EXTERNAL PARTNER GUARDRAILS

Medicare Communications and Marketing Materials

The purpose of this document is to provide guidance to FMO/MGA, and Strategic Alliance agency partners ("Sales Partners"). The following is a summary of guidelines apply specifically to all agency/partner-created communication or marketing materials, however, it is not a comprehensive list of compliance guidelines that apply to the marketing and selling of Humana products.

Sales Partners are responsible for compliance with Chapter 3 of the Medicare Managed Care Manual (i.e., Medicare Communications and Marketing Guidelines, Chapter 2 of the Medicare Advantage Enrollment and Disenrollment Guidance, and any applicable state or federal laws, rules or regulations. This includes not only the content of the material, but also how and when the material is used. All communications or marketing materials must include required CMS disclaimers.

Marketing vs Communications:

MCMG 20 – Communications and Marketing Definitions and 20.1 – Factors for Activity and Material Determination:

CMS distinguishes Communications (activities and use of materials that provide information to a current or prospective member) from Marketing (a subset of Communications intended to draw a person's attention to a particular plan or plans, to influence a person's decision to enroll in a particular plan, or remain enrolled in a particular plan). Marketing materials must be filed with CMS, but Communication materials are exempted from the filing requirement. Communication activities and materials are distinguished from marketing activities and materials based on both intent and content.

- **Intent –** the purpose of marketing activities and materials is to draw a prospective or current enrollee's attention to a plan or group of plans to influence a beneficiary's decision when selecting and enrolling in a plan or deciding to stay in a plan (retention-based marketing).

- **Content –** based on the exclusions in the definition of marketing and marketing materials and the type of information that would be intended to draw attention to a plan or influence a beneficiary's enrollment decision, marketing activities and materials include:
    - Information about benefits or benefits structure;
    - Information about premiums and cost sharing;
    - Comparisons to other Plan(s)/Part D sponsor(s);
    - Rankings or measurements in reference to other Plan(s)/Part D sponsor(s); and/or
    - Information about Star Ratings

- A material that does not mention or include a specific plan, carrier name, or logo, and includes only examples of Medicare plan benefits generally, would not fall within the definition of Marketing.
    - Examples of this include materials that mention benefits such as vision, dental, prescription drug coverage, or $0 premium plans without specifically referencing a carrier's name, logo, or plan name.

General Communication Requirements

Anti-Discrimination 30.1 – Anti-Discrimination:

- Plans/Part D sponsors may not discriminate based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, or geographic location.
- Plans may not target potential enrollees from higher income areas, state or imply that plans are only available to seniors rather than to all Medicare beneficiaries, or state or imply that plans are only available to Medicaid beneficiaries unless the plan is a Dual Eligible Special Needs Plan (D-SNP) or MMP.
- Additionally, web-based communications must be Section 508 compliant (generally—able to be read by a screen reader or other screen reader technology) so the member experience is comparable for those who may be vision or hearing impaired.

1557 Anti-Discrimination Notice:

- The Office of Civil Rights (OCR) Section 1557 of the Affordable Care Act requires Humana to insert an anti-discrimination notice and multi-language tagline on all significant communications and documents.
- Humana Inc. and its subsidiaries comply with applicable Federal Civil Rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion.
- Partner materials that are Humana-specific or branded, or that exclusively reference Humana Medicare plans, are considered significant, and must include either the short-form or long-form notice (determined by size of document).
    - All third party partners that include Humana plan information or Humana specific content on their websites must utilize the long-form notice disclaimer. Websites may provide a link to the plan's full accessibility information, or the long-form notice can appear on the bottom of the screen. Either is acceptable.

Inappropriate Requests for Health Status Information:

- An MA organization may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an MA plan offered by the organization on the basis of any factor that is related to health status, including, but not limited to the following:
    - Medical condition(s), including both mental and physical
    - Claims experience
    - Receipt of health care
    - Medical history
    - Genetic information
    - Evidence of insurability, including conditions arising out of acts of domestic violence
    - Disability
- Ensure questions and language used in lead forms, plan comparisons, sales and enrollment processes/scripts, does not directly, or indirectly requesting this information.

