RITTER
Insurance Marketing®

Agent Handbook

A GENERAL GUIDE TO SELLING MEDICARE ADVANTAGE PRODUCTS

2019

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INTRODUCTION

Welcome to Ritter!

Ritter strives to promote excellence and quality in the products and services we provide to our business partners, agents, and customers. As your Field Marketing Organization, we recognize the value you bring to the marketing of Medicare products. More importantly, we recognize the value you provide to beneficiaries by helping them find the right health plans. This Agent Handbook is intended to act as a general compliance guide for selling Medicare Advantage products. While this Handbook addresses the most commonly asked questions regarding proper marketing conduct, you must use it in conjunction with health-plan-specific policies, as each health plan may have unique policies and processes.

WHO IS RITTER?

Ritter Insurance Marketing, LLC was founded in 2005 with six employees. Today, Ritter employs more than 180 people and supports a network of 3,700 agencies/31,000 independent agents. Our corporate office is located in Harrisburg, Pennsylvania, and our branch offices are located in Atlanta, Georgia; Omaha, Nebraska; Scottsdale, Arizona; Nampa, Idaho; and Uniondale, New York. Ritter was named one of the Best Places to Work in Pennsylvania for the fifth straight year in 2018. While Ritter has experienced tremendous growth in recent years, we remain committed to our agents and providing advanced proprietary technology and product portfolios consisting of top-tier health plans throughout the country. Starting with Craig Ritter, President, the depth of experience and knowledge our leadership team possesses enables us to understand your selling opportunities and compliance challenges.

USING THIS HANDBOOK

This Handbook is intended to provide our agents with knowledge of the regulations and best practices involving the marketing and selling of Medicare Advantage products. This document is subject to periodic review and revision. The term "agent" is used to refer to an agent and the General Agency within the Ritter hierarchy structure unless otherwise noted. Also, the terms Plan/Part D Sponsor and insurance company are used interchangeably.

BACKGROUND

In the following sections, we will reacquaint you with basic Medicare information. This will include several topics that are critically important in the marketing and selling of Medicare Advantage products, which insurance companies typically require agents to discuss with beneficiaries during marketing meetings.

Generally, agents are required to explain the plan's service area, prescription drug formulary, late enrollment penalty, coverage gap, copay tiers, enrollment and disenrollment periods, and differences between in-network providers and out-of-network providers, if applicable. While this is not an exhaustive list, agents are expected to ensure that potential enrollees are properly informed of plan benefits and coverage to avoid any potential disenrollment and beneficiary complaint in the future.

You may use various tools such as a Needs Assessment Checklist and Summary of Benefits that various insurance companies have made available to assist their agents. You may also use questions and follow-up probes regularly during sales meetings to check for understanding. Ultimately, our goal is to make sure the plan being presented is the right fit for the potential enrollee.

MEDICARE BASICS

Medicare is health insurance for U.S. citizens or residents, most people 65 and older, people younger than 65 who have certain disabilities and illnesses, or people of any age with kidney failure that require dialysis or a kidney transplant.

The Medicare program is made up of four parts that help cover specific services:

Medicare Part A helps pay for inpatient care in hospitals and skilled nursing facilities, hospice care, and home health care or each benefit period. Part A is free for most people because they or a spouse already paid for it through their payroll taxes while working. However, there is a deductible per benefit period ($1,364 in 2019). There is also a coinsurance for hospital stays.

The rate for hospital coinsurance is based on the length of the stay:

- 1–60 days: $0 coinsurance
- 61–90 days: $341 per-day coinsurance
- 91 days and beyond: $682 per-day coinsurance (up to 60 days over your lifetime)
- Beyond lifetime reserve days: all costs

The rate for skilled-nursing facility coinsurance is also based on the length of the stay:

- 1–20 days: $0 coinsurance
- 21–100 days: $170.50 per-day coinsurance
- 101 days and beyond: The beneficiary is responsible for all costs

Medicare Part B coverage helps pay for doctor services and other medical services. For most items, Medicare Part B covers 80% of the cost while the beneficiary pays the other 20%. The Part B annual deductible for 2019 is $185.00.

There is a premium for Part B. The Standard Part B premium amount in 2019 is $135.50. Most people with Medicare Part B will be held "harmless" from any increase in premiums in 2019 and will pay a monthly premium less than the full Part B standard premium. If a beneficiary's modified adjusted gross income as reported on their IRS tax return from 2 years ago is above a certain amount, he or she will pay the standard premium amount and an Income Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra charge added to the premium – refer to the Premium Table below.)

Income Related Monthly Adjustment Amount (IRMAA) – Medicare Part B Premium Year 2019

If your yearly income in 2017 (for what you pay in 2019) was			You pay each month (in 2019)
File individual tax return	**File joint tax return**	**File married & separate tax return**	
$85,000 or less	$170,000 or less	$85,000 or less	$135.50
above $85,000 up to $107,000	above $170,000 up to $214,000	Not applicable	$189.60
above $107,000 up to$133,500	above $214,000 up to $267,000	Not applicable	$270.90
above $133,500 up to $160,000	above $267,000 up to $320,000	Not applicable	$352.20
above $160,000 and less than $500,000	above $320,000 and less than $750,000	above $85,000 and less than $415,000	$433.40
$500,000 or above	$750,000 and above	$415,000 and above	$460.50

Together, Medicare A and B are called **Original Medicare**.

Medicare Part C is also known as Medicare Advantage. These products are private health insurance plans, like Health Maintenance Organizations and Preferred Provider Organizations, that combine hospital care, doctor visits, and outpatient care into a single plan. These plans provide all Part A and Part B benefits and may offer extra benefits not provided by Original Medicare. To enroll in Medicare Part C, a beneficiary must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in the plan's service

area. If the individual has End-Stage Renal Disease (ESRD), he/she cannot enroll. However, if the individual develops ESRD while he/she is a member of a Medicare Advantage plan, he/she cannot be disenrolled.

Medicare Part D is the Medicare Prescription Drug Plan that provides prescription drug coverage. To enroll in Medicare Part D, the beneficiary must be entitled to Medicare Part A and/or be enrolled in Medicare Part B and must live in the plan's service area. If the individual is enrolled in Original Medicare only or in Original Medicare and a Medigap plan, the beneficiary can enroll in a stand-alone prescription drug plan. A beneficiary can also enroll in Medicare Part D to add drug coverage to some Medicare Cost Plans, some Medicare Private Fee-for-Service Plans, and Medicare Medical Savings Account Plans. If the individual wants a Medicare Advantage plan and prescription drugs, he/she must enroll in a Medicare Advantage plan with drug coverage.

