

Guidance
Medicare Marketing Manual – Chapter 21 - 50.2.2 – Compliance Committee

Policy

The Company maintains a Compliance Committee to oversee, among other things, compliance and Medicare-related matters that may impact the business of the Company. The Committee is chaired by our Company's regulatory and compliance counsel. The Committee is comprised of representatives from the following departments:

- Compliance
- Career Sales
- Broker Sales
- Licensing
- TPA and New Business

The Compliance Committee's obligations include:

- Meeting on a monthly basis (subject to change)
- Developing strategies to promote compliance
- Reviewing and approving the Compliance and FWA training materials
- Reviewing policies and procedures

Committee meeting notes are distributed to members of senior management and pertinent updates are included in board reports.

Policy

Title:	Outbound Enrollment and Verification Requirements	Number:	L0008
		Original Issue Date:	11/21/2013

Guidance
Medicare Marketing Guidelines Section 70.7 – Outbound Enrollment and Verification Requirements

Policy

Plans/Part D Sponsors are required to maintain a system to ensure beneficiaries are enrolled into the plan they requested and understand the rules applicable to that plan. This system must be maintained for all agent/broker assisted enrollments, including enrollment requests in which an independent or employed agent/broker provided plan-specific information to the individual, thus potentially influencing the individual's plan choice and/or assisting in a subsequent enrollment request.

Plans/Part D Sponsors have the option to complete the enrollment verification process by telephone, email (if beneficiary opted-in for email) or direct mail. The beneficiary must be contacted within fifteen (15) calendar days of receipt of the enrollment request. Plans/Part D Sponsors may integrate the enrollment verification process into an existing practice, such as Welcome Calls, without making a separate call for enrollment verification. If the Plan/Part D Sponsor chooses to utilize a telephonic contact but is unable to speak with the individual or his or her appointed/authorized representative directly, the Plan/Part D Sponsor must either continue call attempts or follow up with a written communication.
The timing and method of contact must be documented and the following information should be provided:

• Introduction and Plan/Part D Sponsor name

• Reason for call, email or letter

• Confirmation of receipt of application into plan (specific plan name)

• Request additional information if needed to complete the enrollment request

• Explanation as to how the plan works (e.g., HMO, PFFS, Section 1876 Cost plan)

• Inform beneficiary that additional enrollment material is forthcoming, including ID card

• Provide at least two cost sharing/coinsurance examples, such as PCP and specialists visits

• Monthly premium (LIS and non-LIS)

Explain physician/pharmacy network may change and may find an up-to-date list on the Plan's/Part D Sponsor's website

• Explain that beneficiary may cancel enrollment within seven (7) calendar days from the date of the email, letter or phone call or by the last calendar day of the month prior to the enrollment effective date, whichever is later. For AEP enrollment requests, the cancellation date is December 31.

Policy

Title:	Records Retention	Number:	L0009
Department:	Legal/Compliance	Original Issue Date:	11/21/2013

Guidance
Medicare Managed Care Manual, Chapter 11; 42 CFR 422.504 (d)(e)

Policy

This policy is designed to supplement the Company's record retention manual. The Company maintains books, records, documents and other evidence of accounting procedures and practices related to Medicare Advantage for ten (10) years.

At a minimum, the records maintenance must be sufficient to do the following:

1. Accommodate periodic auditing of financial records;
2. Enable CMS to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the contract, and the facilities of the organization; and
3. Enable CMS to audit and inspect any books and records of the MA organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract, if applicable.

The Company's records maintenance requirements must include, but are not limited to, maintenance of the following:

4. Financial statements
5. Federal income tax or information returns for the current year and 10 years prior
6. Agreements, contracts, and subcontracts
7. Marketing and management agreements
8. Financial reports filed with other federal programs or state authorities
9. Documents demonstrating compliance with CMS requirements for maintaining privacy and security of protected health information and other personally identifiable information of Medicare enrollees
10. Computer and other electronic systems
11. Enrollment and disenrollment records

CMS may inspect, evaluate and/or audit a company if it determines that there is a reasonable possibility of fraud or similar level of fault.