Sales or Pre-Enrollment scripts:

- During telephonic sales calls agents may ask, **but may not require** the beneficiary to provide information regarding their age (DOB), gender, Medicare ID number, Part A or Part B effective dates, or any other demographic or health information. If the beneficiary does not wish to disclose any of this information, the agent **must** continue the call and provide plan information to the beneficiary. The agent cannot end the call if the beneficiary does not disclose this information, as this could be seen as discriminatory.
- The only information an agent needs from a beneficiary to provide non-beneficiary specific plan information is zip code, county, and/or state.
    - Non-licensed representatives may only conduct activities as permitted by state law. CMS permits non-licensed representatives to perform the following activities, unless otherwise required by state law: provide factual information, fulfill a request for materials or take demographic information in order to complete an enrollment application at the initiative of the prospective enrollee.
    - **Telesales and enrollment scripts are considered marketing and must be submitted to CMS as outlined in Section 90 of the Medicare Communications and Marketing Guidelines. If a sales call progresses to a telephonic enrollment, the sales staff must clearly inform the beneficiary that they are enrolling into the Plan (using the specific Plan name/type).**

Pre-enrollment Checklist (MCMG Appendix 3):

- It is not required that the pre-enrollment checklist is read during the sales call, however, the agency/agent must ensure the beneficiary had access to the required information (SB, checklist, etc.) prior to making an enrollment decision.
- Agents should read all of the applicable disclosures included in the checklist as part of the Summary of Benefits presentation, or update their sales scripts to include the verbiage in one of the ways below.
    - Include the checklist verbatim the script.
    - Embed the disclaimers within the script as appropriate.
    - Advise the beneficiary that the pre-enrollment checklist can be found on the plan's website (or another medium) and refer the beneficiary to review the checklist before making any enrollment decisions.
    - If the beneficiary wants to move forward with an enrollment, and cannot access the website (or other medium), then the agent must review the pre-enrollment checklist, before moving forward with an enrollment.

Correct terminology for agents:

- Acceptable to use the term "Licensed Insurance Agent" or "Licensed Sales Agent".
- If an agent's phone number or one that will route to sales is included, must clearly indicate before the number that it will direct callers to a "licensed sales agent" or "licensed insurance agent".

Customer service numbers:

- Customer service numbers must be toll-free numbers.

Days/Hours of Operation:

- Including hours and days of operation is strongly recommended when any (current or prospective enrollee) customer service number is provided to help facilitate a positive member experience.
    - Note: The hours and days of operation only need to be listed once in conjunction with the customer service number; they do not need to be listed every time a customer service number is provided.

Use of TTY Numbers:

- A TTY number must appear in conjunction with the customer service number in the same font size and style as the other phone numbers except as outlined below. Partners can use either their own TTY numbers or State relay services, so long as the number included is accessible from TTY equipment. TTY customer service numbers must be toll-free.
    - Exceptions:
        - Outdoor advertising (ODA) or banner/banner-like ads
        - Radio advertisements and radio sponsorships (e.g., sponsoring an hour of public radio)
        - In television ads, the TTY number may be a different font size/style than other phone numbers to limit possible confusion

Email Communications:

- A partner may initiate unsolicited email contact with potential enrollees, but **must** provide an opt-out process on each communication for those who no longer wish to receive emails.
    - Note: Text messaging and other forms of electronic direct messaging (e.g., social media platforms) would fall under unsolicited contact and are **not** permitted.
- Once an individual has utilized the opt-out option, the partner is responsible for ensuring that they no longer receive emails or other electronic communications.

Prohibited Terminology/Statements

Partners are prohibited from distributing communications that are materially inaccurate, misleading, or otherwise make misrepresentations or engage in activities that could mislead or confuse beneficiaries or misrepresent the Plan/Part D sponsor:

- Examples include:
    - Identifying a Medicare Supplement plan as a Medicare Advantage plan, etc.
    - Creating materials (e.g. direct mail solicitations, TV commercials, or websites) that look like official government notifications, and may confuse or mislead consumers into thinking the advertisements are from CMS or a government agency.
        - An example of this is the overuse of American flag imagery, Medicare ID card image, or patriotic themed colors (red, white, blue), and other terminology or images.
            - If the above elements are used in materials, ensure it is clear to the consumer that the advertisement is a solicitation to sell insurance, and is coming from a licensed health insurance agency, and not from CMS or a government agency.