Medicare Part D plans typically charge a premium and vary by plans. Beneficiaries with higher income must pay a premium adjustment based on their income. This is known as the Income-Related Monthly Adjustment Amount (IRMAA), and it is paid directly to the federal government. If the beneficiary does not sign up for Part D when he/she is first eligible or if he/she drops Part D and then gets it later, the individual may have to pay a late enrollment penalty for as long as he/she has Part D. The cost of the late enrollment penalty depends on how long the individual went without creditable prescription drug coverage. More on this topic will be discussed later.

The maximum annual deductible for standard Medicare Part D plan is $415 in 2019. Part D premium – if your filing status and yearly income in 2017 was:

File individual tax return	File joint tax return	File married & separate tax return	You pay each month (in 2019)
$85,000 or less	$170,000 or less	$85,000 or less	your plan premium
above $85,000 up to $107,000	above $170,000 up to $214,000	not applicable	$12.40 + your plan premium
above $107,000 up to $133,500	above $214,000 up to $267,000	not applicable	$31.90 + your plan premium
above $133,500 up to $160,000	above $267,000 up to $320,000	not applicable	$51.40 + your plan premium
above $160,000 and less than $500,000	above $320,000 and less than $750,000	above $85,000 and less than $415,000	$70.90 + your plan premium
$500,000 or above	$750,000 and above	$415,000 and above	$77.40 + your plan premium

MEDIGAP (MEDICARE SUPPLEMENT) VS. MEDICARE ADVANTAGE

A Medigap policy is also called Medicare Supplement insurance. Medigap plans are sold by private companies and help pay for some of the health-care costs or "gaps" that Medicare does not cover. Beneficiaries use their Medicare card and Medigap card together at the doctor. Medigap plans also do not have a network, meaning the individual can use any doctor and hospital that accepts Medicare. Medigap plans do not cover prescription drugs, so beneficiaries need separate, stand-alone prescription drug coverage. Medigap is not a Medicare Advantage plan, and it is not to be used with Medicare Advantage plans. Insurance companies can sell only a "standardized" policy identified in most states by letters (e.g., A, C, K). Plans with the same letter offer the same benefits regardless of location and insurance company, except in a few states that offer their own forms of Medigap coverage. While benefits are standardized, premiums are not structured the same way across all companies.

A Medicare Advantage plan is a type of Medicare health plan offered by private insurance companies that contract with the federal government to provide at least the same amount of coverage as Original Medicare (Parts A and B). Certain plans may provide additional benefits that are not covered by Original Medicare. Medicare Advantage includes the following plans: Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Private Fee-for-Service Plans (PFFS), Medical Saving Account Plans (MSA), and Special Needs Plans (SNP). Beneficiaries must continue to pay the Part B premium when enrolled in a Medicare Advantage plan.

MEDICARE ADVANTAGE INITIAL ENROLLMENT PERIOD

A. Newly Eligible: When turning 65, a beneficiary has a seven-month period (three months before and three months after the birth month) to enroll into a Medicare Advantage Plan (MA) and/or Medicare Prescription Drug Plan (PDP).

B. Age-In: When a beneficiary who is already eligible for Medicare and is turning 65, he/she has a seven-month period (three months before and three months after the birth month) to enroll in or change a MA and/or PDP plan.

C. Under 65 with Certain Disabilities: When a beneficiary receives disability benefits from Social Security (SS) or certain disability benefits from the Railroad Retirement Board (RRB) for 24 months, he/she has a seven-month period (three months before the 25th month of SS or RRB disability benefits and three months after the 25th month of getting disability benefits) to enroll into a MA or PDP plan.

There are specific times when a beneficiary can sign up for a Medicare Advantage plan or make changes to an existing plan. Agents are expected to understand the different times and circumstances in which a beneficiary can enroll into a MA or PDP plan.

MEDICARE ADVANTAGE ANNUAL ENROLLMENT PERIOD

The Medicare Annual Enrollment Period (AEP) allows Medicare beneficiaries to enroll in or change prescription drug plans and/or Medicare Advantage plans or return to Original Medicare. The AEP runs from October 15 through December 7. Enrollment changes take effect on January 1.

MEDICARE MSA PLAN ENROLLMENT PERIOD

Individuals may enroll in Medicare MSA plans (should one be offered in their area) only during the Initial Coverage Election Period (ICEP) or the AEP; they may not enroll in Medicare MSA plans during a Special Election Period (SEP) (see exception below). The effective date of coverage is determined by the election period in which an enrollment request is made.

Individuals may disenroll from Medicare MSA plans only during the AEP or an SEP. The effective date of disenrollment during an SEP depends on the type of SEP. Additionally, MSA enrollees may not use the MA OEP to disenroll from the MSA.

Exception: To facilitate the offering of employer/union sponsored MSA plans, CMS will permit individuals to request enrollment into an employer/union sponsored MSA plan using the Employer Group Health Plan Special Enrollment Period (EGHP SEP).

MEDICARE ADVANTAGE OPEN ENROLLMENT PERIOD

Effective 2019, the 21st Century Cures Act eliminates the existing Medicare Advantage Disenrollment Period (Jan 1 – Feb 14) and replaces it with a new Medicare Advantage Open Enrollment Period (OEP) that will take place from January 1st through March 31st annually.

The new OEP allows individuals enrolled in an MA plan, including newly MA-eligible individuals, to make a one-time election to go to another MA plan or Original Medicare with or without a PDP.

Individual enrolled in Medicare Advantage Plans as of January 1st	MA OEP: January 1st – March 31st
New Medicare beneficiaries who are enrolled in an MA plan during ICEP	The month of entitlement to Part A and Part B – the last day of the 3rd month of entitlement

SPECIAL ELECTION PERIODS

The Special Election Period (SEP) is a set time period triggered by certain events during which a beneficiary can change Medicare Advantage plans, Medicare Prescription Drug Plans, or return to Original Medicare.

A. **Plan Non-Renewal:** If the Medicare Advantage Plan or Prescription Drug Plan is terminating at the end of the year (December 31), the beneficiary has an SEP to enroll in a different MA or Part D plan or return to Original Medicare. This SEP is from December 8 of the current year through the end of February of the next year. This SEP gives the beneficiary another chance to enroll in an MA or PDP plan in addition to the Annual Enrollment Period. Any plan changes made before December 31 are effective January 1. Plan changes made after December 31 would be effective the first day of the following month.

B. **Contract Violation:** If CMS determines that a material provision of a contract violation has occurred under MA in relation to the individual, or the MA organization (or its agent) materially misrepresented the plan when marketing the plan, the individual may disenroll from the MA plan and elect Original Medicare or another MA plan. The SEP will begin once CMS determines that a violation has occurred. Its length will depend on whether the individual immediately elects a new MA plan upon disenrollment from the original MA plan or whether the individual initially elects Original Medicare before choosing a new MA plan.