Policy

Title:	Personal/Individual Marketing Appointments	Number:	L0010
		Original Issue Date:	11/21/2013

Guidance
Medicare Marketing Guidelines - 70.9.2 – Personal/Individual Marketing Appointments

Policy

Personal/individual marketing appointments for the sale of Part C (Medicare Advantage) and Part D (Prescription Drug) plans typically take place in the beneficiary's home; however, these appointments can also take place in other venues such as a library or coffee shop that may be permitted by applicable law and CMS guidelines. Appointments must follow the scope of appointment guidance and must take place only in permitted areas.

All one-on-one appointments with beneficiaries wherein Medicare Advantage and Part D plan options are discussed are considered sales/marketing events. The sales agent may not do the following at these appointments:

- Discuss plan options that were not agreed to by the beneficiary in advance.
- Market non-health care related products (such as annuities or life insurance).
- Ask a beneficiary for referrals.
- Solicit/accept an enrollment request (application) for a January 1st effective date prior to the start of the Annual Enrollment Period (AEP) unless the beneficiary is entitled to another enrollment period.

For Medicare Advantage and Part D sales, the agent must:

- Complete a Scope of Appointment
- Use carrier sales presentation material, as applicable
- Review all benefits and exclusions
- Complete the enrollment material in its entirety
- Review enrollment material for accuracy (paper or electronic enrollment)
- Prepare the beneficiary for the outbound enrollment and verification (OEV) call
- Leave CMS/carrier mandated enrollment material with the beneficiary
- Comply with all applicable Company and insurance carrier requirements

Policy

Title:	Effective Training and Education – Written Policies and Procedures	**Number:**	L0011
Department:	Compliance	**Original Issue Date:**	11/21/2013

Guidance
Medicare Managed Care Manual – Chapter 21 – 50.1.2 – Policies and Procedures; 50.3.1 and 50.3.2 – Effective Training and Education

Policy

The Company has established and implemented effective General Compliance; Fraud, Waste and Abuse (FWA); and HIPAA training and education for associates, including first tier, downstream and related entities (FDRs). Training occurs annually and is a part of the orientation for new associates.

General Compliance, HIPAA, and FWA training:

- General Compliance, HIPAA and FWA training are provided within 90 days of initial hire or contracting and annually thereafter.
- Training may be tracked for completion via website, sign in sheets, and attestations.
- Retention of training documents and attestations will be kept for a minimum of ten (10) years and held in the Human Resources Department.

The Compliance Program consists of:

- Compliance program elements
- Standards of conduct
- Compliance policies and procedures
- FWA
- HIPAA
- Pertinent laws and suspected violation reporting process

The FWA Training includes:

- Laws and regulations related to Medicare Advantage and Part D fraud, waste, and abuse (i.e., False Claims Act, Anti-Kickback statute, etc.)
- The obligation to have policies and procedures that address FWA
- Protection for those who report suspected FWA
- Situations that demonstrate the common types of FWA

Policy

Title:	Distribution of Compliance Procedures Standards of Conduct	**Number:**	L0012
Department:	Compliance	**Original Issue Date:**	11/21/2013

Guidance
Medicare Managed Care Manual – Chapter 21 - 50.1.1 – Standards of Conduct

Policy

The Company's code of conduct states the Company's principles and values by which the Company operates. The Company's policies and procedures, along with the standards of conduct, are distributed or made available to associates within ninety (90) days of hire or contracting, as updates occur, and annually thereafter.

The Company offers a code of conduct in its employee handbook, along with a separate agent code of conduct and ethics that is reviewed annually by the Compliance Committee. Agents may be required to sign the agent code of conduct at the time of their initial contracting and annually thereafter.

The code of conduct will be posted on the Company's intranet and/or websites.