    - Providing information about Original Medicare or Medicare plans that is inaccurate or unclear.
- For all types of advertisements, including communications and marketing materials:
    - Materials should clearly identify the agency/agent the solicitation is coming from, and whom the consumer will reach if they respond (i.e. “a licensed sales/insurance agent”).
    - For direct mail solicitations, including “generic” mailers, Humana recommends to include the agency’s name (agent’s name) or agency logo on every mailing to current and prospective enrollees (either on or visible from the front of the envelope, or on the mailing itself when no envelope accompanies the piece).
    - For partners who operate under different consumer-facing names, if the name includes the term “Medicare”, additional clarification is necessary to ensure it is clear the material is coming from the sales agency, and not from the government.
    - Adding the following language is recommended to include as a tagline underneath the partner’s logo and/or clarifying language on the material:
        - "A non-government entity powered by [Agency Name], a health insurance agency"
    - Partners must verify that all information in the communication is up-to-date, accurate and clearly described
    - For MA plans that are not D-SNPs, agents may not:
        - Imply that the plan is designed for dual eligible individuals;
        - Claim that the plan has a relationship with the state Medicaid agency, unless the MA plan (or its parent organization) has contracted with the state to coordinate Medicaid services, and the contract is specific to that MA plan (not for a separate D-SNP or MMP); or
        - Target their marketing efforts exclusively to dual eligible individuals.

Superlatives and Absolute Language:

- Do not use unsubstantiated absolute or qualified superlative language, such as “best”, “greatest,” “#1” or “outstanding” when describing a plan.
- Do not use absolute language such as “guarantee” or “promise” (these are only examples).

Claims of Endorsement:

- Do not make claims that Humana or Humana plans are recommended or endorsed by the Center of Medicare & Medicaid Services (CMS), or the Department of Health & Human Services (DHHS).

Comparisons to Other Plans:

- Do not compare Humana plans to other plans by name (unless substantiated by a study or statistical data) and such comparisons are factually based.
- Comparison cannot be misleading or confusing to members.
- Do not use pejorative language or disparaging comments about other plans.

Plans and Benefits Availability:

- If describing plans, ensure they are available for all of the plans your agency represents, and available in the market it is being used.

    - If plans are not available in all locations, need to include the following disclaimer, “PLAN AVAILABILITY VARIES BY REGION AND STATE.”
- If describing benefits, ensure they are available for all of the plans your agency represents, and available in the market it is being used.
    - If benefits are not available on all plans, need to include the following disclaimer, “Not all benefits listed may be available on all plans or in a single plan benefits package.”
- Any such statements made should be prefaced with “may” or similar terms.

Use of the term Senior:

- Refrain from using the term “senior” as it may imply that people with Medicare are only eligible due to aging in (65+); CMS views the use of the term “senior” in some contexts as potentially discriminatory against those who have Medicare due to a qualifying disability. In some instances the term may be permissible, e.g., for plans only available to those 65 or older, but “people with Medicare” or “Medicare eligible” is the preferred terminology.

Use of the word Free:

- When describing services like, “Free Medicare Plan Comparison”, need to include “no obligation to enroll” in same sentence or in close in proximity to the FREE reference. If there are space issues, an asterisk maybe used to reference language in a footnote
    - Do not use the term “free” to describe a zero dollar premium, reduction in premiums (including Part B buy-down), reduction in deductibles or cost-sharing, low-income subsidy (LIS), or cost sharing for individuals with dual eligibility. Suggest using “no additional cost” as an alternative.
    - It is only permissible to use the term “free” with respect to plan benefits when describing mandatory, supplemental, and preventive benefits provided at a zero-dollar cost sharing for all members.

Use of Qualifying Language:

- Do not use declarative phrases like, “You will save thousands of dollars”, “This is the best plan for you”
- Instead use phrases like “you **may** be able to save money”(if accurate)
- Use other words such as “eligible” or “you might”, “you may” “you could potentially save”, “should” or “maybe” (if accurate)

Exaggerative Words/Phrases:

- Do not use words/phrases such as “all,” “full,” “complete,” “comprehensive,” “unlimited” to describe benefits (these are only examples)

Acceptable Words and Terms to use at the end of AEP:

- Approved phrases to communicate the end of AEP that doesn’t create false sense of urgency:
    - Don’t delay
    - Enroll now
    - Now’s the time
    - The time is now
    - Don’t Miss Out

- Get the answers you need
- AEP is ending soon (may only be used 2 weeks before 12/7)
- AEP ends on 12/7 (may only be used 2 weeks before 12/7)

Words to avoid during in OEP/ROY marketing:

- Using the word NEW in a context that gives the impression that new plans are being released by plan sponsors.