C. **Termination of Plan Contract by Mutual Consent:** A SEP exists for members of plans who will be affected by a termination of contract by the MA organization or a modification or termination of the contract by mutual consent. The SEP begins two months before the proposed termination effective date, and ends one month after the month in which the termination occurs.

D. **Termination of Plan Contract by CMS:** If CMS terminates its contract with the beneficiary's MA plan, a SEP exists for members of plans that will be affected by MA organization contract terminations by CMS. The SEP begins 1 month before the termination effective date and ends 2 months after the effective date of the termination.

E. **Enroll in a PDP during MA OEP:** If the beneficiary disenrolled from an MAPD plan during the Medicare Advantage Open Enrollment Period (MA-OEP) from January 1 through March 31, the beneficiary will have an SEP to enroll in a PDP.

F. **Change in Residence:** If the beneficiary moves out of the plan's service area, he/she has a SEP to enroll in a new plan offered in the new residence area. If the beneficiary notifies the plan before the move, the SEP begins the month before the move and continues for two full months after the move. If the beneficiary notifies the plan after the move, the SEP begins the month of the notification, plus two full months.

G. **Individuals Who Disenroll in Connection with a CMS Sanction:** On a case by case basis, CMS will establish an SEP if CMS sanctions an MA organization, and an enrollee disenrolls in connection with the matter that gave rise to that sanction. The start/length of the SEP, as well as the effective date, is dependent upon the situation.

H. **Individuals Enrolled in Cost Plans that are Non-renewing their Contracts:** An SEP will be available to enrollees of HMOs or Competitive Medical Plans (CMPs) that are not renewing their §1876 cost contracts for the area in which the enrollee lives. This SEP begins December 8 of the current contract year and ends on the last day of February of the following year.

I. **Individuals in the Program of All-inclusive Care for the Elderly (PACE):** Individuals may disenroll from an MA plan at any time in order to enroll in PACE. In addition, individuals who disenroll from PACE have an SEP for up to 2 months after the effective date of PACE disenrollment to elect an MA plan. The effective date would be dependent upon the situation.

J. **First-Time MA Member:** If the beneficiary enrolled in an MA plan during the Initial Coverage Election Period (ICEP) around their 65th birthday, he/she will have a 12-month SEP to disenroll and return to Original Medicare. Individuals entitled to Medicare prior to age 65 are not eligible for the SEP65.

K. **Medigap Trial Period:** If the beneficiary dropped his/her Medigap policy to enroll in an MA plan for the first time, he/she can reenroll in a Medigap policy during a "trial period." The trial period lasts for 12 months after he/she enrolls in a Medicare private health plan for the first time. This SEP allows a qualified individual to make a one-time election to disenroll from their first MA plan to join the Original Medicare Plan at any time of the year. The SEP begins upon enrollment in the MA plan and ends after 12 months of enrollment or when the beneficiary disenrolls, whichever is earlier. The effective date would be dependent upon the situation.

L. **Voluntary/Involuntary Termination of Group Coverage:** If the beneficiary was enrolled in Group Retiree benefits, Employer Group Coverage, or COBRA and disenrolled, he/she will have a two-month SEP to enroll in an MA or PDP plan (must be enrolled in Part B to elect an MA plan).

M. **Involuntary Loss of Creditable Coverage:** If the beneficiary's creditable prescription drug coverage through his/her employer health plan ends, the beneficiary has a two-month SEP to enroll in an MA with a prescription drug plan (enrollment into an MA-only plan is not allowed) or PDP. The SEP starts the day he/she loses coverage or two months after the beneficiary is notified that the current coverage is no longer creditable, whichever is later.

N. **5-Star Special Enrollment Period:** If the beneficiary lives in an area with an MA and/or PDP plan that has an overall plan performance rating of five stars and he/she is otherwise eligible to enroll in the plan, the beneficiary will have an SEP to join that plan. The SEP is from December 8 through November 30. The new coverage will become effective the first day of the following month. The beneficiary can use this SEP to enroll in a five-star plan only once during the SEP.

O. **Dual-eligible Individuals and Other LIS-Eligible Individuals:** There is an SEP for individuals who have Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program. This SEP begins the month the individual becomes dually-eligible and exists as long as he or she receives Medicaid benefits; however, there are limits in how often it can be used. This SEP allows an individual to enroll in, or disenroll from, an MA plan once per calendar quarter during the first nine months of the year. This SEP can be used once during each of first three quarters of the year. This SEP may not be used in the 4th quarter of the year. The effective date of an enrollment request made using this SEP is the first of the month following receipt of an enrollment request.

P. **Individuals who Gain, Lose, or Have a Change in their Dual or LIS-Eligible Status:** The SEP allows the individual one opportunity to make an election within three months of any of the changes noted above, or notification of such a change, whichever is later. The effective date for enrollments under this SEP is the first day of the month following receipt of the enrollment request by the plan.

Q. **Institutionalized:** If the beneficiary is institutionalized (lives in a nursing home, skilled nursing facility, etc.), he/she will have an SEP to enroll into, switch, or disenroll from an MA or PDP plan on a monthly basis. Also, if the beneficiary has moved out of the facility, he/she will have a two-month SEP to change plans. The new coverage is effective the first of the following month.

R. **Enrolling into Part B during Part B GEP:** If the beneficiary enrolled in Part B during the General Enrollment Period (GEP), but is not entitled to Part A without paying a premium, he/she will have an SEP to enroll in a PDP between April 1 and June 30. If the beneficiary enrolled in a PDP during this SEP, the plan becomes effective July 1.

S. **Non-U.S. Citizens who become Lawfully Present:** CMS will provide an SEP for non-U.S. citizens who become lawfully present in the United States. The individual may use this SEP to request enrollment in any MA plan for which he or she is eligible, including an MA-PD. This SEP begins the month the lawful presence starts and ends when the individual makes an enrollment request or two (2) full calendar months after the month it begins, whichever occurs first.

