

Aetna Individual Medicare Producer Guide

2019/2020 Individual Medicare Products

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Making it easy to do business and grow with Aetna

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Welcome!

Thank you for contracting with Aetna and becoming ready to sell our Individual Medicare products.

We recognize and appreciate the valuable role that producers play in helping seniors understand their options and enroll in a plan that meets their needs. Through your dedication and commitment, you help make our success possible.

This is an exciting time to be working with Aetna, a CVS company. In 2019, we've experienced industry-leading membership growth and historic service area expansion. With your input, we're continuing to build an innovative portfolio of Medicare products and benefits that can help meet your clients' needs. And we continue to optimize our tools and processes to make our products easier to sell.

Plus, with CVS Health's recent acquisition of Aetna, the future looks extremely bright. We're very excited about the opportunities that our combined company will bring. Together, we will continue working to create a simpler, more affordable health care experience that puts consumers at the center of their care.

We encourage you to spend some time with this Producer Guide. You'll find essential information on products, enrollment, contracting, compensation, tools and more. Be sure to use the table of contents and active links to help you quickly find what you need.

In closing, THANK YOU for putting your trust in us and for your partnership. The entire Aetna Medicare team is ready to help you achieve your goals. For assistance at any time, just reach out to the Medicare Broker Services Department or your local Aetna Medicare Sales team.

Thank you for all that you do as an Aetna Medicare partner.



Armando Luna, Jr.
Vice President of Individual Medicare Sales & Distribution

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How to use this guide

You can always access the latest version of this guide on [Aetna Producer World](#).

To the extent there is any conflict between the descriptions in this guide and the terms of your contract with Aetna, the terms of the contract control.

Log on to Aetna Producer World

Appointed Aetna agents, this is your go-to site for information, tools for onboarding new agents, contracting and reports on Aetna Medicare (MA/MAPD) and SilverScript PDP products. Use it to learn about products, compensation, certification and licensing. You can order enrollment kits here and get sales and marketing materials.

Log in or register at <http://www.aetna.com/insurance-producer.html>. Click “Log In/Register” in the top navigation bar. Once logged in, click “Individual Medicare” at the top of the page to access all Individual Medicare information and materials.



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You'll regularly get information from us through email. We'll provide updates on:

- Products and benefits
- Updated marketing materials
- Compliance information
- Training opportunities and more

We send communications to the email address you gave us when you first contracted. To start receiving our communications at a new email address, or if you're not getting our communications, please update your email address via NIPR or Producer World.

It's your responsibility to make sure we have a valid email address on file.

To help ensure you receive our emails, please add our sender address MedicareBrokerNews@comms.aetna.com to your email address book or contact list.

If needed, you can always access an archive of past broker communications on [Producer World](#).

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*Market-specific training is required in addition to completing certification.

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Key terms

Take a minute to review key terms and acronyms below, which are used in this guide in addition to other key terms in your Aetna agreement.

AEP	Annual Election Period
Aetna	"Aetna" refers to all products and requirements under Aetna.
Aetna Producer World	Your website for Aetna Individual Medicare information: https://www.aetna.com/producer/Login.do
Certified	A status achieved based on completing the annual certification process training and successfully passing the related tests.
CMS	The Centers for Medicare & Medicaid Services, a federal agency within the U.S. Department of Health and Human Services (DHHS) that administers the Medicare program.
Downline agent	A person or entity whose contract connects to one or more uplines or a licensed-only agent.