"Partnership" or "Alliance":

- Avoid words like "partnership" or "alliance" in reference to the relationship between Humana and the agency/agent or Humana and a vendor. Acceptable terms would be "teamed up" or "working together".

"Low" vs. "Affordable":

- Do not use the word "low" unless the benefit/premium, etc. is either $0 or is lower than 50% across competitors' plans. If these criteria are not met, should use the word "affordable" (if accurate).

Scare and High-Pressure Tactics :

- Avoid using language to create undue fear or anxiety in members/prospects, such as "beware of some plans whose copays could bust your budget", etc.
- Avoid words that would cause a false sense of urgency, such as "Act now, or you may lose your benefits!" etc.
- Avoid repetitive phrases, certain font/colors, and/or punctuation that may communicate this to a potential enrollee.
- Examples may include "**URGENT!**" used on a material with font that is in all caps, oversized and red.

Words to avoid include the following:

- Unbiased
- "Customized" or "personalized" when describing Medicare plans or benefit as plans cannot be customized for an individual's needs.
- Entitled (can only be used when discussing Original Medicare)
- Any ACA reference
- May refer to sales agent as "Advocate" or "expert" if substantiated, approved, **and used in conjunction with "licensed sales agent" or "licensed insurance agent".**

Testimonials (Consent):

- If member testimonials are used, must use actual members who are currently active in the plan they are endorsing. Testimonial must also include the name of the plan in which the member is enrolled.
- Ensure member has given consent for quote to be used in the particular medium, such as on a website.
- If an individual is paid to endorse or promote the plan or product, this must be clearly stated (e.g., "paid endorsement").
- If an individual, such as an actor, is paid to portray a real or fictitious situation, the ad must clearly state it is a "Paid Actor Portrayal."

- Any endorsement or testimonial that is made by a health care provider (even if another individual quotes the provider) must be discussed with and reviewed by Humana prior to use. You may not pay or compensate provider for testimonial in any way.
- Any claim made in an endorsement or testimonial must be substantiated.
- An endorsement or testimonial cannot use negative testimonials about other Plans/Part D Sponsors.

References to Research or Studies

Prohibited Statements:

- May not make unsupported claims in advertising. If a statement is made that requires statistical support or documentation, current and accurate sources must be provided. It is best practice that citations are either built into the text or referenced by footnote and include the date and source of the study or research.
- May not make superlative statements such as "the best" or "highest ranked" or "number one" unless these statements can be validated. If you can't support it, you can't state it.
    - If "highly rated" statement made, need to include the following substantiation language, *"XX% of the plans offered through <Partner name> are highly rated. Highly rated is considered 4 and above out of 5 stars. Medicare evaluates plans based on a 5-Star rating system. Star Ratings are calculated each year and may change from one year to the next.*

General Marketing Requirements

References to Annual Enrollment Period (AEP):

- In order to ensure beneficiaries are not misled or confused about Original Medicare open enrollment versus MA/PDP fall open enrollment and the new January – March Open Enrollment Period (OEP), the following terminology is recommended when describing AEP: "*Medicare Advantage & Prescription Drug Plan Annual Enrollment Period*"
- The terminology of "Medicare Open Enrollment" can be used as long as it is clear in the context of the piece as a whole that a person can enroll in a Medicare Advantage or Prescription Drug Plan beginning October 15-December 7th.
- If there is limited space, and it is clear from the context of a piece that the enrollment period referred to is that in which a person can enroll in a Medicare Advantage and/or Prescription Drug Plan, then the following terminology would be acceptable:
    - Medicare Annual Election Period (AEP)
    - Medicare Annual Enrollment Period (AEP)
    - Use of these terms may require a case-by-case analysis. For example, in the case of a banner ad, the piece as a whole would include the landing page to which the banner ad links, so the abbreviated terminology listed above would be permissible.