T. **SEP for Providing Individuals who Requested Materials in Accessible Formats Equal Time to Make Enrollment Decisions**: CMS will grant an SEP in situations where the organization or CMS was unable to provide required notices or information in an accessible format, as requested by an individual, within the same timeframe that it was able to provide the same information to individuals who did not request an accessible format. This limited SEP ensures that beneficiaries who have requested information in accessible formats are not disadvantaged by any additional time necessary to fulfill their request, including missing an election period deadline. The SEP begins at the end of the election period during which the beneficiary was seeking to make an election. The start and length of the SEP, as well as the effective date, are dependent upon the situation, and are at least as long as the time it took for the information to be provided to the individual in an accessible format.

u. **Individuals Affected by a FEMA-Declared Weather Related Emergency or Major Disaster:** SEP exists for individuals affected by a weather-related emergency or major disaster who were unable to, and did not make an election during another valid election period. This includes both enrollment and disenrollment elections. In addition, the SEP is available to those individuals who don't live in the affected areas but rely on help making healthcare decisions from friends or family members who live in the affected areas. The SEP is available from the start of the incident period and for four full calendar months thereafter.

v. **Significant Change in Provider Network:** An SEP exists for situations in which CMS determines that changes to an MA plan's provider network that occur outside the course of routine contract initiation and renewal cycles are considered significant based on the affect or potential to affect, current plan enrollees. CMS will establish an SEP, on a case by case basis, if it determines a network change to be significant.

w. **CMS and State-Initiated Enrollments**: Individuals who are enrolled into a plan by CMS or a State (i.e., through passive enrollment, auto-enrollment, facilitated enrollment, and reassignment) have an SEP to disenroll from their new plan or enroll into a different plan. The SEP permits a onetime election within three months of the effective date of the assignment, or notification of the assignment, whichever is later. It allows the individual to make an election before the enrollment is effective in the receiving plan or after the coverage in the receiving plan starts. This SEP must be used within three months of the start of coverage in the receiving plan. In the case where the notice is sent after the coverage in the receiving plan starts, the SEP ends three months after the date of the notice. The effective date for enrollments under this SEP is the first day of the month following receipt of the enrollment request by the plan.

Q: What can an agent do from a marketing perspective for beneficiaries affected by non-renewal?

A: When the beneficiary's Medicare Advantage Plan, Medicare Prescription Drug Plan, or Medicare Cost Plan's contract with Medicare is not renewed, the beneficiary is provided with an opportunity (SEP) to enroll in another MA plan. If the beneficiary is in a Medicare Advantage or Prescription Drug Plan that is terminating at the end of the year (December 31), the beneficiary has an SEP to enroll in a different Medicare Advantage or Prescription Drug Plan or return to Original Medicare. This SEP is from December 8 of the current year through the end of February of the next year. Note that this SEP gives the beneficiaries another chance to enroll in a Medicare Advantage or Prescription Drug plan in addition to the Annual Enrollment Period. As required by the Centers for Medicare & Medicaid Services (CMS), agents must not speak with affected members about non-renewals until after the distribution of the member notification.

During this SEP, agents may help beneficiaries enroll in a different Medicare plan. The beneficiaries may choose another Medicare Advantage plan, or they may change to Original Medicare and

choose a Medicare Prescription Drug Plan. Enrollment requests received through December 31 will have a January 1 effective date of the following year. Enrollment requests received in January will have an effective date of February 1. Enrollment requests received in February will have an effective date of March 1. Agents should confirm this SEP eligibility by asking to see the non-renewal letter that the beneficiary received from their current health plan. They should then make sure the attestation of eligibility is appropriately checked to indicate that the beneficiary's current plan is ending its contract with Medicare or that Medicare is ending its contract with the beneficiary's plan.

LATE ENROLLMENT PENALTY FOR PRESCRIPTION DRUG PLAN

Late Enrollment Penalty (LEP) for Prescription Drug Plan is an amount added to the Medicare Part D premium if at any time after the initial enrollment period, there is a period of 63 or more days in a row when the beneficiary did not have Part D or other creditable prescription drug coverage. The exception is when a beneficiary receives Extra Help. The beneficiary does not pay a late enrollment penalty in that case. Agents should be aware of this subject in order to explain the financial consequence to a beneficiary who is impacted by this penalty.

The late enrollment penalty is calculated by multiplying 1% of the "national base beneficiary premium" ($33.19 in 2019) times the number of full, uncovered months the beneficiary was eligible but didn't join a Medicare Prescription Drug plan and went without other creditable prescription drug coverage. The final amount is rounded to the nearest $0.10 and added to the monthly premium.

Example:

Mrs. Martin didn't join when she was eligible in June 2015. She doesn't have prescription drug coverage from any other source. She joined a Medicare drug plan during the Annual Enrollment Period and her coverage begins on January 1, 2019.

Since Mrs. Martin was without creditable prescription drug coverage from July 2015 through December 2018, her penalty in 2019 is 42% (1% for each of the 42 months) of $33.19, which is $13.94. The monthly penalty is rounded to the nearest $0.10, so she'll be charged $13.90 each month in addition to her plan's monthly premium in 2019.

Here's the math:

.42 (42% penalty) × $33.19 (2019 base beneficiary premium) = $13.94

$13.94 (rounded to the nearest $0.10) = $13.90

$13.90 = Mrs. Martin's monthly late enrollment penalty for 2019

PART D COVERAGE GAP

Most Medicare Prescription Drug Plans have a coverage gap (also called the "donut hole"). This means there's a temporary limit on what the drug plan will cover for drugs.

The coverage gap begins after beneficiary and his/her drug plan have spent a certain amount for covered drugs. In 2019, once the beneficiary and the plan have spent $3,820 on covered drugs (the combined amount plus the deductible; the 2019 deductible is $415), the individual is in the coverage gap. This amount may change each year. Also, people with Medicare who get Extra Help paying Part D costs would not enter the coverage gap.

Once the coverage gap is reached in 2019, the beneficiary will pay 25% of the plan's cost for covered brand-name prescription drugs. The difference of 75% (discount) includes a 70% discount paid by the brand-name drug manufacturer and a 5% discount paid by the Medicare Part D plan. The 70% paid by the drug manufacturer combined with the 25% the beneficiary paid, count toward the TrOOP or donut hole exit point. Beneficiaries who reach the coverage gap will also pay a maximum of 37% (63% discount) co-pay on generic drug cost until the beneficiary's yearly out-of- pocket drug costs reach $5,100.

After the out-of-pocket costs have reached $5,100 the individual will hit the catastrophic coverage trigger. This means that the beneficiary has paid the TrOOP or True-Out-of-Pocket amount (the amount the beneficiary paid, not a combination of what the individual and the plan paid). The prescriptions will cost the beneficiary $3.40 for generic/preferred multi-source drugs or $8.50 for other drugs.

CMS Standard Part D Benefit:

- Deductible Stage: $415
- Initial Coverage Stage: 25% of Rx costs between $415 and $3,820 = $851.25
- Coverage Gap Stage: 37% generic drug member cost share; 25% brand drug member cost share
- Catastrophic Stage: $3.40 for generic/preferred multi-source drugs or $8.50 for other drugs

Sometimes, you will see the reference: "Total covered Part D drug spending before catastrophic coverage ($7,653.75)." This amount is the total drug cost ($3,820 + $5,100) minus the beneficiary's (25% Rx cost + deductible). $5,100 + $3,820 - ($851.25 + $415) = $7,653.75

SALES AND MARKETING OF MEDICARE ADVANTAGE PRODUCTS

CMS provides oversight of insurance companies that have entered into contracts with CMS to offer private Medicare coverage. These insurance companies are contractually obligated to ensure that their marketing representatives, agents, and brokers comply with CMS marketing requirements and guidelines. The CMS Medicare Managed Care Manual (CMS Pub. No. 100-16) contains these Marketing Guidelines (refer to the CMS website at https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html for the full CMS Medicare Communications and Marketing Guidelines).