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FDR	Refers to First Tier, Downstream and Related Entities as defined by CMS Managed Care Manual, Chapter 21. A First Tier Entity is any party that enters into a written arrangement acceptable to CMS, with an MA organization or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare-eligible individual under the MA program or Part D program. Downstream Entity written arrangements continue down to the level of the ultimate provider of both health and administrative services. A Related Entity means any entity that is related to an MA organization or Part D sponsor by common ownership or control and performs some of the MA organization or Part D plan sponsor management functions under contract or delegation, furnishes services to Medicare enrollees under oral or written agreement, leases real property or sells materials to the MA organization or Part D plan sponsor at a cost of more than \$2,500 during a contract period.
Telebroker	These agents/brokers perform marketing activities for Medicare Products and/or engage in telephonic enrollment application services on behalf of Aetna as Medicare Distribution Telebrokers. In every case, per the terms of their Aetna Marketing Agreement ("Agreement"), they must be confirmed by Aetna as Ready to Sell (RTS) prior to marketing Aetna Medicare products, and comply with all CMS regulatory and Aetna requirements in accordance with the terms of the Agreement. Additionally, on an annual basis, Telebrokers are required to complete Aetna's National Telebroker product training.
Licensed-only agent or LOA	Any licensed insurance agent who is either employed by or under exclusive contract with an upline to sell or refer insurance products for the upline.
MA/MAPD	Medicare Advantage/Medicare Advantage and Prescription Drug
Medicare Communications and Marketing Guidelines (MCMG)	Medicare Communications and Marketing Guidelines contains CMS' marketing requirements and related provisions for Medicare Advantage Plans (MA), Medicare Advantage Prescription Drug Plans (MAPD), Medicare Prescription Drug Plans (PDP), Employer/Union-Sponsored Group Health Plans, Medicare-Medicaid Plans (MMP) and Section 1876 Cost Plans. http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html
Payee	Someone who receives a commission on behalf of the writing agent. (Both the writing agent and the payee need to be certified, licensed and appointed in the state of sale.)

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PDP	Medicare Part D, a stand-alone prescription drug plan.
Ready to sell (RTS)	When an upline, principal or agent, as applicable, has completed and maintains compliance with all Aetna, CMS and applicable state law requirements for selling specified in the Producer Guide and has received a written confirmation from Aetna specifying that the upline, principal or agent, as applicable, has completed all such requirements and may commence selling a particular Medicare product in a particular state.
Renewal	Means a sale to a Medicare beneficiary, when the Medicare beneficiary was enrolled in any like plan offered by Aetna or its affiliates in the month immediately preceding the Medicare product's effective date.
Telemarketing	Refers to calls that offer, market or promote products or services to consumers or that have a telemarketing purpose. If a call is made to induce the purchase of goods or services, then or in the future, it is a telemarketing call. As a general rule, calls that are not purely informational in purpose and message constitute telemarketing. Per FCC regulations, "Telemarketing" refers to both telemarketing and advertisements. (Note: State telemarketing rules may be more restrictive than the TCPA and must be addressed and appropriate solutions implemented.)
Telephone Consumer Protection Act (TCPA)	A federal consumer privacy statute enacted in 1991. It regulates and restricts the use of automated technology to call mobile phones. The statute applies to outbound telephone calls, including voice messages, prerecorded or artificial voices, SMS text messages and faxes (i.e., telemarketing).
Termination without cause	This Agreement may be terminated for any reason or no reason, at any time, by either party, upon written notice to the other party, which notice shall be provided no later than 30 days prior to the termination date. Any termination effected under this Section 8.2 shall be deemed a termination without cause.
Unlike plan	Means an "unlike plan type" as described by CMS in the applicable MCMG.
Upline	A firm, agency, organization or person with downline agents.
We (and other first-person pronouns)	Your team at Aetna. It includes the departments that support Aetna Medicare products. We'll also use other pronouns here, like "our" and "us."
You (and other second-person pronouns)	You, the reader. We'll note if a topic is specific to upline partners, writing agents or downline agents only. Sometimes we'll use other pronouns, like "your."

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Our core values

Everything we do at Aetna starts with our values — a clear, strongly held set of core beliefs that reflect who we are and what you can expect from us. We created our core values together, with guidance from our customers. Our values carry through our thoughts and actions every day, inspire innovation in our products and services, and drive our commitment to excellence in all we do.