Prohibition on Open Enrollment Period Marketing:

- Agency Partners/agents are prohibited from knowingly targeting or sending unsolicited marketing materials to any MA enrollee or Part D enrollee during the continuous Open Enrollment Period (OEP) (January 1 to March 31).
    - During the OEP, agency partners/agents may:
        - Conduct marketing activities that focus on other enrollment opportunities including but not limited to:
            - Marketing to age-ins (who have not yet made an enrollment decision),
            - 5-star plans marketing the continuous enrollment SEP, and
            - Marketing to dual-eligible and LIS beneficiaries who, in general may make changes once per calendar quarter during the first nine months of the year.
        - Send marketing materials when a beneficiary makes a proactive request
        - At the beneficiary's request, have one-on-one meetings with a sales agent
        - At the beneficiary's request, provide information on the OEP through the call center
        - Partners may include general information on their website about enrollment periods, including the OEP, as long as it is educational in nature, and a call to action is not present.
    - During the OEP, agency partners/agents may not:
        - Send unsolicited materials advertising the ability/opportunity to make an additional enrollment change or referencing the OEP
        - Specifically target beneficiaries who are in the OEP because they made a choice during Annual Enrollment Period (AEP) by purchase of mailing lists or other means of identification
        - Engage in or promote agent/broker activities that intend to target the OEP as an opportunity to make further sales
        - Call or otherwise contact former enrollees who have selected a new plan during the AEP

Prohibition on Marketing New Plans Prior to Oct. 1:

- May not communicate about following year's Medicare plans prior to October 1st of the previous year.

Marketing outside of AEP - Rest of Year (ROY):

- Partners cannot market for an upcoming plan year prior to October 1. Partners are permitted to concurrently market the current year with prospective year starting on October 1, provided marketing materials make it clear what plan year is being discussed.

Marketing for a Special Election Period (SEP):

- When marketing Medicare plans outside of AEP to the general public, only a small percentage of members/prospects will be aging-in, recently moved, or have other SEP qualifying conditions. Accordingly, be careful not to mislead members/prospects into believing they could change their respective plans outside of AEP.
- When marketing plans during ROY, materials must include language clarifying that a prospect may "apply, choose or enroll" in a plan only if they are eligible via an SEP.

- Materials that discuss a beneficiary's enrollment eligibility need to be clear that the piece is describing eligibility for a Special Election Period, or to "enroll in the plan", and not "eligible for more benefits". It is not accurate to use language such as "to see if you qualify", and/or "are eligible for additional benefits".
- If creating advertisements that will be used during OEP or Rest of Year (ROY), one of the following must be included on the materials:
    - Necessary qualifiers that speak to those who may be aging in, new to Medicare, losing coverage, or other SEP qualifying event, so as not to violate the prohibition of knowingly targeting or sending unsolicited marketing material during the Open Enrollment Period (OEP).
    - The disclaimer, "ENROLLMENT IN THE DESCRIBED PLAN TYPE MAY BE LIMITED TO CERTAIN TIMES OF THE YEAR UNLESS YOU QUALIFY FOR A SPECIAL ENROLLMENT PERIOD."

Communication about Providers

Agents should:

- Provide objective information to beneficiaries about the availability of participating Providers near their place of residence as part of a general description of Humana's provider network.
- Be factual, exclude personal opinions, and avoid the use of superlatives (e.g., "better care", "best care", etc.) when describing Providers to prospects and clients.
- Be sure to inform beneficiaries of all network providers that are available and ensure members and prospective members always feel completely free to choose any provider in the network. Agents should always be guided by the enrollee's best interest when discussing provider network.
- ALWAYS use Physician Finder whenever possible to look up provider participation as it is the most up-to-date and comprehensive list of participating providers for Humana. If Physician Finder is not available, agents may refer to the paper or PDF Provider Directory or call Agent Support for assistance.
    - Agents **may:**
        - Provide factual information about a particular provider that is included in the Physician Finder, such as ratings available through the Care Highlights program
        - Schedule meetings with prospective members at a particular provider's office so long as:
            - As applicable, Scope of Appointment (SOA) and other MarketPoint policies and CMS requirements listed in MCMG 50- Outreach Activities, and 60- Activities in a Healthcare Setting are followed.
    - Agents **must:**
        - Provide only factual information about services the particular provider offers that are covered by the Humana plan.
            - Always refer members and prospective members to the relevant provider directory and make it clear that other providers are available in the network.
            - Ensure members and prospective members always feel completely free to choose any provider in the network.
    - Agents must **not**:
        - Hand out materials describing the provider's services or marketing the provider's practice.