Agents are encouraged to be familiar with the CMS Medicare Communications and Marketing Guidelines (MCMG). While they are written to protect beneficiaries, they can help writing agents remain compliant with the Medicare guidelines.

LICENSE AND CERTIFICATION

CMS requires insurance companies to use only agents and sales representatives who are licensed, certified, or registered under state law to market their Medicare Advantage products. CMS expects insurance companies to follow the specific state's appointment process to inform the state insurance regulators of the agents or sales representatives they have appointed to market Medicare Advantage plans on their behalf, as well as report information regarding the termination of any agents. Each year, insurance companies must ensure that agents who sell Medicare products are trained and certified in understanding Medicare rules, regulations, and the specific Medicare product details.

Agents are required to complete the insurance companies' annual mandatory certification process for the carriers they wish to represent. It is imperative that agents complete all steps within the certification, including face-to-face meetings if required, prior to engaging in any Medicare marketing or sales activities for the respective insurance company. Each insurance company may use a different method for confirming an agent's ready-to-sell status. You need to check with the company's system for your current status or contact Ritter for further assistance.

MARKETING AND COMMUNICATIONS MATERIALS

Marketing materials include items such as television, radio, banner, print, outdoor, and Internet ads or direct mail materials. **Marketing** is defined by CMS as activities and use of materials that are conducted by the Plan/Part D sponsor (or agents acting on behalf of the Plan/Part D sponsor) with the intent to draw a beneficiary's attention to a MA plan or plans and to influence a beneficiary's decision-making process when selecting a MA plan for enrollment or deciding to stay enrolled in a plan (that is,

retention-based marketing). Additionally, marketing contains information about the plan's benefit structure, cost sharing, and measuring or ranking standards. Marketing materials exclude materials that might meet the definition of marketing based on content but do not meet the intent requirements of marketing. Also excluded are from marketing materials are certain CMS required materials. **Communications** are activities and use of materials to provide information to current and prospective enrollees.

Communication activities and materials are distinguished from marketing activities and materials based on both **intent** and **content**.

Factors for activity and material determination:

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). Additionally, marketing contains information about the plan's benefit structure, cost sharing, and measuring or ranking standards.

Content: Whether the type of information that would intend to draw attention to a plan or influence a beneficiary's enrollment decision (benefits, premium/cost sharing, comparisons to other plan(s)/Part D Sponsor(s), ranking, and Star Ratings information).

Depending on the material designation, there are specific disclaimers, formatting and other guidelines that must be followed. In addition, individual insurance company may have their own unique branding guideline that must be followed. As such, agents are not permitted to create or distribute materials containing the insurance company's logo or plan-specific information without prior consent from the insurance company. This guideline also applies to materials distributed via the social media platform. Ultimately, it is the insurance company's responsibility to seek such approval from CMS. If unapproved material is used, the agent may place the insurance company at risk of non-compliance.

Certain insurance companies are making the approved marketing materials available via their agent portal, while others may have a different approval process. You may consult with Ritter for further information regarding a specific company's policies or processes.

Q: I maintain a website for my agency and represent several Medicare Advantage carriers. Can I reference an MA plan's marketing materials and the trademarks of those companies I represent?

A: Agents may not reference any Medicare Advantage or Prescription Drug Plan marketing materials or the insurance company's trademark/service mark on their website. This is because any time a plan-specific or company-specific reference is used in connection with a Medicare health plan, such material is considered the company's marketing material, according to the CMS MCMG and

must be filed and prior approved by CMS. Making such references without the MA plan or Part D Sponsor's prior approval may place the insurance company at risk of non-compliance with CMS guidelines. If an agent wants to reference any MA plan information or the insurance company logo on their website, the agent must work with the specific insurance company to obtain their prior approval.

Q: Can an agent reference any Medicare Advantage or Prescription Drug Plan information on direct mail marketing material?

A: Agents may not reference any Medicare Advantage or Prescription Drug Plan marketing materials or the insurance company's trademark/service mark on the agent's individual direct mail marketing material. This is because any time a plan-specific reference is used in connection with a Medicare health plan, such material is considered marketing material according to the CMS Medicare Communications and Marketing Guidelines (MCMG) and must be filed and prior approved by CMS. While CMS allows brand promotion without specific product information, agents must seek prior approval before referencing the carrier's logo or name. Making such references without the MA Plan or Part D Sponsor's prior approval may place the insurance company at risk of non-compliance with CMS' Marketing Guidelines or other branding guidelines. If an agent wants to reference any MA plan information or the insurance company logo on their marketing material, the agent must work with the specific insurance company to obtain their prior approval. Alternatively, the agent may use the company's preapproved marketing materials. Note that generic direct mail marketing material without any plan or company-specific information does not require prior approval, provided all other marketing guidelines are met.

Q: Can I use the term "Medicare" on my business card or marketing material?

A: The use of the term "Medicare" is governed by Section 1140 of the Social Security Act. Under Section 1140 of the Social Security Act, 42 U.S.C. 1320b–10, it is forbidden for any person to use words or symbols including "Medicare," "Centers for Medicare & Medicaid Services," "Department of Health and Human Services," or "Health & Human Services" in a manner that would convey the false impression that the business or product mentioned is approved, endorsed, or authorized by Medicare or any other government agency. This rule extends to Plans, Part D Sponsors, and downstream contractors such as agents/brokers that may be directly or indirectly involved in marketing Medicare plans. Agents should avoid using terms such as "specialist" or "expert" following the word "Medicare" to avoid being perceived as misleading someone to think they are a representative of Medicare.

CONTACTING PROSPECTIVE CLIENTS

As a general rule, agents may not market Medicare Advantage business through unsolicited direct contact, which includes door-to-door solicitation, approaching beneficiaries in common areas, and through telephonic or electronic solicitation, like leaving voicemail messages.

An agent can only call a prospective Medicare client when permission to contact (PTC) is explicitly provided by the beneficiary. PTC is the permission that has been given by a beneficiary to allow an agent to call him/her. An agent may not call a beneficiary without obtaining PTC. Doing so will be considered an unsolicited sales call and is not permitted by CMS. A PTC is event specific and may not be treated as open- ended permission for future contacts.

Q: I received a phone call from a beneficiary for a general Medicare question six months ago, but was unsuccessful in returning the call. It is now the Annual Enrollment Period. Can I call the beneficiary to solicit MA/PDP business?

