Cornerstone Senior Marketing

AN INTEGRITY COMPANY

CMS POLICIES

Contents:

P1124 - CMS 5.1 Internal Compliance Policy

Contents

Purpose:

The purpose of this policy is to ensure our organization implements and maintains an effective Medicare compliance program in order to operate compliantly according to Centers for Medicare and Medicaid Services ("CMS") and carrier guidelines.

Scope:

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

Statement:

PROCEDURE

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

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

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

DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy may be subject to discipline up to and including termination. Corrective actions can include retraining, suspension of marketing privileges, termination, and reporting of misconduct to the carrier and any relevant regulatory authorities.

Term	Definition
Carrier	Medicare Advantage organization (MA), or Part D Plan Sponsor as defined by CMS.
Centers for Medicare and Medicaid Services (“CMS”)	CMS is the federal agency that administers health

	insurance programs like Medicare, Medicaid, Health Insurance Marketplace, and Children's Health Insurance Program.
Organization, We, Us Our Company	

Policy Sections:

Policy References:

P1124 - CMS 5.1 Internal Compliance Policy		
Document Author	**Name:** **Title:** **Email:**	Karen Garay Regulatory Compliance Specialist Karen.Garay@integrity.com
Document Owner	**Name:** **Title:** **Email:** **Approved Date:**	Kathy Helgason Chief Compliance Officer, Health Kathy.Helgason@integrity.com 5/7/2025
Legal Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Monica Pinon Senior Counsel, Health Monica.Pinon@integrity.com 5/7/2025
Executive Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Jayne Rothman Chief Legal Officer Jayne.Rothman@integrity.com 5/8/2025

Last Published Date: 5/8/2025

Document Version Number 2.0

P1125 - CMS 5.2 Exclusion and Background Screening Policy

Contents

Purpose:

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

Scope:

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

Statement:

Our organization conducts the Office of Inspector General ("OIG"), General Services Administration ("GSA"), and State exclusion checks prior to hiring and monthly thereafter.

BACKGROUND CHECKS

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

OIG CHECKS / GSA CHECKS

Human Resources will conduct prior-to-hire OIG checks as part of the onboarding process using a third-party vendor, Sterling Check. The screening process will consist of checking against the OIG's LEIE, which includes individuals and group providers who have been excluded from federal healthcare programs; and the GSA Excluded Parties Lists System ("EPLS"), which identified suppliers and vendors that were excluded from receiving Federal contracts, certain subcontracts, and some types of Federal financial and non-financial assistance.

If a candidate has been excluded from federal healthcare programs, Human Resources will notify the manager intending to hire the candidate immediately that the candidate cannot have duties related to MA/PDP business and cannot have access to MA/PDP client information must be removed from all duties related to MA/PDP business and cannot have access to MA/PDP client information.

After hiring, a third-party vendor, Provider Trust, will conduct a monthly screening of non-agent employees.

AGENT CHECKS

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

DOCUMENTATION

All documentation related to prior-to-hire and monthly screenings will be stored in accordance with CMS and carrier requirements and for at least (10) years as required.

DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy may be subject to discipline up to and including termination. Corrective actions can include retraining, suspension of marketing privileges, termination, and reporting of misconduct to the carrier and any relevant regulatory authorities.

Term	Definition
Carrier	Medicare Advantage organization (MA), or Part D Plan Sponsor as defined by CMS.
Centers for Medicare and Medicaid Services (“CMS”)	CMS is the federal agency that administers health insurance programs like Medicare, Medicaid, Health Insurance Marketplace, and Children’s Health Insurance Program.
General Services Administration (“GSA”)	A U.S. government agency responsible for managing federal property, providing procurement support, and developing policies and regulations for various aspects of government operations. 41 CFR Part 105 et seq.
GSA Excluded Parties Lists System (“EPLS”)	The EPLS is a widely available source of the most current information about persons who are excluded or disqualified from covered transactions. When a federal agency takes an action to exclude a person under the nonprocurement or procurement debarment and suspension system, the agency enters information about the excluded person into the EPLS. 41 CFR § 105-68.520.
Medicare Advantage (“MA”)	Medicare Advantage (also known as “Part C”) is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for health care coverage.
Non-Agent Employees	Employees that are not agents, including contractors.
Office of Inspector General (“OIG”)	OIG conducts independent audits, inspections, evaluations, and investigations to promote economy and efficiency and to prevent and detect waste, fraud, abuse, and mismanagement in the programs and operations of the Department of State and the U.S. Agency for Global Media (USAGM). 42 CFR Chapter V.
OIG’s List of Excluded and Entities (“LEIE”)	The OIG maintains and regularly updates the LEIE, which consists of individuals and entities who have been excluded from participating in federal healthcare programs.
Prescription Drug Plan (“PDP”)	Prescription drug coverage that is offered through a

	private PDP sponsor, MA-PD plan, PACE Plan, or Cost plan, contracted with CMS.
The System for Award Management (“SAM”)	The SAM is an official website of the U.S. Government, which can be used to: register to do business; update, renew, or check the status of your entity registration; search for entity registration and exclusion records; search for assistance listings, wage determinations, contract opportunities, and contract data reports; view and submit BioPreferred and Service Contract Reports; and access publicly available award data via data extracts and system accounts.
Organization, We, Us, or Our Company	

Policy Sections:

Policy References:

P1125 - CMS 5.2 Exclusion and Background Screening Policy		
Document Author	**Name:** **Title:** **Email:**	Karen Garay Regulatory Compliance Specialist Karen.Garay@integrity.com
Document Owner	**Name:** **Title:** **Email:** **Approved Date:**	Kathy Helgason Chief Compliance Officer, Health Kathy.Helgason@integrity.com 5/7/2025
Legal Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Monica Pinon Senior Counsel, Health Monica.Pinon@integrity.com 5/7/2025
Executive Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Jayne Rothman Chief Legal Officer Jayne.Rothman@integrity.com 5/8/2025

Last Published Date: 5/8/2025

Document Version Number 2.0

P1126 - CMS 5.3 Employee Training Policy

Contents

Purpose:

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

Scope:

In order to satisfy the Centers for Medicare and Medicaid Services ("CMS") and carrier requirements, our organization will administer effective training and education to all non-agent employees who handle or access Medicare Advantage ("MA") or Part D Plan ("PDP") plan business or client information. Downline independent insurance agents within our hierarchy will satisfy these training requirements through their applicable carriers.

Statement:

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

GENERAL TRAINING

Training is given through a cloud-based software program, Workday, which allows for tracking and notification of compliance training given to employees. Training will be assigned to all non-agent employees and with a requirement to complete the entire training course or document and attest to its completion and understanding. To document completion, each employee will complete an acknowledgement or attestation of receipt and understanding.

As part of training, employees are required to review our Policies & Procedures and Code of Conduct. Our workforce also completes numerous trainings, including but not limited to FWA, CMS requirements, and privacy and security training as required by HIPAA. For more information on our HIPAA training, please see our Workforce Training Policy in the HIPAA & Privacy/Security section.

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

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

All non-agent employees will receive training within 90 days of hire and annually thereafter through a learning management system. Some of the topics covered in training will include:

- HIPAA Privacy and Security Rule, including:
    - Minimum necessary requirements for PHI
    - Safeguarding PHI

  - Disclosure or amendment of PHI upon request
  - Retaining PHI
  - Transmitting PHI via email, fax, or by mail
  - Business Associate Agreements
- IT-related topics, including:
  - Phishing
  - Incident and Breach Reporting
  - Information Security
  - Network
  - Data protection and lifecycle protection
  - Identity and Access
- CMS related topics, including:
  - Exclusion and background screening
  - Agent compensation
  - Application Submission
  - Complaints and violations
  - Record retention
  - Vendor management
  - Agent licensing
  - Compliant marketing and sales requirements
  - Scope of appointment requirements
- Code of Conduct topics, including:
  - Conducting business in an ethical manner
  - Avoiding false, negative, or negligent statements
  - Avoiding conflict of interest
  - Laws and regulations
  - Disciplinary standards
  - Reporting options
- Fraud Waste and Abuse topics, including:
  - Impact of Fraud, Waste, and Abuse
  - Defining Fraud, Waste, and Abuse
  - Detecting Fraud, Waste, and Abuse
  - Legal Consequences for Fraud, Waste and Abuse
  - Anti-Kick Back Statute
  - False Claims Act
  - Ways to report Fraud, Waste, and Abuse

REVIEW AND APPROVAL FOR TRAINING

Training content is reviewed and approved by Chief Compliance Officer, Health and Chief Legal Officer before being used in employee training.

TRACK RESULTS

The cloud-based software program, Workday, will track the progress of workforce members and their completion. If workforce members have not completed their training by the requested time, a notification will be sent to their employee

email address notifying them they need to complete their training.

DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy may be subject to discipline up to and including termination. Corrective actions can include retraining, suspension of marketing privileges, termination, and reporting of misconduct to the carrier and any relevant regulatory authorities.