- Provide information about any free services or cost-sharing waivers offered by a provider unless they are part of the Humana plan benefit (e.g. complementary transportation).
- Recommend a provider or share opinion about which provider is best (e.g. do not use superlatives when describing a particular provider).
- Use aggressive marketing or high pressure tactics.
- Offer or give anything to members or prospective members to persuade them to choose a particular provider.
- Accept anything, directly or indirectly, from a provider in exchange for communicating about that particular provider (e.g. do not accept promises that provider's patients will choose Humana plans, charitable donations, sponsorships, gifts, cash, etc).
- Engage with providers in a way that may influence the agent's interaction with a member or prospect regarding their choice of a Provider, including but not limited to, entering into any arrangements with Providers, or offering, receiving or agreeing to offer or receive anything of value from a Provider or a Provider's representative
- Engage with providers in a way that would influence the provider to steer patients toward a certain plan or set of plans, or encourage a provider to steer patients towards Humana plans. Under the Medicare Communications and Marketing Guidelines, providers are prohibited from steering towards a particular plan.

Communications and Materials that mention providers:

- Any communication or marketing material that mentions a provider must be submitted to Humana for review prior to use.
- If requested by a Beneficiary, a Provider may assist the Beneficiary with objective assessments of their needs and possible MA and PDP options, but may not market or steer a Beneficiary toward a particular MA/PDP. Providers should remain neutral and keep the best interest of the Beneficiary in mind during any such discussion.
- Provider images should not show a specific provider (should be a stock photo of a provider) and/or clinic, the provider pictured should not be a contracted provider, and associated text and voiceover should describe only clinical, educational information (such as describing preventive services), and should not be promoting the agency or any plans.

Communications and Materials with Provider/Celebrity Spokesperson

- Humana recognizes the request for Agency Partners who want to create generic materials that involve a provider spokesperson and/or celebrity personality, in order to promote on behalf of their agency.

- The partner will be responsible for submitting materials for Humana's corporate review system. The materials will go through the normal marketing corporate review process, and the partner should complete the intake form, and need to include the following information in the provider section of the intake form:
    - Name of provider/celebrity personality:
    - Are they currently a practicing physician? If not, please list the date that they stopped practicing.
    - Are they contracted with any medical groups?

- Are they contracted with any MAO/Part D Plan sponsors?
- What is their specialty?
- If a TV personality, please provide a brief description of their program (is it on TV, internet, etc)

- Once Humana has reviewed and approved these materials, the agency partner may move forward with using the approved materials, with all edits and comments incorporated and creating future similar materials.

- In the case of future similar materials, the partner does not have to submit these materials to Humana again prior to use, if the following:
  - The content does not change drastically from the previously-approved version, and the only changes to the material are minor updates to the general, clinical information or general Medicare educational information.
  - They incorporate all of the previous Humana comments/edits, and follow all applicable laws and regulations, Humana policies and the guardrails.

- The partner is required to submit the material for review again if revised in future and if the following apply:
  - The provider spokesperson changes
  - Any information is added that is not general, educational Medicare information
  - Any specific plan information is added
  - There is a new concept that drastically changes from the previously-approved content

- Materials Must NOT:
  - Include a contracted provider
  - Market or steer a Beneficiary toward a particular MA/PDP or a set of MA/PDP plans, such as Humana plans.
  - Include the host promoting or appearing to promote the agency or the plans offered by the agency, such as stating "*ABC agency is the best and only represents the best plans."* The host may state the agency's name and number, and advise consumers to call the agency to learn about plans that may be right for them.