A: If you were unsuccessful in returning a beneficiary's call initially for the specific question, you may not call the beneficiary six months later to solicit MA/PDP business. A good practice is to establish a process that captures the date, time, and purpose of the contact (at a minimum) for all PTCs. In addition to the Medicare guidelines, you also need to be mindful of the Federal Do Not Call regulations. Under the Federal Do Not Call regulations, if a consumer makes an initial inquiry, the company (agent) can call for three months.

Q: Can I purchase a contact list to solicit Medicare Supplement business?

A: As long as you are following the appropriate state guidelines, there is no issue with soliciting Medicare Supplement business. Certain states such as Ohio prohibit agents from engaging in unfair or deceptive acts, which include door-to-door and unsolicited telephone contact.

You also need to check with the specific Medicare Supplement insurance company's policy regarding their marketing guidelines. In addition, it is possible that the Medicare Supplement sales discussion may lead to questions regarding Medicare Advantage products. If this should occur, we advise that you obtain a signed Scope of Appointment in order to discuss the Medicare Advantage products. In addition, you need to ensure the Federal Do Not Call guidelines are followed before making those initial Medicare Supplement calls.

Q: Can I send email to prospective clients?

A: You may initiate contact via email to prospective clients and to retain enrollment for current enrollees. You must include an opt-out process on each communication for the recipients to elect to no longer receive email. Note that text messaging and other forms of electronic direct

messaging (e.g., social media platforms) would fall under unsolicited contact and is not permitted.

PERSONAL/INDIVIDUAL MARKETING APPOINTMENTS

Individual appointments are one-on-one appointments between a sales agent and the beneficiary, regardless of venue (e.g. in home, telephonic, or library). Individual appointments are designed to steer potential enrollees toward a plan or limited number of plans. CMS considers all "individual appointments" between an agent and a beneficiary to be marketing/sales appointments regardless of the content discussed.

All individual appointments between an agent and a beneficiary are considered marketing/sales appointments regardless of the content discussed by CMS. All individual appointments, regardless of venue, must follow the Scope of Appointment guidelines discussed in next section.

Agents are required to explain the plan benefits and limitations thoroughly to the beneficiary at the marketing meeting to ensure the right plan is being selected. A compliant sales presentation includes, but is not limited to, the following:

- Obtain the Scope of Appointment Form prior to the start of the meeting
- Explain that to enroll in a Medicare Advantage plan, beneficiary must be enrolled in Medicare and continue to pay Part B premium
- Explain the Income Related Monthly Adjustment Amount (IRMAA) for Part B and Part D, if applicable
- Explain the Part B and Part D late enrollment penalty, if applicable
- Explain the public assistance program, if applicable
- Explain the enrollment period (AEP, SEP and Lock-in Period) and disenrollment process
- Describe original Medicare and Medicare Advantage
- Describe the differences between Medicare Advantage and Medicare Supplement plans
- Explain the plan's deductibles, copays, coinsurance, and out-of-pocket cost
- Verify the enrollee's primary care physician, if applicable, and how to look up a provider
- Explain in vs out-of-network, emergency and urgent care coverage?
- Explain the Part D drugs copays and deductibles
- Explain the different Part D coverage stages (deductible, initial, coverage gap, and catastrophic)
- Verify the enrollee's prescription drug list against the plan's formulary
- Explain certain prescription drugs' restrictions (prior authorization, quantity limits, step therapy)
- Explain the use of preferred pharmacists, if applicable, and how to use the pharmacy directory
- Review star ratings

SCOPE OF APPOINTMENT

A Medicare beneficiary must agree to the scope of the Medicare products that will be discussed with an agent prior to any one-on-one personal/individual marketing appointments. The Scope of Appointment can be documented by agents via a signed CMS-approved Scope of Appointment (SOA) form. The Scope of Appointment can be recorded telephonically but generally when it's administered by the Plans/Part D Sponsors or an approved delegated entity. In either case, the beneficiary agrees to the Medicare products that can be discussed (i.e., the scope) at a personal/ individual marketing appointment. Note that certain insurance companies may have unique branded Scope of Appointment forms and agents are expected to only use the branded form.

Certain insurance companies require the agent to submit the SOA along with the enrollment application while others only require the agent to submit the SOA upon request. Please check with Ritter for further information regarding a specific company's policies or processes.

Q: What is the purpose of the SOA form?

A: The SOA guidelines are established to protect a Medicare beneficiary from being sold Medicare plans/products during a one-on-one marketing appointment beyond the scope he/she agreed upon prior to the appointment.

Q: From whom must the agent obtain an SOA form?

A: Before any one-on-one personal/individual marketing appointment regardless of venue (e.g., telephonic, in home, or library), the agent must obtain an SOA form in advance from the beneficiary. The agent must use an SOA form that has been approved by CMS and obtain the signed form in advance of the appointment.

Q: When must an SOA form be obtained?

A: The SOA form must be obtained prior to the appointment.

Q: What documentation is required?

A: The documentation of an SOA must be in writing in the form of a signed agreement by the beneficiary. The SOA form must be a CMS-approved form. Generally, a CMS-approved generic SOA form is acceptable, but certain Plan/Part D Sponsors prefer agents to use their branded SOA form. Agents should check with Ritter for specific Plan/Part D Sponsors' requirements.

Scope of Appointment can be completed via hardcopy, telephonic recording, or electronically signed. However, a telephonic SOA is typically administered by a Plan Sponsor or an approved delegated entity as a specific script must be followed.

Q: What information must be collected on the SOA form?

A: It is important to complete the SOA form accurately and completely. The beneficiary or authorized representative must be the person who completes the SOA form, not the agent. The beneficiary or authorized representative must initial in the boxes provided on the SOA form and indicate the type of plan(s) they want the agent to discuss. The beneficiary or authorized representative's signature and date are required. The agent must complete all applicable boxes in the "To be completed by agent" section.

Q: Can an agent discuss other products not checked on the SOA form?

A: No. The agent is bound to only discuss the products that have been agreed upon by the beneficiary during that appointment. If another Medicare product (MA, MAPD, or PDP) needs to be discussed at the request of the beneficiary that was not previously agreed to be discussed, a second SOA form must be completed for the new product type, and then the marketing appointment may be continued.

If a beneficiary requests information on a non-health care product (e.g., annuities, life insurance, or long-term care) during a MA, MAPD, or PDP appointment, the agent must make a second appointment. The follow-up appointment CANNOT be scheduled until 48 hours after the initial appointment has occurred (cooling-off period). It is permissible to market health-care related products during a marketing activity for Medicare Advantage or Part D plans. Examples of health-care related products include supplemental insurance such as dental, prescription, and hospital indemnity.

Q: Is the SOA form good for multiple appointments?