Simplicity

To us, a better health care system starts with a simpler process, one that lets you see behind the scenes — to find out what a procedure costs before you get it, for example.

Focus

A better health care system is about more than saving money, of course. It's about keeping you healthy. We're working with doctors, hospitals and health networks to align the economic incentives so everyone's focus stays on your health.

Connection

Finally, we think a better system is one that is connected. The right technology connects you and your health care team seamlessly. And it puts valuable information where it needs to be so you get the right care at the right time.



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The Aetna Individual Medicare product portfolio is stronger than ever

We offer an Individual Medicare product portfolio that includes Medicare Advantage (MA), Medicare Advantage Prescription Drug (MAPD), stand-alone SilverScript Prescription Drug Plans (PDP), Medicare Supplement and Ancillary products to meet the varied needs of your clients. Our Individual Medicare products reach 54 million Medicare beneficiaries across the United States.

- MA/MAPD plans available in 45 states + D.C. and 1,681 counties
- Stand-alone SilverScript PDP products are available to market and sell nationally
- Medicare Dual Eligible Special Needs Plans (D-SNP):
 - A Medicare Dual Eligible Special Needs Plan (D-SNP) is for beneficiaries who are eligible for both Medicare and Medicaid. Dual-eligible members qualify for Special Election Periods (SEP) and they switch plans once a quarter for each of the first three quarters of the year. Aetna Medicare D-SNPs are only available in certain markets

Individual Medicare Dual Eligible Special Needs Plans (D-SNP)

- Combine the benefits of Medicare Parts A, B and D
- Provides supplemental benefits that include, but are not limited to, hearing, dental, vision, transportation, SilverSneakers,[®] and over-the-counter (OTC) benefits
- Includes care management for all D-SNP members
- Aetna offers Special Needs Plans: AL, FL, GA, IA, KS, LA, MO, NC, NE, OH, PA, TX, VA*, WV

*NOTE: VA D-SNP plans are non-commissionable.

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*Not all products are available in every state.

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D-SNP eligibility:

- The Dual Eligible Special Needs Plans (D-SNP) program is available to eligible members:
 - Meeting dual-eligibility status requirements (state-specific)
 - Residing within the program's service area
- Dual-eligibility qualification is determined by the member's enrollment in:
 - A federally administered Medicare program
 - The state-administered Medicaid program based on low income, assets and age or disability status

CMS Managed Care Manual Chapter 16-B guidance specifies the following:

40.2.2 — Verification of Eligibility for D-SNPs

(Rev. 123, Issued: 08-19-16, Effective: 08-19-16, Implementation: 08-19-16)

A D-SNP must confirm an individual's Medicare and Medicaid eligibility prior to enrollment into the D-SNP. Acceptable proof of Medicaid eligibility may include, for example: a current Medicaid card; a letter from the state agency that confirms entitlement to Medical Assistance; or verification through a systems query to a state eligibility data system. Additional enrollment guidance is located in the Medicare Advantage Enrollment and Disenrollment Guidance.

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Medicare Advantage/Medicare Advantage Prescription Drug Plans

- HMO and PPO plans
- Medicare Joint Venture products
 - Medicare Advantage market expansion into Minnesota to offer Allina Health | Aetna Medicare Advantage PPO products (select Minnesota counties)
 - Allina Health | Aetna Medicare Advantage is the result of a partnership between Aetna and Allina Health, two nationally recognized leaders in health care
 - Innovation Health Medicare Advantage HMO and PPO available in select Northern Virginia counties

Marketing of any Joint Venture product and its Medicare Advantage plans, and any marketing of Aetna and its Medicare Advantage plans, must be done separately.

(Separate Scope of Appointment required; review Marketing Do's and Don'ts in section "Compliance and Agent Oversight.")

We offer the "Explorer" travel benefit in select counties in 18 states + DC.* This feature will be geared toward mobile members who may need to obtain preventive or urgent care outside their plan service area, and within Aetna's multistate provider and pharmacy network. In addition, these members will also have customized member service support, access to travel discounts and a travel pass — a helpful summary of their medical and pharmacy information.