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

Websites

General Requirements:

- Websites must be clear and easy to navigate.
- Websites containing any marketing content must be submitted to CMS.
- When marketing Medicare plans:
    - If communicating about two plan years (e.g 2019 and 2020 plans), it must be clear to which plan year the information is referencing.
- May only require users to enter zip code, county, and/or state for access to non-beneficiary specific website content, and function as such.
- Third-party websites may request, but not require, age (DOB), gender, or health status information. There must be relevant consumer notification that this information is not required, and it is communicated as 'optional' to the consumer.
- Partners must ensure their websites maintain a separate and distinct section for their Medicare information covered by these guidelines if they market other lines of business.
- May not include or market Medicare Supplement (Medigap) content in their Medicare information section.
- Must contain accurate 'Calls to Action'- Calls to action must accurately reflect the result the user will see/experience in the subsequent step, such as speaking with a "licensed sales agent" or a "licensed insurance agent" when calling.

Social Media

- Partners must submit social media posts (e.g., Facebook, Twitter, YouTube) that meet the definition of marketing to Humana for corporate review, and CMS filing.

Permission to Contact

- If a potential enrollee provides permission to be called or otherwise contacted, the contact must be event-specific, and may not be treated as open-ended permission for future contacts.
- TCPA guidelines (dated August 2016) stipulate when requesting contact information from a proposed member, plans need to, at the minimum, disclose:
    - Calls may be made by auto dialer, text (if applicable) or robocall (if applicable)
    - Calls are for marketing purposes
    - Cellular carrier charges may apply
    - Providing permission does not impact eligibility to enroll or the provision of services
    - Can change permission preferences at any time.

Lead Forms and Lead Sources

- Partners are responsible for compliance oversight including ensuring all lead sources used to solicit Humana products are compliant with CMS guidelines, Humana policies and procedures, and all other state or federal regulations.

- Lead Sources MUST NOT:
    - Require consumers to give any health status, gender, date of birth information, or any other information that would give the appearance of cherry picking, to solicit for Medicare Advantage or Prescription Drug Plans.
    - Require consumers to enter any information other than a zip code, county, and/or state for access to non-beneficiary specific website, i.e. access to general website content, such as a list of plans in the area.
    - Be false or misleading, including giving the perception that the beneficiary is interacting with a government entity.
    - Offer or imply to offer any incentives or rewards other than those permitted by nominal gift guidelines.
- Lead Sources MUST:
    - Ensure the permission to contact form and overall lead form language make clear to the consumer they are agreeing to provide their contact information and requesting a licensed sales agent contact them regarding MA/PDP plan information.
    - Be clear, easy to understand and navigate (if a website).
    - Clearly indicate the phone number they are calling will connect with a licensed insurance/sales agent to inquire about Medicare Advantage plans.
        - This language should be located in a prominent location on the material, where it is easily visible and clear to the consumer.
        - The language should be separate from other disclaimer language included on the material.
        - Example of recommended language to use, "Please fill out the form if you would like to have a licensed sales agent contact you regarding Medicare Advantage and/or Prescription *Drug Plans."*

Nominal Gifts

- Gifts may be given to Medicare beneficiaries for marketing purposes so long as the total retail value is no more than $15 retail value, $75 aggregate, per person, per year and all nominal gifts guidelines are met. Materials promoting/offering a gift must state that the gift is available with no obligation to enroll.
- Must be offered to all potential enrollees regardless of whether they enroll, and without discrimination.
- May not be in the form of cash, rebates or VISA/Am-X/Mastercard type gift cards. Other types of gift cards may not be used by agents as a nominal gift for Medicare beneficiaries unless prior approval is received from Humana.
- May not be items that are considered drug/health benefits (e.g., a free checkup), including optional mandatory supplemental benefits; may not **be tied directly or indirectly to the provision of any other covered item or service.**

Describing Medicare

- When comparing Original Medicare to MAPD or Medicare Supplement Insurance plans, must be more specific than just "Medicare".

- It is preferable to describe Original Medicare as “Medicare Part A and Part B” on documents that also contain reference to Medicare Supplement because some states that regulate Medicare Supplement object to the term “Original Medicare.” CMS has no objection to the term “Original Medicare”, so if the document is not related to Medicare Supplement marketing, the term “Original Medicare” is acceptable.

Educational or Sales Materials:

- Materials that include invitations to educational or sales events must clearly be advertised as ‘educational’ or sales on the material(s) itself.
- If advertising for both educational and marketing events on the same material, details regarding the time of each event must be specific on the material so it is clear when each event is taking place.

For specific guidance on Generic Communication Materials, refer to the Humana Job Aid for Generic Materials.