Term	Definition
Anti-Kickback Statute	The statute prohibits anyone from soliciting or receiving remuneration of any type in exchange for referring a patient for services where a federal healthcare program pays for purchasing an item or service for which a federal healthcare program pays. 42 U.S.C. § 1320a-7b.
Carrier	CMS is the federal agency that administers health insurance programs like Medicare, Medicaid, Health Insurance Marketplace, and Children's Health Insurance Program.
Centers for Medicare and Medicaid Services ("CMS")	CMS is the federal agency that administers health insurance programs like Medicare, Medicaid, Health Insurance Marketplace, and Children's Health Insurance Program.
False Claims Act	The Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. 31 U.S. Code § 3729.
Fraud, Waste, and Abuse ("FWA")	Fraud is intentionally submitting false information to the government or government contractor to get money, a benefit, or something else of value. Waste is a practice that, directly or indirectly, results in unnecessary costs to the Medicare Program, such as overusing services. Abuse involves paying for items or services when there is no legal entitlement to that payment, and that provider has not knowingly or intentionally misrepresented facts to obtain payment. 42 CFR § 455.2; Medicare Managed Care Manual, Chapter 21, CMS.
Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule	The regulations at 45 CFR 160 and 164, which detail the requirements for complying with the standards for privacy under the administrative simplification provisions of HIPAA..
Health Insurance Portability and Accountability Act ("HIPAA") Security Rule	The regulations at 45 CFR 160 and 164, which detail the requirements for complying with the standards for

	security under the administrative simplification provisions of HIPAA.
Medicare Advantage (“MA”)	Medicare Advantage (also known as “Part C”) is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for health care coverage.
Prescription Drug Plan (“PDP”)	Prescription drug coverage that is offered through a private PDP sponsor, MA-PD plan, PACE Plan, or Cost plan, contracted with CMS.
Organization, We, us or Our Company	

Policy Sections:

Policy References:

P1126 - CMS 5.3 Employee Training Policy		
Document Author	**Name:** **Title:** **Email:**	Karen Garay Regulatory Compliance Specialist Karen.Garay@integrity.com
Document Owner	**Name:** **Title:** **Email:** **Approved Date:**	Kathy Helgason Chief Compliance Officer, Health Kathy.Helgason@integrity.com 5/7/2025
Legal Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Monica Pinon Senior Counsel, Health Monica.Pinon@integrity.com 5/7/2025
Executive Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Jayne Rothman Chief Legal Officer Jayne.Rothman@integrity.com 5/8/2025

Last Published Date: 5/8/2025

Document Version Number 2.0

P1127 - CMS 5.4 Agent Compensation Payments Policy

Contents

Purpose:

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

Scope:

The respective carrier or carriers generally pay agent compensation. Our organization will only pay agent commission directly to agents when required to do so. Since Centers for Medicare and Medicaid Services ("CMS") and the federal government regulate compensation payments for Medicare Advantage ("MA") and Prescription Drug Plan ("PDP") products, we will adhere to these regulations when making compensation payments to downline agents.

Statement:

COMPENSATION

Our organization follows and keeps up to date with CMS guidelines for compensation. The compensation amount paid to an agent or broker for enrollment of a Medicare beneficiary into an MA and PDP plan.

"Compensation," as defined by CMS in sections 422.2274 and 423.2274 of the Federal Code of Regulations, includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commissions, bonuses, gifts, prizes, awards, and finder's fees. Compensation also includes (1) all payments to agents or brokers that are tied to enrollment in an MA plan or product; (2) payment of fees to comply with State appointment laws, training, certification, and testing costs; (3) reimbursement for mileage to, and from, appointments with beneficiaries; (4) reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials; and (5) any other payments made to an agent or broker that are tied to enrollment, related to an enrollment in an MA plan or product, or for services conducted as a part of the relationship associated with the enrollment into an MA plan or product.

For compensation regarding the initial enrollment year, agents and brokers will be compensated at or below Fair Market Value ("FMV") for enrolling a Medicare beneficiary into an MA or PDP plan. For compensation regarding the renewal year, agents and brokers may be compensated at a rate of up to 50 percent at FMV.

AGENT REQUIREMENTS: LICENSING AND CERTIFICATION

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

1. Be licensed and appointed under State law (if required under applicable state law);
2. Be trained and tested annually and achieve an 85% or higher on all forms of testing; and
3. Secure and document a scope of appointment ("SOA") forty-eight (48) hours prior to meeting with potential enrollees.

COMPENSATION CYCLE

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

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

Compensation must be recovered when:

• A beneficiary disenrolls from a plan within the first three (3) months of enrollment (rapid disenrollment); or

• Any other time a beneficiary is not enrolled in a plan, but the Plan sponsor paid compensation for that period.

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

DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy may be subject to discipline up to and including termination. Corrective actions can include retraining, suspension of marketing privileges, termination, and reporting of misconduct to the carrier and any relevant regulatory authorities.

Term	Definition
Agent	Independently contracted (1099) insurance agent (not W-2 employee).
Beneficiary	A person who is entitled to Medicare benefits and/or has been determined to be eligible for Medicaid. 42 CFE § 400.200.
Carrier / Plan sponsor	Medicare Advantage organization (MA), or Part D Plan Sponsor as defined by CMS.
Centers for Medicare and Medicaid Services (“CMS”)	CMS is the federal agency that administers health insurance programs like Medicare, Medicaid, Health Insurance Marketplace, and Children’s Health Insurance 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. Compensation also includes (1) all payments to agents or brokers that are tied to enrollment in a Medicare Advantage plan or product; (2) payment of fees to comply with State appointment laws, training, certification, and testing costs; (3) reimbursement for mileage to, and from, appointments with beneficiaries; (4) reimbursement for actual costs associated with beneficiary sales

	appointments such as venue rent, snacks, and materials; and (5) any other payments made to an agent or broker that are tied to enrollment, related to an enrollment in an MA or PDP plan or product, or for services conducted as a part of the relationship associated with the enrollment into an MA or PDP plan or product. 42 CFR § 422.2274; 42 CFR § 423.2274.
Fair Market Value ("FMV")	The amount that CMS determines could reasonably be expected to be paid for an enrollment or continued enrollment into a Medicare Advantage (“MA”) plan. 42 CFR § 422.2274(a); 42 § 423.2274(a).
Initial Enrollment Year	The first year that a beneficiary is enrolled in a plan versus subsequent years that a beneficiary remains enrolled in a plan. 42 § 422.2274(a); 42 § 423.2274(a).
Medicare Advantage (“MA”)	Medicare Advantage (also known as “Part C”) is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for health care coverage.
Parent Organization	A legal entity that exercises a controlling interest in a Carrier, through the ownership of shares, the power to appoint voting board members, or other means directly or through a subsidiary or subsidiaries, and which is not a subsidiary of any other legal entity.
Plan Year and Enrollment Year	The year beginning January 1 and ending December 31. 42 CFR § 422.2274(a); 42 CFR § 423.2274(a).
Prescription Drug Plan (“PDP”)	Prescription drug coverage that is offered through a private PDP sponsor, MA-PD plan, PACE Plan, or Cost plan, contracted with CMS.
Renewal Year	All years following the initial enrollment year in the same plan or in different plan that is a like plan type. 42 CFR § 422.2274(a); 42 CFR § 423.2274(a).
Scope of Appointment (“SOA”)	The SOA is a required document that outlines the specific Medicare topics a beneficiary wants to discuss with an insurance agent. It is a form to document an in-person appointment with a beneficiary to ensure that no other types of products are discussed beyond what the beneficiary originally requested.
Organization, We, us or Our Company	

Policy Sections:

Policy References:

P1127 - CMS 5.4 Agent Compensation Payments Policy		
Document Author	**Name:** **Title:** **Email:**	Karen Garay Regulatory Compliance Specialist Karen.Garay@integrity.com
Document Owner	**Name:** **Title:** **Email:** **Approved Date:**	Kathy Helgason Chief Compliance Officer, Health Kathy.Helgason@integrity.com 5/7/2025
Legal Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Monica Pinon Senior Counsel, Health Monica.Pinon@integrity.com 5/7/2025
Executive Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Jayne Rothman Chief Legal Officer Jayne.Rothman@integrity.com 5/8/2025

Last Published Date: 5/8/2025

Document Version Number 2.0

P1128 - CMS 5.5 Application Submission Policy

Contents

Purpose:

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

Scope:

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

Statement:

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

APPLICATION INTAKE

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

APPLICATION COMPLETION

Certain products, such as Medicare Advantage ("MA") and Medicare Prescription Drug Plan ("PDP"), are regulated by the Centers for Medicare and Medicaid Services ("CMS") and therefore have regulations on the timeliness of their submission. For these regulated products, it is required that the **completed** application or enrollment form be submitted by our carriers to CMS within seven calendar days from the signature date. Because of this requirement, carriers have their own timeframe requirements for application submission as well.

Our organization follows CMS requirements for the SOA. Agents complete a SOA form forty-eight (48) hours prior to meeting with the beneficiary.

APPLICATION SUBMISSION

In order to meet timeliness requirements for application submission laid forth by CMS, agents are responsible for submitting applications to the carriers within a timely manner or as specific carrier requirements dictate.

DOCUMENTATION RETENTION

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

DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy may be subject to discipline up to and including termination. Corrective actions can include retraining, suspension of marketing privileges, termination, and reporting of misconduct to the carrier and any relevant regulatory authorities.