We offer the Travel Advantage program to some Individual Medicare Advantage HMO plan members. It's not available to California (CA) members, members enrolled in our Medicare Program Prime Plan or Medicare Joint Venture products.

- Medicare Advantage non-Open Access HMO members (whose plans need referrals and PCP choices) have to change their PCP to another PCP in the service area they're visiting. The new PCP renders primary care services and refers members to other providers in the service area they're visiting

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*Not all products are available in every state.

Please contact your Aetna representative for assistance or questions regarding the use of Aetna brands.

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	<ul style="list-style-type: none">• Medicare Advantage Open Access HMO members don't choose PCPs. When enrolled in Travel Advantage, members can continue using any Aetna Medicare Advantage HMO provider without a referral <p><small>*The Explorer PPO plan will be offered in 29 states total. Specific plans offering Explorer option will be identified in the Summary of Benefits and Plan Guides only on contract H5521.</small></p>
	<p>SilverScript Part D</p> <p>2 stand-alone Prescription Drug Plans</p> <ul style="list-style-type: none">• SilverScript Choice (PDP)• SilverScript Plus (PDP)

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*FL and NY only as of 7/28/17; commission eligibility varies.

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Please note that this Producer Guide only provides information related to MA/MAPD and PDP products.

There is a separate appointment and contracting process to sell these Medicare Supplement and Ancillary products. For information about our Medicare Supplement and Ancillary products, please contact our Medicare Supplement Agent Services team at (800) 264-4000, Option 3, and then Prompt 1. Or by email: AetSSIInformation@aetna.com.

Click [here](#) to access the new Medicare Supplement and Ancillary products Producer Guide.

Individual Medicare Supplement and Ancillary products are available in most states. For product availability, please click [here](#).



Aetna Health and Life Insurance Company (AHLIC)

Aetna Life Insurance Company (ALIC)*

American Continental Insurance Company (ACI)

Continental Life Insurance Company of Brentwood, Tennessee (CLI)

Aetna Health Insurance Company (AHIC)

Senior Supplemental Insurance

- Offered through AHLIC, ALIC,* ACI, AHIC and CLI

We also have two exchange products on FHL and CHL paper.

Ancillary products

- Dental, Vision and Hearing from CLI
- Hospital Indemnity Flex from CLI
- Cancer and Heart Attack or Stroke from CLI and ALIC*
- Home Care from CLI
- Nursing Facility Care from CLI
- Recovery Care from CLI
- Final Expense insurance from ACI and CLI

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Aetna continues to offer high-quality Managed Care Plans!

- Once again, Aetna's MAPD plans earned an overall weighted average rating of 4.0 out of 5.0 stars
- 79% of Aetna's Medicare members are enrolled in plans rated 4.0 stars or higher
- Our 2019 Star Ratings for MAPD plans reflect Aetna's commitment to improving member health and experience
- Aetna improved or maintained year-over-year performance on 73% of the Star Rating measures
- Aetna will expand into 358 new counties for 2019, offering Individual Medicare plans with 2019 Star Ratings in a total of 1,311* counties across the country; this includes expansion into Idaho, Rhode Island, New Hampshire, New Mexico, Oregon and Minnesota. Of these counties, 1,103 — or 84 percent — will have a plan offering rated 4.0 stars or greater

*Aetna offers products in 1,311 counties where its Medicare contract is large enough to receive a Star Rating. Overall, Aetna has MAPD plans in 1,416 counties.



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*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. See www.medicare.gov for individual plan ratings.