Policy

Title:	Scope of Appointment Procedure (SOA)	Number:	L0013
Department:	Sales	Original Issue Date:	7/2/2013
Guidance			
Medicare Marketing Guidelines – Chapter 70.9.3 – Scope of Appointment (SOA)			

Policy

When conducting marketing activities, a Plan/Part D Sponsor may not market any health care related product during a marketing appointment beyond the scope that the beneficiary agreed before the meeting with that individual. The Plan/Part D Sponsor must document the scope of the agreement 48 hours prior to the appointment, when practicable. Distinct lines of plan business include MA, PDP and Cost Plan products. If a Plan/Part D Sponsor would like to discuss additional products during the appointment in which the beneficiary indicated interest, but did not agree to discuss in advance, the Plan/Part D Sponsor must document a second scope of appointment (SOA) for the additional product type to continue the marketing appointment.

SOA documentation is subject to the following requirements:

• The documentation may be in writing, in the form of a signed agreement by the beneficiary, or a recorded oral agreement. Any technology (e.g., conference calls, fax machines, designated recording line, pre-paid envelopes, and email) can be used to document the scope of appointment.
• Date of appointment
• Beneficiary contact information (e.g., name, address, telephone number)
The product type(s) (e.g., MA, PDP, MMP) the beneficiary has agreed to discuss during the scheduled appointment
• Agent information (e.g., name and contact information)
• An explanation why the SOA was not documented 48 hours prior to the appointment, if applicable
• A statement clarifying that: – beneficiaries are not obligated to enroll in a plan
– current or future Medicare enrollment status will not be impacted
– that the beneficiary is not automatically enrolled in the plan(s) discussed

A beneficiary may sign an SOA at a marketing/sales event for a future appointment. Marketing/sales events, as defined in section 70.9, do not require documentation of beneficiary agreement.
Note: All business reply cards (BRC) used for documenting a beneficiary's SOA, agreement to be contacted, confirmation of attendance to a sales event, or request for additional information must be submitted in HPMS. Plans/Part D Sponsors should include a statement on the BRC informing the beneficiary that a sales person may call as a result of their returning a BRC.

Policy

Title:	Annual Sales Training and Testing Documentation	Number:	L0014
Department:	Sales - Career	Original Issue Date:	6/28/2013

Guidance
Medicare Marketing Guidelines – Section 120.3 - Agent/Broker Training and Testing

Procedure

Specifications for training/testing criteria and documentation requirements are provided annually by the Centers for Medicare and Medicaid Services (CMS).

CMS will provide guidance, updated annually, for agents/brokers training/testing. Plan sponsors must ensure that their agents/brokers training and testing programs are designed and implemented in a way that maintains the integrity of the training and testing and must have the ability to provide this information to CMS upon request.

Agents must complete all required training, successfully pass testing with a score of 85% or better (per carrier guidelines) and obtain a distinct carrier writing number prior to presenting or selling their plan.

Upon completion of America's Health Insurance Plans (AHIP) and/or carrier certification:

- Agents will submit a copy of their passing certification to their general manager and/or broker upline and the administrative assistant.
- The administrative assistant will forward a copy to the Company's Licensing Department.
- The Licensing Department will:
  - Save certifications in the Company's database and key the data into the database for reporting.
  - Reports are generated and distributed within the following timelines:
    - Medicare Advantage Certifications – minimum of weekly during training season (July – October), monthly thereafter
- In addition to a copy being maintained by the Licensing Department, the career entity will also be required to maintain a copy of the agent's certifications in either a paper file or e-file (at the discretion of the general manager on the file storage method).
- If required, a sales agent must fulfill face to face carrier education.

Under no circumstances will an agent be permitted to represent a carrier or enroll a beneficiary in a plan without carrier approval.

If a sales agent presents and/or enrolls a beneficiary without meeting the carrier's certification requirements, the agent may not be compensated for the enrollment and disciplinary action will take place up to and including termination of an agent's contractual relationship.