A: No. An SOA form is good for one personal appointment only. If the appointment needs to be rescheduled, the previously signed SOA form may be used for the rescheduled appointment as long as the rescheduled appointment is conducted during the same election period and the products agreed to be discussed have not changed.

Q: If a beneficiary wants to consider his/her options after an appointment and asks an agent to return at a later time, does the agent have to complete another Scope of Appointment for the follow-up meeting?

A: No. A new Scope of Appointment is not needed as long as the follow-up meeting adheres to the agreed-upon scope.

Q: Is an SOA form required for an agent to meet with an existing client to discuss Medicare products?

A: Yes. The CMS Scope of Appointment rule does not differentiate current clients and prospective

clients. The difference between current clients and prospective clients is that you can call current clients, whereas you cannot call prospective clients unless they provide an explicit permission to contact. The SOA rule applies to both current and prospective clients.

Q: Is the SOA form required at a sales or marketing event?

A: No. Sales or marketing events are usually open to the general public at large and are not personal/individual sales appointments. The agent does not need to secure an SOA if beneficiaries wish to enroll without an additional appointment. However, if a one-on-one personal/individual marketing appointment is requested by the beneficiary and scheduled as a follow-up to a sales event, health fair, or retail sales event, an SOA form may be completed at the sales event and the follow-up appointment can take place at a later day.

Q: Is an SOA form required to be submitted with all enrollment applications?

A: Generally, yes. The agent is required to submit an SOA form for all applications that involved a personal/individual appointment. Certain carriers may only require the submission of an SOA upon request. Please refer to the carrier's specific policy.

Q: What should I do when unexpected beneficiaries showed up at a properly scheduled face-to-face appointment?

A: An SOA form is required for each beneficiary. Prior to starting the presentation, the agent will need to obtain a properly documented and signed SOA form from each unexpected beneficiary.

Q: Is an SOA form required for applications that are submitted through regular mail?

A: Yes, if the application is mailed to the Medicare beneficiary for completion after a one-on-one discussion of a plan material (i.e., telephonic presentation). An SOA form is required for any one-on-one personal/individual appointment regardless of venue.

Q: Is a documented permission to contact the same as an SOA form?

A: No. Permission to contact the beneficiary and an SOA form are two different matters. A permission to call or contact is simply permission provided by the beneficiary to be contacted. It is not a substitute for the SOA form. Similarly, a SOA form does not give the agent permission to contact the beneficiary after the sales presentation.

Q: How long do I have to keep SOA forms?

A: All documentation must be maintained for the selling year plus 10 additional years. This includes initial and second SOA forms obtained at the same appointment and any SOA form obtained

regardless of whether or not an enrollment application results from it. SOA forms must be produced upon the request of either CMS or the Plan Sponsor.

Q: Can I take an SOA at an educational event?

A: Yes. According to the latest CMS issued MCMG, you may take an SOA at an educational event.

SALES EVENTS

Marketing/sales events are designed to steer or attempt to steer potential enrollees toward a plan or limited set of plans. You may provide specific benefits, premium information, and services offered, and you may distribute/accept enrollment forms.

There are two types of marketing/sales events and both must be filed through the insurance company. CMS no longer requires insurance companies to file each event in the Health Plan Management System (HPMS). However, agents are still required to register the sales events with the insurance company. Formal marketing/sales events are typically structured in an audience/presenter style with a formal

presentation provided to attendees. On the other hand, informal marketing/sales events typically utilize a table, kiosk, or recreational vehicle. At an informal event, agents can only discuss the merits of a plan's products and answer questions when approached by Medicare beneficiaries.

Agents are expected to follow all sales and marketing guidelines set forth by CMS or the insurance company the agents represent. It is critical that you adhere to the general guidelines listed below as you will be the agent on record accountable for the event. Agents must also check with the specific insurance company's policies regarding cancellation or scheduling changes.

Dos

- Follow the specific insurance company's filing and reporting procedures prior to event or advertised date.
- Follow the specific insurance company's cancellation and schedule change procedures.
- Use only the insurance company's approved materials.
- Collect enrollment applications.

Don'ts

- Offer meals.
- Offer cash or cash-equivalent gifts.
- Use absolute or qualified superlative statements (e.g., *the best…, one of the best…).*
- Use scare tactics (i.e., *you must enroll today…).*
- Cross-sell or promote non-health-related products.
- Require a sign-in sheet (a sign-in sheet may be used but must state it is optional).
- Attract consumers or call them over to speak with them in an informal or retail sales event.

EDUCATIONAL EVENTS

Educational events are designed to inform Medicare beneficiaries about Medicare Advantage Prescription Drug or other Medicare programs such as Medicare Supplement or even Original Medicare. An educational event must not include marketing or plan-specific information of any kind. An educational event must be held in a public venue. If the event is being advertised, it must include an explicit message that states it's an educational event and no sales activities will be conducted.

Agents may not engage in any sales activities at an educational event, distribute any marketing materials, or distribute/collect Scope of Appointment forms or plan applications. Business reply cards and sign-up sheets may not be distributed or displayed.

Dos

- State the disclaimer: "*This event is only for educational purposes and no plan-specific benefits or details will be shared.*"
- Distribute educational materials free of plan-specific information.
- Distribute communication materials.
- Distribute educational health-care materials.
- Provide business cards.
- Obtain Scope of Appointment from the attendees.
- Set up future appointment.

Don'ts

- Distribute plan-specific materials or enrollment applications
- Conduct sales presentations.
- Conduct a sales event immediately after the educational event.
- Collect a beneficiary's contact information or sign-in sheets.

Q: What is the difference between a sales event and an educational event?

A: The major difference between a sales event and an educational event is the marketing aspect. Agents are not permitted to engage in any marketing or sales activities at an educational event, whereas a sales event is intended to steer or attempt to steer potential enrollees toward a plan or limited set of plans. There are other specific rules regarding these events that you should be familiar with. Refer to the Dos and Don'ts Tables above for specific information.

Q: Can I market Medicare Advantage plans from different companies at the same sales event?

A: The Medicare marketing/sales events are filed with the insurance company. If the agent intends to market Medicare products from multiple companies, it is in the best interest to file with all companies, provided that each company permits such practice within their own policy.

Q: The informal Medicare sales events I participate in are scheduled from 9 a.m. to 12 p.m. If I am running late, can I just make up the time by staying late? Also, can I send a replacement agent if I can't make the event?

A: All Medicare sales events, formal or informal, are required to be registered with the MA Plan/Part D Sponsor. The insurance company is ultimately responsible for the events since their products are being represented. Therefore, an agent should adhere to the commitment to the best of his/her ability to avoid any potential compliance issues for the agent and the sponsoring plan.

Q: Am I allow to conduct marketing activities in a provider waiting room?