**Includes publicly traded companies with over 250,000 Medicare Advantage enrollees.

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For more information about our 2019 product offerings,* see our 2019 First Look on [Aetna Producer World](#)

MA/MAPD markets

Arizona (AZ)

California (CA)

Capitol (DC, MD, VA)

Innovation Health Medicare Advantage HMO and PPO (in select northern Virginia counties)

Florida (FL)

Georgia/Gulf States (AL, GA, LA, MS)

Great Lakes (IL-North, IN, MI, WI)

Heartland (AR, IL-South, KS, MO)

Keystone (DE, PA, WV)

Mid South (NC, SC, TN)

Midlands (CO, IA, NE, SD)

Minnesota (MN)

Allina Health | Aetna Medicare Advantage PPO (in select Minnesota counties)

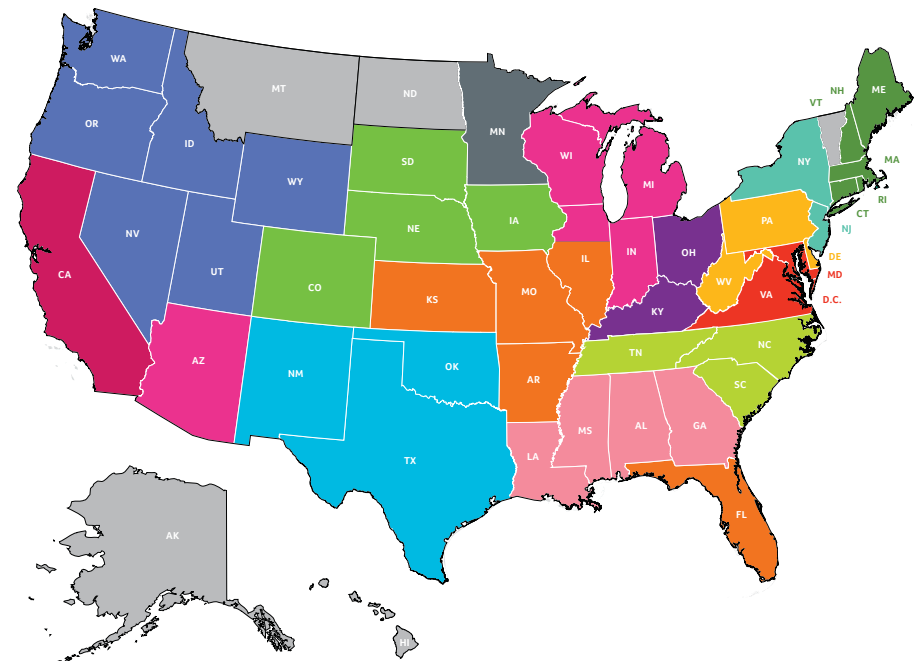
New England (CT, MA, ME, NH, RI)

New York/New Jersey (NJ, NY)

Northwest/Mountain (ID, NV, OR, UT, WA, WY)

Ohio/Kentucky (KY, OH)

South Central (NM, OK, TX)



MA/MAPD plans available in 45 states + D.C.

2 Stand-alone SilverScript PDP products:
Choice (PDP) available in each of the 34 regions covering all 50 states and DC, and
Plus (PDP) available in 33 regions - 49 states and DC.

*Not all products are available in every state.

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2020 market name/market territory

Market name	Market territory
Arizona	AZ
California	CA
Capitol	DC, MD, VA
Florida	FL
Georgia/Gulf States	AL, GA, LA, MS
Great Lakes	IL-North, IN, MI, WI
Heartland	AR, IL-South, KS, MO
Keystone	DE, PA, WV
Mid South	NC, SC, TN
Midlands	IA, NE, SD
Minnesota	MN
New England	CT, MA, ME, NH, RI
New York/ New Jersey	NJ, NY
Northwest/ Mountain	AK, ID, NV, OR, UT, WA, WY
Ohio/Kentucky	KY, OH
South Central	NM, OK, TX