Policy

Title:	Lead Generation	Number:	L0015
		Original Issue Date:	11/21/2013

Guidance
Medicare Marketing Guide - Section 70.5 – Marketing through Unsolicited Contacts; Lead Generation

Policy

In general, Medicare Advantage Plans and Prescription Drug Plan (Part D) Sponsors may not market through unsolicited direct contact, including but not limited to:

- Door-to-door solicitation, including leaving information such as a leaflet or flyer at a residence or car.
- Approaching beneficiaries in common areas, (e.g., parking lots, hallways, lobbies, sidewalks, etc.).
- Telephonic or electronic solicitation, including leaving electronic voicemail messages or text messaging.

NOTE: Agents/brokers who have a pre-scheduled appointment which becomes a "no-show" may leave information at the no-show beneficiary/individual's residence.

The prohibition on marketing through unsolicited contacts for Medicare Advantage and Part D plans does not extend to mail and other print media (e.g., advertisements, direct mail). In addition, permission given to be called or otherwise contacted must be short-term, event-specific, and may not be treated as open-ended permission for future contacts.

What lead sources does the Company use?
The Company uses various sources to generate consumer leads including the following:

- Direct Mail
- Workshops
- Print Advertising
- Television Advertising

How does the Company manage leads?

The Company's offices may use the Microsoft® Customer Relationship Management (CRM) software for effective lead management. CRM is a web-based application that enables each office to access their lead database, while allowing general managers to also assign and monitor leads at the agent level.

Policy

Title:	Monitoring and Implementation of Corrective Action	**Number:**	L0016
Department:	Legal/Compliance	**Original Issue Date:**	11/25/2013

Guidance
Medicare Managed Care Manual – Chapter 21 and Prescription Drug Benefit Manual Chapter 9, Section 50.7.2

Policy

The Company's Compliance Department will establish, manage, and evaluate a standard process for timely implementation of corrective actions for agents who are the subject of corrective action regarding the sale of Medicare Advantage and Part D (Prescription Drug Plan) plans and other sales as warranted by the Compliance Department. This core function assures compliance with established and distributed disciplinary procedures in order to achieve and maintain operational compliance.

The Company's Compliance Department monitors the submission and receipt of inquiries, conducts investigations and agent coaching, implements corrective action plans (CAP), and/or notifies agents of the termination of agent appointments. When warranted, the Compliance Department will implement corrective action for the Company's agents. All agent correspondence regarding corrective action is documented in the compliance database. The agent cases will be considered closed after any necessary investigation, if any.

Policy

Title:	Conflict of Interest Policy	Number:	L0017
Department:	Legal/Compliance	Original Issue Date:	11/25/2013

Guidance

Medicare Marketing Manual Section 50.3.1 – General Compliance Training

Policy

A conflict of interest exists when a person's private or personal interest interferes in any way, or gives the appearance that it interferes, with the interests of the Company. A conflict situation can arise when an associate takes actions or has interests that may make it difficult to perform his or her work for the Company objectively and effectively. Conflicts of interest may also arise when an associate, or member of his or her family, receives improper personal benefits as a result of his or her position or relationship with the Company.

It is generally a conflict of interest for a Company associate to work simultaneously for a competitor, customer, or supplier. Associates are not permitted to work for a competitor, consultant, or supplier as a consultant or board member. The best policy is to avoid any direct or indirect business connection with the Company's customers, suppliers, or competitors, except on the Company's behalf. A conflict of interest situation may include, without limitation, ownership of a competitor (other than ownership of one percent or less of a publicly-traded entity) and receipt of gifts of more than a nominal value from actual or potential competitors, consultants, or suppliers.

Conflict of interest attestations are distributed on an annual basis and conflicts or potential conflicts are identified on conflict of interest disclosure forms. Copies of the current versions of these forms are attached hereto as Exhibit "A." These forms may be modified by the Company. Any associate who becomes aware of a conflict or potential conflict should immediately bring it to the attention of a supervisor, manager or other appropriate personnel or follow the procedure for reporting Compliance issues. Potential conflicts will be reviewed by the Compliance Department, Human Resources Department, and/or the Legal Department, as applicable. Associates may also be required to complete other documentation related to the disclosure a potential conflict of interest. If a conflict is found to be valid, the Company will take appropriate action and notify the applicable parties, via e-mail, of any potential conflicts and will document the action taken. The Company's Human Resources Department will maintain the attestations.