Term	Definition
Applications	Applications are enrollment request forms submitted by agents on behalf of their clients as a request for insurance coverage.
Beneficiary	A person who is entitled to Medicare benefits and/or has been determined to be eligible for Medicaid. 42 CFR § 400.200.
Carrier	Medicare Advantage organization (MA), or Part D Plan Sponsor as defined by CMS.
Centers for Medicare and Medicaid Services (“CMS”)	CMS is the federal agency that administers health insurance programs like Medicare, Medicaid, Health Insurance Marketplace, and Children’s Health Insurance Program.
Medicare Advantage (“MA”)	Medicare Advantage (also known as “Part C”) is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for health care coverage.
Prescription Drug Plan (“PDP”)	Prescription drug coverage that is offered through a private PDP sponsor, MA-PD plan, PACE Plan, or Cost plan, contracted with CMS.
Scope of Appointment ("SOA")	The SOA is a required document that outlines the specific Medicare topics a beneficiary wants to discuss with an insurance agent. It is a form to document an in-person appointment with a beneficiary to ensure that no other types of products are discussed beyond what the beneficiary originally requested.
Organization, We, us or Our Company	

Policy Sections:

Policy References:

P1128 - CMS 5.5 Application Submission Policy		
Document Author	**Name:** **Title:** **Email:**	Karen Garay Regulatory Compliance Specialist Karen.Garay@integrity.com
Document Owner	**Name:** **Title:** **Email:** **Approved Date:**	Kathy Helgason Chief Compliance Officer, Health Kathy.Helgason@integrity.com 5/7/2025
Legal Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Monica Pinon Senior Counsel, Health Monica.Pinon@integrity.com 5/7/2025
Executive Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Jayne Rothman Chief Legal Officer Jayne.Rothman@integrity.com 5/8/2025

Last Published Date: 5/8/2025

Document Version Number 2.0

P1129 - CMS 5.6 Complaints and Violations Policy

Contents

Purpose:

The purpose of this policy is to ensure member complaints and agent violations are logged and handled according to the Centers for Medicare and Medicaid Services ("CMS") and carrier requirements and to demonstrate proper oversight of downline agents.

Scope:

Our organization will log, and process reported complaints and/or violations in accordance with the Centers for Medicare and Medicaid Services ("CMS") and carrier guidelines.

Statement:

DIRECT REPORTS OF CONSUMER COMPLAINTS

When we receive a complaint or grievance directly from a consumer, it will be documented on our preferred tracking mechanism (i.e. CRM database, tracking log, etc.). We will then report said complaint or grievance to the appropriate carrier or carriers. Our organization will work with the applicable carrier to ensure the complaint is processed and remediated according to carrier processes and procedures. Should we receive any inquiries or investigations directly from a State Department of Insurance, we will notify any applicable carrier when required.

CARRIER REPORTED COMPLAINTS AND VIOLATIONS

Our organization relies on carrier reports or communications to identify agent infractions.

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

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

CARRIER REPORTED COMPLAINTS AND VIOLATIONS

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

DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy may be subject to discipline up to and including termination. Corrective actions can include retraining, suspension of marketing privileges, termination, and reporting of misconduct to the carrier and any relevant regulatory authorities.

Term	Definition
Carrier	Medicare Advantage organization (MA), or Part D Plan Sponsor as defined by CMS.
Centers for Medicare and Medicaid Services (“CMS”)	CMS is the federal agency that administers health insurance programs like Medicare, Medicaid, Health Insurance Marketplace, and Children’s Health Insurance Program.
Complaint / Grievance	Means any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of an MA or PDP organization's or provider's operations, activities, or behavior, regardless of whether remedial action is requested. 42 CFR § 422.561; 42 CFR § 423.561.
Complaint Violation Tracker	Mechanism used within our organization to log and track complaints and violations.
Consumer	“Consumer” for the purpose of this policy refers to any of the following: Prospective or current clients, beneficiaries, policyholders, or members.
Customer Relationship Management System ("CRM")	A database, for managing all your company’s relationships and interactions with customers and potential customers.
Marketer	Employee of our organization who is responsible for sales, recruiting, communication, and support.
Organization, We, us or Our Company	

Policy Sections:

Policy References:

P1129 - CMS 5.6 Complaints and Violations Policy		
Document Author	**Name:** **Title:** **Email:**	Karen Garay Regulatory Compliance Specialist Karen.Garay@integrity.com
Document Owner	**Name:** **Title:** **Email:** **Approved Date:**	Kathy Helgason Chief Compliance Officer, Health Kathy.Helgason@integrity.com 5/7/2025
Legal Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Monica Pinon Senior Counsel, Health Monica.Pinon@integrity.com 5/7/2025
Executive Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Jayne Rothman Chief Legal Officer Jayne.Rothman@integrity.com 5/8/2025

Last Published Date: 5/8/2025

Document Version Number 2.0

P1130 - CMS 5.7 CMS Record Retention Requirements Policy

Contents

Purpose:

The purpose of this policy is to ensure that record retention requirements are being met in accordance with the Centers for Medicare and Medicaid Services ("CMS") and carrier guidelines.

Scope:

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

• Training material and related attestations and test results

• Background checks

• Office of Inspector General ("OIG")/General Services Administration ("GSA") GSA exclusion database search results (pre-hire and monthly)

• Complaints and disciplinary actions

• Contracting documentation

• Audit records

• Documents related to the marketing or sale of MA and PDP products, including enrollment forms, Scope of Appointment ("SOA") forms, Business Reply Cards, etc.

Statement:

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

The documents are retained for a minimum of ten (10) years.

DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy may be subject to discipline up to and including termination. Corrective actions can include retraining, suspension of marketing privileges, termination, and reporting of misconduct to the carrier and any relevant regulatory authorities.

Term	Definition
Carrier	Medicare Advantage organization (MA), or Part D Plan Sponsor as defined by CMS.
Centers for Medicare and Medicaid Services (“CMS”)	CMS is the federal agency that administers health insurance programs like Medicare, Medicaid, Health Insurance Marketplace, and Children’s Health Insurance Program.
Customer Relationship Management System ("CRM")	A database, for managing all your company’s relationships and interactions with customers and potential customers.
General Services Administration (“GSA”)	A U.S. government agency responsible for managing federal property, providing procurement support, and developing policies and regulations for various aspects of government operations. 41 CFR Part 105.
GSA Excluded Parties Lists System (“EPLS”)	The EPLS is a widely available source of the most current information about persons who are excluded or disqualified from covered transactions. The GSA maintains the EPLS. When a federal agency takes an action to exclude a person under the non-procurement or procurement debarment and suspension system, the agency enters information about the excluded person into the EPLS. 41 CFR § 105-68.520.
Health Insurance Portability and Accountability Act (“HIPAA”)	A federal law (Public Law 104-191), which, in part, governs the standards for the electronic exchange, privacy and security of health information. The definition of “HIPAA”, as used herein, includes the regulations promulgated thereunder (45 CFR Parts 160 and 164).
Medicare Advantage (“MA”)	Medicare Advantage (also known as “Part C”) is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for health care coverage.
Office of Inspector General (“OIG”)	OIG conducts independent audits, inspections, evaluations, and investigations to promote economy and efficiency and to prevent and detect waste, fraud, abuse, and mismanagement in the programs and operations of the Department of State and the U.S. Agency for Global Media (USAGM). 42 CFR Chapter V.
Prescription Drug Plan (“PDP”)	Prescription drug coverage that is offered through a private PDP sponsor, MA-PD plan, PACE Plan, or Cost plan, contracted with CMS.
Scope of Appointment ("SOA")	The SOA is a required document that outlines the specific Medicare topics a beneficiary wants to discuss with an insurance agent. It is a form to document an in-person appointment with a beneficiary to ensure that no other types of products are discussed beyond what the beneficiary originally requested.
Organization, We, us or Our Company	

Policy Sections:

Policy References:

P1130 - CMS 5.7 CMS Record Retention Requirements Policy		
Document Author	**Name:** **Title:** **Email:**	Karen Garay Regulatory Compliance Specialist Karen.Garay@integrity.com
Document Owner	**Name:** **Title:** **Email:** **Approved Date:**	Kathy Helgason Chief Compliance Officer, Health Kathy.Helgason@integrity.com 5/7/2025
Legal Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Monica Pinon Senior Counsel, Health Monica.Pinon@integrity.com 5/7/2025
Executive Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Jayne Rothman Chief Legal Officer Jayne.Rothman@integrity.com 5/8/2025

Last Published Date: 5/8/2025

Document Version Number 2.0

P1131 - CMS 5.8 Carrier Reporting Responsibility Policy

Contents

Purpose:

The purpose of this policy is to meet contractual obligations with carriers in regards to reporting certain compliance related items, including “For Cause” terminations.

Scope:

In the event a downline agent is terminated “For Cause” by a Medicare Advantage ("MA") or Prescription Drug Plan ('PDP") carrier, the terminated agent will be reported, when required, to other applicable MA or PDP carriers.

Statement:

Our organization will report the following to our carrier partners within required time frames when necessary:

- For Cause Terminations
- Fraud, Waste, and Abuse Violations
- Compliance Violations
- Exclusion Screening Results (positive matches)
- New Applicable Subcontracting Relationships
- Staff Disciplinary Action

FOR-CAUSE TERMINATIONS

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

FRAUD, WASTE, AND ABUSE AND COMPLIANCE VIOLATIONS

In accordance with Chapters 9 and 21 of the Medicare Managed Care Manual, our organization will report confirmed compliance violations and any instances of Fraud, Waste, and Abuse violations committed by staff, employees, downline agents, owners, board members, subcontractors, etc. when required.