A: Agents now have the opportunity to conduct marketing activities in a provider waiting room. While it is permissible to do so under the CMS MCMG, agents must obtain permission from the provider office prior to marketing in their space. Since carriers are ultimately responsible for marketing activities conducted on their behalf, agents must follow the proper procedures to notify the carriers in which they represent. Agents must not approach consumers at the provider office. Finally, agents must follow the proper guidelines to protect the consumer's personal and private information during the engagement of the marketing activities.

ENROLLMENT APPLICATION

You may proceed with an enrollment application after thoroughly explaining all plan benefits, coverage, limitations, and rules to the beneficiary and after receiving consent from them. Depending on the insurance company, the enrollment method may vary as certain insurance companies offer electronic enrollment and other electronic tools, such as an iPad application, in addition to the traditional paper enrollment application. Regardless of the enrollment method, the information you need to collect for the enrollment application is the same. For the purpose of this section, we will focus on the enrollment information aspect as opposed to enrollment method.

As your Field Marketing Organization, Ritter processes Medicare Advantage enrollment applications on behalf of certain insurance companies. In this case, you are required to submit the enrollment applications to Ritter directly in accordance with the specific company guidelines. As part of your agent onboarding process, you will be informed of how to submit enrollment applications to Ritter using specific processes.

Prior to submitting the enrollment application, you must ensure that all required information is provided on the application. At a minimum, the following information must be provided:

- Beneficiary's name as shown on their Medicare card
- Beneficiary's date of birth
- Beneficiary's permanent residence address/physical street address (PO Box is not acceptable)
- Beneficiary's contact phone number
- Medicare Beneficiary Identifier (MBI)
- Proof of Medicare Part A and/or Part B entitlement
- Requested effective date
- Plan selection
- Method of payment
- Signature(s) and date
- Your National Producer Number (NPN)
- All relevant information in the "Office Use Only Section" including the election period code and FMO Code, if applicable

Once the application is completed, you must ensure the information collected (electronic or otherwise) is properly safeguarded while in your possession or during transit to ensure compliance with the HIPAA privacy guidelines. After receiving your enrollment application, Ritter will perform a quality control review to ensure the application is completed properly. Ritter may follow up with you to request information or clarification regarding any missing or incorrect information. The upline General Agency is expected to assist Ritter in ensuring timely resolution of incomplete or pending enrollment applications when requested. The agent must promptly respond to any requested information to avoid further delay. This process is not to find flaws, but rather to make sure the beneficiaries are enrolled properly and timely.

AGENT OVERSIGHT

You are responsible for maintaining a current state insurance license and satisfying all insurance companies' ongoing and annual training certification. You are also responsible for ensuring ongoing compliance with the insurance company or Ritter's marketing and enrollment policies.

Occasionally, your on-field conducts may be monitored through the Ride-Along Program as predicated upon by the specific Field Marketing Organization Agreement. This monitoring activity may be carried out by Ritter, your upline General Agency, or directly by the insurance company. If the monitoring activity is conducted by Ritter, we will make every attempt to inform you of such monitoring activity in advance. Insurance companies may conduct such activities directly and may employ a secret shopper in an anonymous fashion. If you suspect that you are being monitored by a secret shopper, do not treat the anonymous secret shopper any differently than you would treat a potential enrollee, as the result

may be reported back to the sponsoring insurance company.

From time to time, you may be requested to respond to certain complaint or compliance inquiries either by Ritter or directly by the insurance company. You must cooperate fully with the requested information and respond promptly within the required time frame. The upline General Agencies are expected to assist in the collection of agent responses when requested. In most cases, you will be notified of the outcome along with any disciplinary or corrective actions.

AGENCY RESPONSIBILITY

Ritter is required to flow down certain First Tier, Downstream or Related Entity (FDR) compliance requirements to all downstream entities, such as Ritter's general agencies, under the Ritter Medicare contracts. For the purposes of this section, an agency is defined as any general agency with at least one downline agent within the agency's hierarchy. The agency is required to comply with the FDR compliance requirements listed below and is required to have proper procedures to demonstrate compliance. The agency will be considered meeting some of the requirements if the agency's organization does not employ any non-licensed personnel or individuals who are not actively selling the Medicare Advantage products (currently not in a ready-to-sell status with an insurance company). Such applicable requirement is individually notated within each requirement. As an agency, you may be required to acknowledge compliance or provide evidence of compliance on a regular basis by the specific insurance company or Ritter.

Code of Business Conduct (COBC) and/or Compliance Policies

Agencies must either disseminate the applicable insurance company's Code of Business Conduct or their own comparable COBC and/or Compliance Program policies to all employees within 90 days of hire, upon revision, and annually thereafter. Such information should include how to report suspected or detected non-compliance or potential fraud, waste and abuse matters. You may request employees to either report concerns directly to the applicable insurance company, to your own organization's reporting mechanisms, or to Ritter. You may refer to the Ritter's Compliance Program for additional information.

Pre-employment and monthly Employees/contractors OIG/GSA screening

Agencies must review the DHHS OIG List of Excluded Individual and Entities (LEIE List) and the GSA Excluded Parties Lists System (EPLS) to ensure their non-agent employees (non-licensed staff or licensed staff who are not appointed by any insurance carrier), management, temporary workers or subcontractors, if applicable, are not listed on these exclusion lists. These databases must be checked ***prior to hiring and during the term thereafter not less than monthly***. Agencies must retain documentation that confirms the screening as conducted. The PDF format with date/time stamp, and website used is an acceptable proof.

Note that if your supporting staff are licensed insurance agents and are appointed with the specific insurance companies your agency supports and that your agency does not have any other non-licensed staff/contractors, this requirement is met as contracted agents are required to be screened as part of the agent onboarding process.

CMS General Compliance and FWA Training

Effective January 1, 2019, CMS no longer requires FDRs to use the CMS-published training modules. However, FDRs are still required to comply with all statutes, regulations and CMS guidelines. As such, it is advisable that you continue to educate and document efforts to ensure your non-agent employees (non-licensed staff or licensed staff who are not appointed by any insurance carrier), management, temporary workers or subcontractors are aware of the statutory and regulatory guidelines. You may develop your own training material or utilize carriers' Code of Conduct or training material, if available. You may also utilize the Ritter Code of Conduct and training material published on the Ritter website. Such training must be provided within ***90-days of hiring and annually after***.

Again, if your supporting staff are licensed insurance agents and are appointed with the specific insurance companies your agency supports and that your agency does not have any other non-licensed staff/contractors, this requirement is met as contracted agents are required to be screened as part of the agent onboarding process.

Offshore Subcontractors

Agencies are prohibited to offshore any of their Medicare Advantage activities unless prior approval is obtained from the insurance companies whose Medicare functions are being offshored.