Policy

Title:	Conducting a Timely Inquiry of Alleged Detected Offenses	**Number:**	L0018
Department:	Legal/Compliance	**Original Issue Date:**	1/2/2014

Guidance
Medicare Marketing Manual Chapter 50.7.1 – Conducting a Timely and Reasonable Inquiry of Detected Offenses

Policy

The Company's compliance procedures call for the Company to be able to inform the applicable carrier that the Company's agent has been duly notified a response is required to either a carrier complaint or outreach. That means that the Company will engage in the following steps regarding carrier complaints and outreach:

1. Notification to the agent of the existence of a complaint/corrective action within the first twenty-four (24) hours of receipt.
2. Providing a copy of the complaint/corrective action to the agent.
3. Advising the agent of the requirement of a response and the deadline by which he/she must respond to the allegation.
4. Informing the agent that following the carrier's review of the agent statement, corrective action my follow, as determined by the carrier and/or the Company.
5. Notifying the agent that in some cases, corrective action may be initiated by the Company's Compliance Department, individual agency and/or marketing company, as applicable, per individual contracting relationship.

All complaint and outreach documentation that the Company receives is maintained in the compliance database.

Policy

Title:	Marketing/Sales Events	Number:	L0019
Department:	Legal/Compliance	Original Issue Date:	1/10/2014

Guidance
Medicare Marketing Manual Section 70.9 – Marketing/Sales Events – Reporting and Cancellation Guidelines

Policy

Marketing/sales events for Medicare Advantage (MA) or Part D Prescription Drug Plans (PDP) are events designed to steer, or attempt to steer, potential enrollees toward a plan or limited set of plans. At marketing/sales events, plan representatives may discuss plan-specific information and collect applications. There are two main types of marketing/sales events: formal and informal.

Formal marketing/sales events
These events are typically structured in an audience/presenter style with a sales person or plan representative formally providing specific MA or PDP information via a presentation on the products being offered.

Informal marketing/sales events
MA/PDP informal events are conducted with a less structured presentation or in a less formal environment. For these events, an agent will typically utilize a table, kiosk or a recreational vehicle (RV) and discuss the merits of a plan's products.

Carriers must notify CMS of all formal and informal marketing/sales events via Health Plan Management System (HPMS) prior to advertising the event or seven (7) calendar days prior to the event's scheduled date, whichever is earlier. Changes to marketing/sales events, (e.g., cancellations and room changes), should be updated in HPMS at least forty-eight (48) hours prior to the scheduled event.

Cancellations - Notification of cancelled sales events should be made, whenever possible, more than forty-eight (48) hours prior to the originally scheduled date and time of the event. Carriers should notify beneficiaries of event cancellations according to the following requirements. (The method used to notify beneficiaries of the cancellation may vary depending on the individual plan's circumstances.)

1. If a sales event is cancelled less than forty-eight (48) hours before its originally scheduled date and time, the Plan/Part D Sponsor must:
   - Cancel the event in HPMS
   - Ensure a representative is present at the site of the cancelled sales event at the time the event was scheduled to occur, inform attendees of the cancellation and distribute information about the Plan/Part D Sponsor. The representative should remain on site at least 15 minutes after the scheduled state of the event.

- NOTE: If the event was cancelled due to inclement weather, a representative is not required to be present at the site.

2. If contracted carriers have stricter guidelines relating to event submission and/or cancellation, the carrier rules supersede CMS rules so the carrier can effectively meet all HPMS guidelines.

Disciplinary action for non-adherence to guidelines:

The general discipline for non-adherence with event guidelines is set forth below. Steps may be added or removed at the discretion of the Company or carrier.

a) First offense (Coaching) – as dictated by the carrier's disciplinary guidelines and additional corrective action, if any, as deemed by the Company's Compliance Department and/or the Company's leadership.
b) Second offense (Corrective Action Plan (CAP)) – as dictated by the carrier's disciplinary guidelines and additional corrective action, if any, as deemed by the Company's Compliance Department and the Company's leadership.