EXCLUSION SCREENING RESULTS

In accordance with Chapters 9 and 21 of the Medicare Managed Care Manual, our organization will report to our carrier partners, when required, any persons or entities who are confirmed matches on applicable Federal exclusion lists if said individual or entity has provided services on behalf of said carrier partners.

NEW APPLICABLE SUBCONTRACTED RELATIONSHIPS

In accordance with Chapters 9 and 21 of the Medicare Managed Care Manual, our organization will report to our carrier partners, when required, any new subcontracted relationships pertaining to marketing, lead generation, and enrollment. Information that will

be reported to carrier partners is the Name of the Subcontractor Agency, Contact Name within the subcontractor agency, and an Email, Phone, and Address of the Subcontractor Agency.

STAFF DISCIPLINARY ACTION

In accordance with Chapters 9 and 21 of the Medicare Managed Care Manual, our organization will report to our carrier partners, when required, any staff disciplinary action issued directly by our organization for applicable compliance reasons related to the state, marketing, administration, lead generation, and enrollment of Medicare Advantage and/or Prescription Drug Plans.

DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy may be subject to discipline up to and including termination. Corrective actions can include retraining, suspension of marketing privileges, termination, and reporting of misconduct to the carrier and any relevant regulatory authorities.

Term	Definition
Carrier	Medicare Advantage organization (MA), or Part D Plan Sponsor as defined by CMS.
Centers for Medicare and Medicaid Services (“CMS”)	CMS is the federal agency that administers health insurance programs like Medicare, Medicaid, Health Insurance Marketplace, and Children’s Health Insurance Program.
"For Cause"	Termination based on a breach, malfeasance, or other inappropriate action of an agent that is in violation of internal, Carrier or CMS policy.
Fraud, Waste, and Abuse ("FWA")	Fraud is intentionally submitting false information to the government or government contractor to get money, a benefit, or something else of value. Waste is a practice that, directly or indirectly, results in unnecessary costs to the Medicare Program, such as overusing services. Abuse involves paying for items or services when there is no legal entitlement to that payment, and that provider has not knowingly or intentionally misrepresented facts to obtain payment. 42 CFR § 455.2; Medicare Managed Care Manual, Chapter 21, CMS.
Medicare Advantage (“MA”)	Medicare Advantage (also known as “Part C”) is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for health care coverage.
Medicare Managed Care Manual	Guidance for Chapters 9 and 21, designed to assist sponsors in establishing and maintaining an effective compliance program for MA Organizations and Medicare PDPs.
Prescription Drug Plan (“PDP”)	Prescription drug coverage that is offered through a private PDP sponsor, MA-PD plan, PACE Plan, or Cost plan, contracted with CMS.
Organization, We, us or Our Company	

Policy Sections:

Policy References:

P1131 - CMS 5.8 Carrier Reporting Responsibility Policy		
Document Author	**Name:** **Title:** **Email:**	Karen Garay Regulatory Compliance Specialist Karen.Garay@integrity.com
Document Owner	**Name:** **Title:** **Email:** **Approved Date:**	Kathy Helgason Chief Compliance Officer, Health Kathy.Helgason@integrity.com 5/7/2025
Legal Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Monica Pinon Senior Counsel, Health Monica.Pinon@integrity.com 5/7/2025
Executive Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Jayne Rothman Chief Legal Officer Jayne.Rothman@integrity.com 5/8/2025

Last Published Date: 5/8/2025

Document Version Number 3.0

P1132 - CMS 5.9 Vendor Management Policy

Contents

Purpose:

The purpose of this policy is to ensure proper processes are followed whenever we contract with third-party entities or vendors to handle or process Medicare Advantage ("MA") or Prescription Drug Plan ("PDP") business.

Scope:

Our organization shall complete due diligence in selecting third-party vendors, by having them complete a Vendor Security Questionnaire and ensuring they complete certain First-Tier, Downstream, and Related Entities ("FDR") requirements.

Statement:

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

We will ensure that third-parties defined as Downstream entities are aware they are responsible for performing required compliance elements, including training their employees on General Compliance and Fraud, Waste, and Abuse ("FWA") principles and checking their own non-agent staff and entity against the Office of Inspector General ("OIG"), General Services Administration ("GSA") and any applicable State Exclusion lists (unless other arrangements are made in writing between the third-party and our organization).

PRESCREENING PROCESS

For applicable individual contractors, we will administer the training courses upon contract and on an annual basis thereafter through our enterprise learning management system. We will utilize Provider Trust's VendorProof to conduct the OIG, GSA, and State exclusion checks upon assignment and on a monthly basis thereafter. Documentation of training completion and exclusion checks will be retained for a period of ten (10) years and made available upon request.

For applicable vendors, we will require the vendor to complete required trainings upon hire or assignment and on an annual basis thereafter; perform the required exclusion checks upon hire or assignment and on a monthly basis thereafter; and retain documentation of training completions and exclusion checks for a period of ten (10) years, with such evidence to be made available upon request. We will monitor this performance through regular surveys and attestations within our governance, risk and compliance tool.

REPORTING

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

DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy may be subject to discipline up to and including termination. Corrective actions can include retraining, suspension of marketing privileges, termination, and reporting of misconduct to the carrier and any relevant regulatory authorities.

Term	Definition
Carrier	Medicare Advantage organization (MA), or Part D Plan Sponsor as defined by CMS.
Centers for Medicare and Medicaid Services (“CMS”)	CMS is the federal agency that administers health insurance programs like Medicare, Medicaid, Health Insurance Marketplace, and Children’s Health Insurance Program.
First-Tier, Downstream, and Related Entities ("FDR")	First tier entity means any party that enters into a written arrangement, acceptable to CMS, with a MA organization/Part D plan sponsor or applicant to provide administrative services or health care services for a Medicare eligible individual under MA/Part D. Downstream entity means any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between a MA organization/Part D plan sponsor (or applicant) and a first-tier entity. Related entity means any entity that is related to the MA Organization/PDP sponsor by common ownership or control and (1) performs some of the MA organization's/Part D plan sponsor's management functions under contract or delegation, (2) Furnishes services to Medicare enrollees under an oral or written agreement, or (3) Leases real property or sells materials to the MA organization/Part D plan sponsor at a cost of more than $2,500 during a contract period. 42 CFR § 422.2; 42 CFR § 423.4.
Fraud, Waste, and Abuse (“FWA”)	Fraud is intentionally submitting false information to the government or government contractor to get money, a benefit, or something else of value. Waste is a practice that, directly or indirectly, results in unnecessary costs to the Medicare Program, such as overusing services. Abuse involves paying for items or services when there is no legal entitlement to that payment, and that provider has not knowingly or intentionally misrepresented facts to obtain payment. 42 CFR § 455.2; Medicare Managed Care Manual, Chapter 21, CMS.
General Services Administration (“GSA”)	A U.S. government agency responsible for managing federal property, providing procurement support, and developing policies and regulations for various aspects of government operations. 41 CFR Part 105 et seq.
GSA Excluded Parties Lists System (“EPLS”)	The EPLS is a widely available source of the most current information about persons who are excluded or disqualified from covered transactions. The GSA maintains the EPLS. When a federal agency takes an action to exclude a person under the nonprocurement or procurement debarment and suspension system, the agency enters information about the excluded

	person into the EPLS. 41 CFR § 105-68.520.
Medicare Advantage (“MA”)	Medicare Advantage (also known as “Part C”) is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for health care coverage.
Office of Inspector General (“OIG”)	OIG conducts independent audits, inspections, evaluations, and investigations to promote economy and efficiency and to prevent and detect waste, fraud, abuse, and mismanagement in the programs and operations of the Department of State and the U.S. Agency for Global Media (USAGM). 42 CFR Chapter V.
OIG’s List of Excluded and Entities (“LEIE”)	The OIG maintains and regularly updates the LEIE, which consists of individuals and entities who have been excluded from participating in federal healthcare programs.
Prescription Drug Plan (“PDP”)	Prescription drug coverage that is offered through a private PDP sponsor, MA-PD plan, PACE Plan, or Cost plan, contracted with CMS.
Organization, We, us or Our Company	

Policy Sections:

Policy References:

P1132 - CMS 5.9 Vendor Management Policy		
Document Author	**Name:** **Title:** **Email:**	Karen Garay Regulatory Compliance Specialist Karen.Garay@integrity.com
Document Owner	**Name:** **Title:** **Email:** **Approved Date:**	Kathy Helgason Chief Compliance Officer, Health Kathy.Helgason@integrity.com 5/7/2025
Legal Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Monica Pinon Senior Counsel, Health Monica.Pinon@integrity.com 5/7/2025
Executive Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Jayne Rothman Chief Legal Officer Jayne.Rothman@integrity.com 5/8/2025

Last Published Date: 5/8/2025

Document Version Number 2.0

P1133 - CMS 5.10 Agent Oversight Policy

Contents

Purpose:

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

Scope:

All agents contracted under our organization must adhere to all Centers for Medicare and Medicaid Services ("CMS") regulations, CMS Medicare Communication and Marketing Guidelines ("MCMGs"), other CMS guidance, Telephone Consumer Protection Act ("TCPA"), and carrier guidelines regarding the marketing and selling of all Medicare related products, including Medicare Advantage ("MA") and Medicare Prescription Drug Plan ("PDP"). We will take reasonable steps to educate and communicate relevant guidelines to downline agents and agencies in order to help them conduct compliant sales and marketing activities.