2019 market name/market territory

Market name	Market territory
Arizona/Nevada	AZ, NV
California	CA
Capitol	DC, MD, VA
Deep South	AL, GA, LA, MS
Florida	FL
Great Lakes	IL-North, IN, MI, MN, WI
Heartland	AR, KS, MO-West, OK
Keystone	DE, PA, WV
Mid South	NC, SC, TN
Midlands	IA, NE, ND, SD
New England	CT, MA, ME, NH, RI, VT
New Jersey	NJ
New Mexico/Texas	NM, TX
New York	NY
North Mountain	CO, MT, UT, WY
Northwest	AK, ID, OR, WA
Ohio/Kentucky	OH, KY
St. Louis (Show Me)	IL-Central/South, MO-East

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Arizona

Arizona

Cochise

Coconino

Gila

Graham

Maricopa

Mohave

Pima

Pinal

Santa Cruz

Yavapai

Yuma

California

California

Alameda

Fresno

Kern

Los Angeles

Orange

Riverside

San Bernardino

San Diego

San Francisco

Santa Clara

Capitol D.C.

District of Columbia

Maryland

Frederick

Howard

Montgomery

Prince George's

Virginia

Accomack

Albemarle

Alexandria City

Alleghany

Amelia

Amherst

Appomattox

Arlington

Augusta

Bath

Bedford

Bland

Botetourt

Bristol City

Brunswick

Buchanan

Buckingham

Buena Vista City

Cambell

Caroline

Carroll

Charles City

Charlotte

Charlottesville City

Chesapeake City

Chesterfield

Clarke

Colonial Heights City

Covington City

Craig

Culpeper

Cumberland

Danville City

Dickenson

Dinwiddie

Emporia City

Essex

Fairfax

Fairfax City

Falls Church City

Fauquier

Floyd

Fluvanna

Franklin

Franklin City

Frederick

Fredericksburg City

Galax City

Giles

Gloucester

Goochland

Grayson

Greene

Greensville

Halifax

Hampton City

Hanover

Harrisonburg City

Henrico

Henry

Highland

Hopewell City

Isle of Wight

James City

King and Queen

King George

King William

Lancaster

Lee

Lexington City

Loudoun

Louisa

Lunenburg

Lynchburg City

Madison

Manassas City

Manassas Park City

Martinsville City

Mathews

Mecklenburg

Middlesex

Montgomery

Nelson

New Kent

Newport News City

Norfolk City

Northampton

Northumberland

Norton City

Nottoway

Orange

Page

Patrick

Petersburg City

Pittsylvania

Poquoson City

Portsmouth City

Powhatan

Prince Edward

Prince George

Prince William

Pulaski

Radford City

Rappahannock

Richmond

Richmond City

Roanoke

Roanoke City

Rockbridge

Rockingham

Russell

Salem City

Scott

Shenandoah

Smyth

Southampton

Spotsylvania

Stafford

Staunton City

Suffolk City

Surry

Sussex

Tazewell

Virginia Beach City

Warren

Washington

Waynesboro City

Westmoreland

Williamsburg City

Winchester City

Wise

Wythe

York

Florida

Florida

Baker

Broward

Charlotte

Citrus

Clay

Collier

DeSoto

Duval

Escambia

Hernando

Highlands

Hillsborough

Indian River

Lake

Lee

Levy

Manatee

Marion

Martin

Miami-Dade

Nassau

Orange

Osceola

Palm Beach

Pasco

Pinellas

Polk

Santa Rosa

Sarasota

Seminole

St. Johns

St. Lucie

Sumter

Georgia/Gulf States

Alabama

Autauga

Barbour

Bibb

Blount

Bullock

Calhoun

Chambers

Cherokee

Chilton

Clay

Coffee

Colbert

Coosa

Covington

Cullman

Dale

Dallas

DeKalb

Escambia

Etowah

Fayette

Franklin

Geneva

Henry

Houston

Jackson

Jefferson

Lamar

Lauderdale

Lawrence

Limestone

Lowndes

Macon

Madison

Marion

Mobile

Monroe

Montgomery

Morgan

Pickens

Randolph

Russell

Shelby

St. Clair

Talladega

Tuscaloosa

Walker

Washington

Winston

Georgia

Appling

Baker

Baldwin

Banks

Barrow

Bartow

Bibb

Bryan

Burke

Butts

Camden

Catoosa

Chatham

Chattahoochee

Chattooga

Cherokee

Clarke

Clay

Clayton

Cobb

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- Senior Supplemental Insurance
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MA/MAPD availability by local market, state and county (continued)