   Note: An agent "No Show" automatically warrants a CAP.
c) Third offense – Disciplinary action up to and including possible termination of agent's capability to participate in future events.

Policy

Title:	Website Guidance	Number:	L0020
Department:	All Departments and Affiliate websites	Original Issue Date:	3/24/2014

Guidance
Medicare Marketing Guidelines (MMG) – 90.2.2 – Marketing Review Process; Submission of Websites for Review

Policy

The Company and contracted carriers maintain requirements regarding the content on agent and agency websites. Website content must comply with all applicable laws, rules and regulations. Specific compliance emphasis relating to regulations implemented by the Centers for Medicare and Medicaid Services (CMS) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) must be applied to website content regarding MA and PDP.

Specific guidelines and approvals have been set when referring to:

- Websites containing carrier benefits
- Agent-facing websites
- Consumer-facing websites

Policy

Title:	Do Not Call/Do Not Contact	Number:	L0021
Department:	Legal/Compliance	Original Issue Date:	4/4/2014

Guidance
Federal Commissions Communication – Unwanted Telephone Marketing Calls

Policy

The Company will adhere to all applicable governmental telemarketing rules and regulations regarding communication with consumers. The Company has implemented this Do-Not-Call Policy to provide the guidelines necessary to follow all applicable and enforceable federal and state Do-Not-Call laws for communication with consumers.

The laws governing how companies contact consumers through the use of the telephone generally cover the following areas:

- Do-Not-Call Lists
- Do-Not-Call-List Exceptions
- Company Specific Do-Not-Call Lists
- Use of Automated or Predictive Dialers
- Use of Artificial or Prerecorded Voices
- Abandoned Calls
- Wireless Telephone Numbers
- Caller ID Requirements
- Time of Day Restrictions
- Sales and Upsell Disclosures
- Facsimile Restrictions

Policy

Title:	Replacement Report – General Manager Review	Number:	L0022
Department:	Legal/Compliance	Original Issue Date:	7/1/2014

Guidance
General Manager review of all submitted business written and submitted from the previous week.

Policy

Each Monday, each General Manager will receive a weekly Replace Report of all insurance applications submitted the previous week from agents in the General Manager's agency/office.

The General Manager will:

- Print the replace report
- Review for replacement suitability and determine if appropriate
- Discuss potentially unsuitable applications, if any, with the writing agent
- Document any notes on the replace report
- Date, sign and return the replace report to the Compliance Department by close of business the following Wednesday (two days later)

The Compliance Department will:

- Document receipt of the General Manager's replace report
- Review General Manager comments on the replace report
- Perform a review of business written and submitted each week
- Discuss potential issues with the General Manager (as needed), and Vice President of the Career Agencies

Policy

Title:	CMS' Right to Contact FDRs Directly	Number:	L0023
Department:	Legal	Original Issue Date:	3/30/2015

Guidance
CMS' Right to Contact First Tier, Downstream and Related Entities (FDRs) Directly – Final rule delivered May, 2014

Policy

Purpose of Rule: To allow CMS access to FDR data in a timely manner. CMS noted that they will default to requesting information through the Plan and will use the "*direct access route in circumstances where either (a) the results of data analytics, complaints, and/or investigations indicate a suspicion of fraud, waste, or abuse in the Medicare Part C or D programs or (b) in the case of an urgent law enforcement matter*."

As the Company already has established and implemented effective lines of communication regarding compliance matters, this policy addresses CMS' right for direct contact to any first tier, downstream or related entity. Actions the FDR must immediately take when notice is received:

- notification or Legal/Compliance (to include NSGA)
- communicate details of the request, notifying party and timeframe

Compliance will notify the associated carrier of CMS' contact (within 24 hours of initial receipt), requests and provide a copy of the response.