Statement:

DOWNLINE AGENT AND AGENT OVERSIGHT

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

Our organization also assists carriers in communicating to downline agents and agencies the need to complete First-Tier, Downstream, and Related Entity ("FDR") requirements on their own non-agent employees. These FDR requirements include:

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

In addition, we provide agent oversight by logging and handling reported complaints and/or violations that we receive. Please refer to the Complaints and Violations Policy. We also provide support and assistance to downline agents and agencies who request a

review of their materials. Please refer to the Compliant Marketing & Sales Practices Policy.

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

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

TPMO REQUIREMENTS

Our organization follows and keeps up with new CMS rules for Third-Party Marketing Organizations ("TPMO").

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

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

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

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

TPMOs must adhere to any requirements that apply to the applicable MA or PDP carriers in their lead generation, marketing, sales, and enrollment-related activities. TPMOs should be able to make available lead sources for enrollments upon request by MA or PDP carriers. TPMOs should also obtain one-to-one consent from consumers with a clear, conspicuous disclosure when TPMOs intend to call or text using an automatic telephone dialing system or make a call containing an artificial or prerecorded voice. On comparison-shopping websites, each seller/TPMO is responsible for obtaining the prior express written consent from the called party through a “clear and conspicuous” disclosure on the lead generator or comparison-shopping website to robocall or robotext the consumer.

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

- Report to applicable MA or PDP carriers monthly any staff disciplinary actions associated with beneficiary interaction.
- Report to applicable MA or PDP carriers monthly any violations that apply to the MA or PDP plan associated with beneficiary interaction.
- Disclose to the MA or PDP carrier any subcontracted relationships used for marketing, lead generation, and enrollment.

TPMO OVERSIGHT

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

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

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

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

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

DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy may be subject to discipline up to and including termination. Corrective actions can include retraining, suspension of marketing privileges, termination, and reporting of misconduct to the carrier and any relevant regulatory authorities.

Term	Definition
Carrier	Medicare Advantage organization (MA), or Part D Plan Sponsor as defined by CMS.
Centers for Medicare and Medicaid Services (“CMS”)	CMS is the federal agency that administers health insurance programs like Medicare, Medicaid, Health Insurance Marketplace, and Children’s Health Insurance

	Program.
First-Tier, Downstream, and Related Entity ("FDR")	First tier entity means any party that enters into a written arrangement, acceptable to CMS, with a MA organization/Part D plan sponsor or applicant to provide administrative services or health care services for a Medicare eligible individual under MA/Part D. Downstream entity means any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between a MA organization/Part D plan sponsor (or applicant) and a first-tier entity. Related entity means any entity that is related to the MA Organization/PDP sponsor by common ownership or control and (1) performs some of the MA organization's/Part D plan sponsor's management functions under contract or delegation, (2) Furnishes services to Medicare enrollees under an oral or written agreement, or (3) Leases real property or sells materials to the MA organization/Part D plan sponsor at a cost of more than $2,500 during a contract period. 42 CFR § 422.2; 42 CFR § 423.4.
General Services Administration (“GSA”)	A U.S. government agency responsible for managing federal property, providing procurement support, and developing policies and regulations for various aspects of government operations. 41 CFR Part 105 et seq.
Medicare Advantage (“MA”)	Medicare Advantage (also known as “Part C”) is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for health care coverage.
Medicare Communication and Marketing Guidelines ("MCMGs")	Guidelines that outline the rules that private insurance companies and TPMOs must follow when marketing and communicating with current and potential enrollees of Medicare Advantage (MA) plans, section 1876 cost plans, and Medicare Prescription Drug Plans.
Office of Inspector General (“OIG”)	OIG conducts independent audits, inspections, evaluations, and investigations to promote economy and efficiency and to prevent and detect waste, fraud, abuse, and mismanagement in the programs and operations of the Department of State and the U.S. Agency for Global Media (USAGM). 42 CFR Chapter V.
One-to-One Consent	CMS requirement that personal beneficiary data collected by a TPMO for marketing or enrolling the individual into a Medicare Advantage or Part D plan may only be shared with another TPMO when prior express written consent is given by the individual.
Prescription Drug Plan (“PDP”)	Prescription drug coverage that is offered through a private PDP sponsor, MA-PD plan, PACE Plan, or Cost plan, contracted with CMS.
Prior Express Written Consent	A written agreement between a caller and the receiver of the call that clearly authorizes the caller to deliver “advertisements or telemarketing messages using an automatic telephone dialing system or an artificial pre-recorded voice" as defined by the Federal Communications

	Commission ('FCC").
Telephone Consumer Protection Act ("TCPA")	A federal law that protects consumers from unwanted telemarketing calls, robocalls, and text messages. It restricts telemarketing communications via voice calls, SMS texts, and faxes. The TCPA also places restrictions on the use of automatic dialing systems and artificial or prerecorded voice messages. 47 U.S.C. § 227.
Third-Party Marketing Organization ("TPMO")	Organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA or PDP plan or plans to making an enrollment decision) on behalf of MA or PDP plans. 42 CFR § 422.2260.
Organization, We, Us, or Our Company	

Policy Sections:

Policy References:

P1133 - CMS 5.10 Agent Oversight Policy		
Document Author	**Name:** **Title:** **Email:**	Karen Garay Regulatory Compliance Specialist Karen.Garay@integrity.com
Document Owner	**Name:** **Title:** **Email:** **Approved Date:**	Kathy Helgason Chief Compliance Officer, Health Kathy.Helgason@integrity.com 5/7/2025
Legal Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Monica Pinon Senior Counsel, Health Monica.Pinon@integrity.com 5/7/2025
Executive Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Jayne Rothman Chief Legal Officer Jayne.Rothman@integrity.com 5/8/2025

Last Published Date: 5/8/2025

Document Version Number 2.0

P1134 - CMS 5.11 Agent Licensing & Certification Policy

Contents

Purpose:

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

Scope:

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

Statement:

LICENSING AND APPOINTMENT

We follow all state and federal guidelines and carrier-specific requirements regarding agent licensing and appointments. Agents are responsible for ensuring they maintain a current and active insurance license and hold appropriate state appointments within each carrier they represent for each state in which they are marketing. It is ultimately the agent's responsibility to ensure that agents are Licensed, Appointed, and Certified. We rely on the carrier's Ready to Sell ("RTS") reports in order to communicate RTS status to our downline agents to help ensure they are RTS before selling MA/PDP products.

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

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

State law determines activities that require a licensed agent/broker. Unless required by state law, the following do not require the use of state-licensed marketing representatives:

- Providing factual information;
- Fulfilling a request for materials; or,
- Taking demographic information to complete an enrollment application.

PRODUCT CERTIFICATIONS

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

DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy may be subject to discipline up to and including termination. Corrective actions can include retraining, suspension of marketing privileges, termination, and reporting of misconduct to the carrier and any relevant regulatory authorities.

Term	Definition
Carrier	Medicare Advantage organization (MA), or Part D Plan Sponsor as defined by CMS.
Centers for Medicare and Medicaid Services (“CMS”)	CMS is the federal agency that administers health insurance programs like Medicare, Medicaid, Health Insurance Marketplace, and Children’s Health Insurance Program.
Medicare Advantage (“MA”)	Medicare Advantage (also known as “Part C”) is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for health care coverage.
Prescription Drug Plan (“PDP”)	Prescription drug coverage that is offered through a private PDP sponsor, MA-PD plan, PACE Plan, or Cost plan, contracted with CMS.
Ready to Sell	For MA and PDP carriers, "Ready to Sell" means an agent is actively licensed, appointed (in each State), and certified (for each product) and has verified "Ready to Sell" status with each company.
Organization, We, Us or Our Company	

Policy Sections:

Policy References:

P1134 - CMS 5.11 Agent Licensing & Certification Policy		
Document Author	**Name:** **Title:** **Email:**	Karen Garay Regulatory Compliance Specialist Karen.Garay@integrity.com
Document Owner	**Name:** **Title:** **Email:** **Approved Date:**	Kathy Helgason Chief Compliance Officer, Health Kathy.Helgason@integrity.com 5/7/2025
Legal Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Monica Pinon Senior Counsel, Health Monica.Pinon@integrity.com 5/7/2025
Executive Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Jayne Rothman Chief Legal Officer Jayne.Rothman@integrity.com 5/8/2025

Last Published Date: 5/8/2025

Document Version Number 2.0

P1135 - CMS 5.12 Compliant Marketing & Sales Practices Policy

Contents

Purpose:

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

Scope:

Our organization and its agents will adhere to Centers for Medicare and Medicaid Services ("CMS') regulations, CMS Marketing Communications and Marketing Guidelines ("MCMG"), and other CMS guidance when marketing and selling Medicare Advantage ("MA") and Prescription Drug Plan ("PDP") products. Carriers are ultimately responsible for the compliance of their agents, but we will assist them in their efforts of ensuring compliance with CMS regulations and Medicare Communication and Marketing Guidelines.

Statement:

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

CONTACT RULES

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

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

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

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

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

- Door-to-door solicitation, which includes:
  - Leaving information (i.e., leaflets, flyers, etc.) at a residence,
  - Going to a residence without a previously scheduled appointment for that date and time, or
  - Going to a residence on the basis of a returned Business Reply Card (BRC) or other documentation whereby a potential client requested additional information and provided their address.

- Approach potential clients in common/public areas (i.e., parking lots, hallways, lobbies, sidewalks, etc.).
- Telephonic solicitation (i.e., cold-calling), texts, or electronic voicemails.
- Other prohibited telephonic activities include:
    - Unsolicited call about other lines of business to generate Medicare leads (considered bait and switch),
    - Calls based on referrals (i.e. referrals from current clients are not considered permission to contact),
    - Calls to market products to former clients who have disenrolled,
    - Calls to potential clients who attended a sales event, unless the client gave express permission at the event for a follow-up call (there must be documentation of permission to be contacted), or
    - Calls to prospective enrollees to confirm receipt of mailed information.

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

HIGH-PRESSURE, MISLEADING, OR DISCRIMINATORY SALES PRACTICES

In order to protect Medicare consumers, our organization and its agents must not engage in misleading or high-pressure sales tactics and will refrain from discrimination based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, or geographic location. In line with non-discrimination and the protection of consumers, agents may not charge beneficiaries for their services concerning MA or PDP plan business.

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

AEP AND PRE-AEP MARKETING

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

OEP MARKETING

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

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

COMMUNICATION AND MARKETING MATERIALS

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

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

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

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

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

Communications Materials

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

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

Marketing Materials

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

- Reference products or plans, benefits, costs, or plan rankings, in marketing materials unless the names of the MA or PDP Carriers (or their marketing names) offering the referenced products or plans, benefits, or costs, are listed on the material as follows:
    - In print, the names must be in 12-point font and not be in the disclaimer or fine print.
    - In TV, online, or social media, be either read at the same pace as the phone number or displayed throughout the entire advertisement in a font size equivalent to the advertised phone number, contact information, or benefits.
    - In radio or other voice-based advertisements, be read at the same pace as the advertised phone numbers or other contact information.
- Market any benefits in a service area where those benefits are not available unless the marketing is in local media and marketing to beneficiaries outside of the service area is unavoidable, such as TV or newspaper that is distributed across multiple service areas.

- Market savings available to potential enrollees that are based on unrealized costs of a Medicare beneficiary, including but not limited to, savings available to potential enrollees that are based on a comparison of typical expenses borne by uninsured individuals or unpaid costs of dually eligible beneficiaries.
- Market the 5-Star Special Enrollment Period after November 30 of the current contract year if the contract has not received an overall 5-star rating for the next contract year.
- Display Star Rating unless: (i) it is clear that the rating is out of 5 stars; (ii) the Star Ratings contract year is clearly identified; (iii) the Star Ratings is marketed in the service area(s) for which the Star Rating is applicable (unless using Star Ratings to convey overall performance in a way that is not confusing or misleading); (iv) references to individual Star Rating measures also include references to the overall Star Rating for MAPDs and the summary rating for MA only plans; and (v) an individual underlying category, domain, or measure is not used to imply an overall higher Star Rating.

TPMO DISCLAIMER

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

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

If a TPMO does not sell all plans in the service area, the disclaimer reads as follows:

"We do not offer every plan available in your area. Currently we represent [insert number organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program to get information on all of your options."

If a TPMO sells all plans in the service area, the disclaimer reads as follows:

"Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program for help with plan choices."

The TPMO disclaimer must be used as provided by CMS and is not permitted to be altered, including adding any other language. The disclaimer is not required for TPMOs that sell plans on behalf of only one MA carrier or PDP carrier.

CALL RECORDING

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

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

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

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

TPMO BENEFICIARY DATA DISTRIBUTION

Agents should ensure that prior express written consent is captured from beneficiary when personal data will be shared with another TPMO for purposes of marketing enrollment. This consent language must include “clear and conspicuous” language listing each individual/entity that will receive said data (i.e., one-to-one consent). We educate our agents regarding these requirements, especially when dealing with third-party lead vendors to help ensure adherence to these guidelines.

COMPLIANT AND THOROUGH SALES PRESENTATION

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

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

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

DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy may be subject to discipline up to and including termination. Corrective actions can include retraining, suspension of marketing privileges, termination, and reporting of misconduct to the carrier and any relevant regulatory authorities.

Term	Definition
Agent	Independently contracted (1099) insurance agent (not W-2 employee).
Annual Enrollment Period ("AEP")	Also known as the Annual Election Period, AEP is a

	period of time in which Medicare-eligible people are given the opportunity to shop for and commit to enroll in new Medicare Advantage or Part D plans. AEP is from October 15 to December 7.
Carrier	Medicare Advantage organization (MA), or Part D Plan Sponsor as defined by CMS.
Centers for Medicare and Medicaid Services (“CMS”)	CMS is the federal agency that administers health insurance programs like Medicare, Medicaid, Health Insurance Marketplace, and Children’s Health Insurance Program.
Medicare Advantage (“MA”)	Medicare Advantage (also known as “Part C”) is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for health care coverage.
Marketing Communications and Marketing Guidelines ("MCMG")	Guidelines that outline the rules that private insurance companies and TPMOs must follow when marketing and communicating with current and potential enrollees of Medicare Advantage (MA) plans, section 1876 cost plans, and Medicare Prescription Drug Plans.
Open Enrollment Period ("OEP")	OEP is the period when a beneficiary who is already enrolled in a Medicare Advantage plan can switch to another MA plan or go back to Original Medicare. OEP is from January 1 to March 31.
Prescription Drug Plan ("PDP")	Prescription drug coverage that is offered through a private PDP sponsor, MA-PD plan, PACE Plan, or Cost plan contracted with CMS.
Third-Party Marketing Organization ("TPMO")	Organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA or PDP plan or plans to making an enrollment decision) on behalf of MA or PDP plans. 42 CFR § 422.2260.
Organization, We, Us or Our Company	

Policy Sections:

Policy References:

P1135 - CMS 5.12 Compliant Marketing & Sales Practices Policy		
Document Author	**Name:** **Title:** **Email:**	Karen Garay Regulatory Compliance Specialist Karen.Garay@integrity.com
Document Owner	**Name:** **Title:** **Email:** **Approved Date:**	Kathy Helgason Chief Compliance Officer, Health Kathy.Helgason@integrity.com 5/7/2025
Legal Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Monica Pinon Senior Counsel, Health Monica.Pinon@integrity.com 5/7/2025
Executive Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Jayne Rothman Chief Legal Officer Jayne.Rothman@integrity.com 5/8/2025

Last Published Date: 5/8/2025

Document Version Number 2.0

P1136 - CMS 5.13 Event Compliance Policy

Contents

Purpose:

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

Scope:

Our organization will assist applicable carriers in their efforts to ensure all Centers for Medicare and Medicaid Services ("CMS") regulations, CMS Medicare Communication and Marketing Guidelines ("MCMG"), other CMS guidance, and carrier guidelines are followed regarding sales and educational events. Agents should report all sales events, and, when required, educational events to the appropriate carriers. Furthermore, agents should follow all CMS regulations, CMS MCMGs, other CMS guidance, and carrier guidelines during these events.

Statement:

MARKETING/SALES EVENTS

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

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

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

EDUCATIONAL EVENTS

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

- Must be explicitly advertised as educational.
- Must be hosted in a public venue.
- May answer beneficiary-initiated questions.
- Must not set up a future marketing appointment.
- May collect beneficiary contact information, such as Business Reply Cards ("BRCs").

- Must not make available or collect Scope of Appointment forms.
- Must not include marketing or sales activities or distribution of marketing materials or enrollment forms.

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

DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy may be subject to discipline up to and including termination. Corrective actions can include retraining, suspension of marketing privileges, termination, and reporting of misconduct to the carrier and any relevant regulatory authorities.

Term	Definition
Agent	Independently contracted (1099) insurance agent (not W-2 employee).
Business Reply Cards ("BRC")	A postcard that the prospect can complete and return or provide with their permission to be contacted by an agent.
Carrier	Medicare Advantage organization (MA), or Part D Plan Sponsor as defined by CMS.
Centers for Medicare and Medicaid Services (“CMS”)	CMS is the federal agency that administers health insurance programs like Medicare, Medicaid, Health Insurance Marketplace, and Children’s Health Insurance Program.
Educational Event	Events hosted by agents or Plans that are designed to inform or educate beneficiaries about Medicare including MA, PDP, or other Medicare Programs. 42 CFR §422.2264(c).
Medicare Communication and Marketing Guidelines ("MCMG")	Guidelines that outline the rules that private insurance companies and TPMOs must follow when marketing and communicating with current and potential enrollees of Medicare Advantage (MA) plans, section 1876 cost plans, and Medicare Prescription Drug Plans.
Medicare Advantage (“MA”)	Medicare Advantage (also known as “Part C”) is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for health care coverage.
Prescription Drug Plan (“PDP”)	Prescription drug coverage that is offered through a private PDP sponsor, MA-PD plan, PACE Plan, or Cost plan, contracted with CMS.
Sales/Marketing Event	Events hosted by agents or Plans where all allowable types of Marketing Activities can occur. Events can be formal (presenter/audience format) or informal (kiosk, table, etc.) – referred to as “Sales Event” within this policy.
Scope of Appointment ("SOA"')	The SOA is a required document that outlines the

	specific Medicare topics a beneficiary wants to discuss with an insurance agent. It is a form to document an in-person appointment with a beneficiary to ensure that no other types of products are discussed beyond what the beneficiary originally requested.
Organization, We, Us or Our Company	

Policy Sections:

Policy References:

P1136 - CMS 5.13 Event Compliance Policy		
Document Author	**Name:** **Title:** **Email:**	Karen Garay Regulatory Compliance Specialist Karen.Garay@integrity.com
Document Owner	**Name:** **Title:** **Email:** **Approved Date:**	Kathy Helgason Chief Compliance Officer, Health Kathy.Helgason@integrity.com 5/7/2025
Legal Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Monica Pinon Senior Counsel, Health Monica.Pinon@integrity.com 5/7/2025
Executive Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Jayne Rothman Chief Legal Officer Jayne.Rothman@integrity.com 5/8/2025

Last Published Date: 5/8/2025

Document Version Number 2.0

P1137 - CMS 5.14 Scope of Appointment Policy

Contents

Purpose:

The purpose of this policy is to ensure that CMS regulations, CMS MCMG, other CMS guidance, and carrier guidelines are followed regarding SOA forms.

Scope:

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

Statement:

SOA TIMING REQUIREMENTS

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

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

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

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

SOA REQUIRED CONTENT

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

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

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

RECORD RETENTION

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

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

DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy may be subject to discipline up to and including termination. Corrective actions can include retraining, suspension of marketing privileges, termination, and reporting of misconduct to the carrier and any relevant regulatory authorities.

Term	Definition
Agent	Independently contracted (1099) insurance agent (not W-2 employee).
Annual Enrollment Period ("AEP")	Also known as the Annual Election Period, AEP is a period of time in which Medicare-eligible people are given the opportunity to shop for and commit to enroll in new Medicare Advantage or Part D plans. AEP is from October 15 to December 7.
Beneficiary	A person who is entitled to Medicare benefits and/or has been determined to be eligible for Medicaid. 42 CFR § 400.200.
Carrier	Medicare Advantage organization (MA), or Part D Plan Sponsor as defined by CMS.
Centers for Medicare and Medicaid Services ("CMS")	CMS is the federal agency that administers health insurance programs like Medicare, Medicaid, Health Insurance Marketplace, and Children's Health Insurance Program.
Initial Coverage Election Period ("ICEP")	ICEP is the first opportunity to enroll in a Medicare Advantage plan; typically, the 7 months around a beneficiary's 65th birthday.
Medicare Communication and Marketing Guidelines ("MCMG")	Guidance for chapters 9 and 21, designed to assist sponsors in establishing and maintaining an effective compliance program for MA Organizations and Medicare PDPs.
Medicare Advantage ("MA")	Medicare Advantage (also known as "Part C") is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for health care coverage.

Open Enrollment Period ("OEP")	OEP is the period when a beneficiary who is already enrolled in a Medicare Advantage plan can switch to another MA plan or go back to Original Medicare. OEP is from January 1 to March 31.
Prescription Drug Plan (“PDP”)	Prescription drug coverage that is offered through a private PDP sponsor, MA-PD plan, PACE Plan, or Cost plan, contracted with CMS.
Scope of Appointment ("SOA")	The SOA is a required document that outlines the specific Medicare topics a beneficiary wants to discuss with an insurance agent. It is a form to document an in-person appointment with a beneficiary to ensure that no other types of products are discussed beyond what the beneficiary originally requested.
Special Election Period ("SEP")	SEP is a period of time, triggered by specific events or situations, to enroll or change a Medicare Advantage plan or PDP outside of the Initial Coverage Election Period (ICEP) or Medicare’s Annual Election Period (AEP).
Organization, We, us or Our Company	

Policy Sections:

Policy References:

P1137 - CMS 5.14 Scope of Appointment Policy		
Document Author	**Name:** **Title:** **Email:**	Karen Garay Regulatory Compliance Specialist Karen.Garay@integrity.com
Document Owner	**Name:** **Title:** **Email:** **Approved Date:**	Kathy Helgason Chief Compliance Officer, Health Kathy.Helgason@integrity.com 5/7/2025
Legal Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Monica Pinon Senior Counsel, Health Monica.Pinon@integrity.com 5/7/2025
Executive Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Jayne Rothman Chief Legal Officer Jayne.Rothman@integrity.com 5/8/2025

Last Published Date: 5/8/2025

Document Version Number 2.0

P1138 - CMS 5.15 CMS Call Center Compliance Policy

Contents

Purpose:

The purpose of this policy is to ensure that all Medicare Advantage ("MA") / Prescription Drug Plan ("PDP") Telesales activity conducted in a call center setting is done so in accordance with CMS and carrier regulations.

Scope:

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

Statement:

PRE-APPROVAL

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

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

OVERSIGHT AND QUALITY ASSURANCE

1. Call center businesses must have an internal oversight and quality assurance program in place to ensure compliance with Federal, State, and carrier regulations; and to ensure that quality customer service is being provided by all call center agents.
    - Call centers should have Policies & Procedures in place that describe how their business will go about meeting these regulations, requirements, and standards. This documentation must be provided to our Compliance Officer during the onboarding process and should detail the processes in place to ensure the call center is operating compliantly.
    - As part of the quality assurance program, call center businesses must complete call reviews to ensure agents are operating compliantly and exhibiting quality customer service. call centers can use their own call evaluation forms and methods, or they can adopt ours if they so choose.
    - At a minimum, call center businesses must review one call per agent per month per carrier, unless otherwise instructed, and have a process to address corrective actions when issues are identified during the call review process. Each carrier has its own standard regarding call reviews, so our organization has developed its minimum standard

based on compilations of multiple carrier requirements.
    - For oversight and monitoring purposes, call centers will upload three call reviews (including the call recordings) per month, per carrier to our secure File Transfer Protocol ("FTP") site in order to demonstrate compliance with this requirement.
  - Call center businesses should have a policy and processes in place to review and monitor lead sources for compliance.
  - Call centers should have Policies & Procedures in place that outline a process for self- reporting issues of non-compliance to applicable carriers.
2. Our organization will also maintain an effective oversight and quality assurance program to ensure downline call center businesses are operating compliantly and meeting certain minimum standards in terms of customer service. Our oversight program includes:
  - Completion of the Call Center Onboarding Packet.
  - Collection of call center's applicable Policies and Procedures.
  - Monthly call reviews when required by the carrier.
    - The number of call reviews may vary in number based on a variety of factors, but when it is required, we will review three calls per month for each carrier that requires we do so. We will review the call and score/rate it using our Telesales Call Review Evaluation Form and then compare it to the downline call center's review of that same call to ensure call review effectiveness.
    - Our organization will utilize secure FTP to receive or transmit call recordings. Requests for call recordings will be initiated via email or phone call. When requested, downline call centers shall transmit call recordings within two business days via this method.
  - Annual Telesales Compliance Review completed by all downline Telesales agencies.
    - Compliance personnel from our organization will initiate the review, and they will work with representatives from the call center throughout the completion of the review. The review will consist of various compliance questions, the request for certain compliance metrics and reports, and an attestation of compliance. Once completed, the call center representative should return it within the specified timeframe given by our compliance representative.
  - Oversight will also include continued monitoring and ongoing support by our organization, which can include:
    - Review of complaints and violations received by the carrier.
    - Identification of coaching opportunities and/or possible risk areas that need to be addressed.
    - Ongoing support with compliance and marketing strategies.
    - Communication of compliance requirements.
    - Support with audits, investigation, and call reviews/evaluations (which can include corrective action plans and coaching opportunities identified in call reviews falling below the acceptable threshold of 85%).
      - Corrective actions taken can vary depending on the severity of risk, but most often will include coaching and or re-training on identified risk areas.
3. When carriers allow a downline call center to contract call center agencies underneath their hierarchy, said call center must have an appropriate oversight plan in place to ensure compliance standards are being met by those downline agencies. Call center entities can adopt our oversight plan or utilize their own. If using their own, the call center should be prepared for reviews or audits to prove the effectiveness of their oversight plan.

CMS TELEPHONIC CONTACT RULES

1. Pursuant to Section 40.3 of the Medicare Communications and Marketing Guidelines, Telesales agents must have compliant "Permission to Contact" prior to making outbound calls to prospective clients regarding federally regulated Medicare products (i.e. Medicare Advantage and Prescription Drug Plans, and certain Carrier's Medicare Supplement Plans). Examples

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

2. Telesales agents are allowed to contact current customers at any time to discuss their current plan business per Medicare Marketing Guideline regulations. Calls to current customers can be made to discuss plan business, promote other Medicare plan types, and conduct normal business activities related to enrollment; as well as to discuss benefits, plan information, upcoming plan changes, AEP dates, conduct disenrollment surveys (after the disenrollment date), and other related activities that meet CMS standards.
3. Telesales agents are prohibited from using bait and switch strategies, making outbound calls based on referrals, calling former customers who have disenrolled or are in the process of disenrolling (disenrollment surveys are permitted), calling customers from a sales event (unless express permission is given with documentation of permission), and calling customers to confirm the receipt of mailed information. Calls to former enrollees after the disenrollment effective date are permitted to conduct disenrollment surveys for quality improvement purposes (disenrollment surveys conducted telephonically, by email or conventional mail may not include sales or marketing information).

SALES SCRIPT AND TELEPHONIC ENROLLMENT

1. Only pre-approved telephonic scripts can be used for the purposes of marketing and/or enrollment into federally regulated Medicare products.
2. Sales and Enrollment scripts must be reviewed and approved annually and/or when CMS guidance is updated to ensure compliance.
3. A thorough needs assessment must be completed and a complete sales presentation covering all necessary elements of a plan must be given prior to enrollment, in order for the consumer to make an informed and educated decision. Agents should also fully review the Summary of Benefits with each client in order to ensure understanding.
4. Call center agents should not discriminate based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, medical history, genetic information, evidence of insurability, or geographic location.
5. If the consumer requests an in-home appointment for further information, pursuant to Section 50.3, Telesales agents should record a verbal Scope of Appointment for the future in-home appointment. If any revisions or amendments to the SOA are needed in the field, the agent may need to complete a paper form at that time.
6. Sales calls must include a privacy statement clarifying that the customer is not required to provide any health-related information to the plan representative unless it will be used to determine enrollment eligibility.
7. **May only enroll consumers telephonically as a result of an inbound call.**
8. Inbound calls made directly to a sales department or a sales agent must clearly inform the customer if/when the nature of the call moves from a sales presentation to telephonic enrollment. This must be done with the full and active concurrence of the customer, ideally with a yes/no question.
9. Once an enrollment request has been identified and recorded, the Telesales agent will transition from the approved Telephonic Sales Script to an approved Telephonic Enrollment Script which is to be utilized verbatim.

10. Each telephonic enrollment must be recorded (audio) and include a statement of the individual's agreement to be recorded, along with all required elements necessary to complete the enrollment and a verbal confirmation of the intent to enroll ("Statement of Understanding" must be read verbatim from the CMS approved enrollment application). If the request is made by someone other than the consumer, a recording of the individual's such authority under State Law along with their contact information is required.
11. All telephonic enrollment recordings must be reproducible and maintained in a manner that meets CMS and carrier standards.
12. Consumers must be advised they are completing an enrollment into a Medicare Part C or Part D plan.
13. Collection of financial information (i.e. credit card number or bank account) is prohibited at any time during the call.
14. Upon completion of the telephonic enrollment, the Telesales agent must provide the consumer with a confirmation number for tracking purposes.
15. A notice of acknowledgement and any other required information must be provided to the consumer.

OPERATIONAL STANDARDS AND REPORTING REQUIREMENTS

1. Certain operational standards must be met in order to be approved for Telesales activities and to maintain good standing and the ability to continue Telesales activities. These standards can be dependent upon the individual carrier and can include, but are not limited to the following:
    - The use of alternative technologies such as voice-mail or an answering service for weekends, holidays, and off business hours is permitted/required. Must indicate the voicemail is secure.
    - All licensed agents must complete the following:
        - Fraud, Waste, and Abuse ("FWA") Training (administered by the Plan Sponsor or AHIP),
        - America's Health Insurance Plans ("AHIP") Training or other CMS specific (administered by the Plan Sponsor or AHIP),
        - Plan specific training, and
        - Resident and non-resident state licensing (as applicable).
    - Provide free interpreter services to all non-English speaking and LEP consumers or have the ability to transfer such calls to the carrier for interpreter services.
    - Bi-lingual agents are required to complete plan specific language certifications when required.
    - Provide TTY service to all hearing impaired current or potential customers or can transfer such calls to the carrier for TTY services.
    - Call centers shall provide interpreter services free of charge to callers when required.
    - Establish and follow an explicitly defined process for handling member complaints.
    - Licensed call center agents are expected to adhere to all applicable Medicare and TCPA regulations, Code of Conduct, Information Protection and Ethics standards.
    - Establish and follow a policy for maintenance and monthly scrubbing against the Federal Do Not Call and the call center's own Internal Do Not Call lists (when applicable).
    - Branded and generic marketing materials must receive Plan and CMS approval prior to use, when required. Materials must be reviewed for compliance prior to submitting to carriers for their pre-approval prior to CMS submission.
    - Secret Shopper compliance (standard threshold set by each applicable carrier).
    - Call centers cannot use non-licensed customer service representatives to perform functions that require State marketing licensure.
    - Call centers must ensure that associates (both agents and employees) who support Medicare Advantage or Part D products complete a General Compliance and Fraud, Waste, and Abuse Training course within 90 days of hire and annually thereafter. Call center organizations should either independently provide the training or help facilitate

through other means (ex. AHIP or Plan Sponsor trainings).

- Call centers are allowed to use non-licensed administrative support staff to conduct certain customer service activities such as:
  - Conducting plan changes
  - Answering calls
  - Setting appointments
  - Providing information as outlined in this policy
  - Providing factual information
  - Fulfilling material requests
  - Taking demographic information for enrollment when initiated by the enrollee
  - "For-Cause" review of materials and activities for complaint investigation
  - "Secret shopper" activities where CMS requests materials such as enrollment packets
  - In the event the call center uses licensed benefit advisors and/or Telesales agents as customer service representatives to answer inbound calls or make outbound calls, sales management ensures (when/if applicable):
    - The licensed benefit advisors and/or Telesales agents are trained in customer service processes and systems
    - The licensed benefit advisors and/or Telesales agents are removed from inbound sales queues that are assigned in the phone system
    - The phone queue supervisor is provided a list of benefit advisors and/or Telesales agents' names via email to remove agents from sales queues
      - Confirm benefit advisors and/or Telesales agents have been removed by receiving a screen print of their active queue list.
    - Benefit advisors and/or Telesales agents are added back to assigned sales queues once the customer service project has been completed

2. Telesales businesses must also be able to track certain metrics for reporting purposes. Each Carrier may have its own set of metrics it requires to be tracked for those reporting purposes. These metrics can include, but are not limited to the following, and must be reproducible for a period of ten (10) years upon request:
   - Average hold times
   - Average ring times / # of rings
   - Disconnect rates
   - Abandoned/Dropped call rates
   - Average "handle" or "talk" time
   - Total calls handled
   - Enrollments (both total and per agent)
   - Call to Enrollment ratio
   - Call volume data
   - Adherence %
   - Quality measurement

DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy may be subject to discipline up to and including termination. Corrective actions can include retraining, suspension of marketing privileges, termination, and reporting of misconduct to the carrier and any relevant regulatory authorities.

Term	Definition
Business Reply Cards ("BRC")	A postcard that the prospect can complete and return or provide with their permission to be contacted by an agent.
Carrier	Medicare Advantage organization (MA), or Part D Plan Sponsor as defined by CMS.
Centers for Medicare and Medicaid Services (“CMS”)	CMS is the federal agency that administers health insurance programs like Medicare, Medicaid, Health Insurance Marketplace, and Children’s Health Insurance Program.
Do Not Call ("DNC")	A list of phone numbers from consumers who have indicated their preference to limit the telemarketing calls they receive.
File Transfer Protocol ("FTP")	A standard network protocol used for the transfer of files from one host to another over a TCP-based network, such as the Internet.
Fraud, Waste, and Abuse (“FWA”)	Fraud is intentionally submitting false information to the government or government contractor to get money, a benefit, or something else of value. Waste is a practice that, directly or indirectly, results in unnecessary costs to the Medicare Program, such as overusing services. Abuse involves paying for items or services when there is no legal entitlement to that payment, and that provider has not knowingly or intentionally misrepresented facts to obtain payment. 42 CFR § 455.2; Medicare Managed Care Manual, Chapter 21, CMS.
Medicare Advantage (“MA”)	Medicare Advantage (also known as “Part C”) is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for health care coverage.
Prescription Drug Plan (“PDP”)	Prescription drug coverage that is offered through a private PDP sponsor, MA-PD plan, PACE Plan, or Cost plan, contracted with CMS.
Telephone Consumer Protection Act ("TCPA")	A federal law that protects consumers from unwanted telemarketing calls, robocalls, and text messages. It restricts telemarketing communications via voice calls, SMS texts, and faxes. The TCPA also places restrictions on the use of automatic dialing systems and artificial or prerecorded voice messages. 47 U.S.C. § 227.
Telesales	Telesales refers to all telephonic marketing, sales, and enrollment activities for MA/PDP products conducted within a call center environment.
Organization, We, us or Our Company	

Policy Sections:

Policy References:

P1138 - CMS 5.15 CMS Call Center Compliance Policy		
Document Author	**Name:** **Title:** **Email:**	Karen Garay Regulatory Compliance Specialist Karen.Garay@integrity.com
Document Owner	**Name:** **Title:** **Email:** **Approved Date:**	Kathy Helgason Chief Compliance Officer, Health Kathy.Helgason@integrity.com 5/7/2025
Legal Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Monica Pinon Senior Counsel, Health Monica.Pinon@integrity.com 5/8/2025
Executive Management Approval	**Name:** **Title:** **Email:** **Approved Date:**	Jayne Rothman Chief Legal Officer Jayne.Rothman@integrity.com 5/8/2025

Last Published Date: 5/8/2025

Document Version Number 2.0