Franklin
Fulton
Gilmer
Glynn
Greene
Gwinnett
Habersham
Hall
Hancock
Haralson
Harris
Hart
Heard
Henry
Houston
Irwin
Jackson
Jasper
Jefferson
Johnson
Jones
Lamar
Laurens
Lee
Liberty
Lincoln
Macon
Madison
Marion
McDuffie
McIntosh
Meriwether
Monroe
Morgan
Murray
Muscogee
Newton
Oconee
Oglethorpe
Paulding
Peach
Pickens
Pierce
Pike
Polk
Quitman
Randolph
Richmond
Rockdale
Schley

Screven
Spalding
Stephens
Stewart
Sumter
Tattnall
Taylor
Terrell
Tift
Toombs
Towns
Treutlen
Troup
Turner
Twiggs
Union
Upson
Walton
Ware
Warren
Washington
Wayne
White
Worth

Louisiana
Acadia
Ascension
Assumption
Avoyelles
Beauregard
Bienville
Bossier
Caddo
Calcasieu
Claiborne
De Soto
East Baton Rouge
East Feliciana
Evangeline
Franklin
Iberia
Iberville
Jefferson
Lafayette
Lafourche
Lincoln
Livingston
Morehouse
Natchitoches

Orleans
Ouachita
Rapides
Sabine
St. Bernard
St. Charles
St. James
St. John the Baptist
St. Landry
St. Martin
St. Mary
St. Tammany
Tangipahoa
Terrebonne
Union
Vermilion
Vernon
Washington
Webster
West Baton Rouge
Winn

Mississippi
Benton
DeSoto
Forrest
George
Hancock
Itawamba
Jones
Marshall
Panola
Pearl River
Stone
Tate
Tishomingo

Great Lakes
Illinois
Boone
Bureau
Carroll
Cook
DeKalb
DuPage
Hancock
Henderson
Henry
Jo Daviess
Kane

Kankakee
Kendall
Lake
Lee
McHenry
Mercer
Ogle
Rock Island
Stephenson
Warren
Whiteside
Will
Winnebago

Indiana
Adams
Allen
Boone
Brown
Clay
Clinton
Daviss
DeKalb
Delaware
Elkhart
Grant
Hamilton
Hancock
Hendricks
Howard
Huntington
Jackson
Jasper
Jennings
Johnson
Knox
Kosciusko
Lake
LaPorte
Lawrence
Madison
Marion
Marshall
Montgomery
Morgan
Porter
Posey
Putnam
Shelby
St. Joseph

Starke
Tippecanoe
Vanderburgh
Vigo
Warrick
Wayne
Wells
Whitley

Michigan
Allegan
Antrim
Bay
Benzie
Calhoun
Charlevoix
Clare
Crawford
Genesee
Gladwin
Grand Traverse
Jackson
Kalamazoo
Kalkaska
Kent
Leelanau
Livingston
Macomb
Manistee
Midland
Missaukee
Monroe
Montcalm
Muskegon
Oakland
Otsego
Ottawa
Saginaw
St. Clair
Washtenaw
Wayne
Wexford

Wisconsin
Brown
Green
Kenosha
Manitowoc
Milwaukee
Outagamie

Ozaukee
Racine
Rock
Sheboygan
Walworth
Washington
Waukesha
Winnebago

Heartland
Arkansas
Benton
Boone
Carroll
Cleburne
Conway
Crawford
Faulkner
Franklin
Garland
Johnson
Logan
Madison
Marion
Montgomery
Newton
Perry
Polk
Pope
Pulaski
Saline
Scott
Searcy
Sebastian
Stone
Van Buren
Washington
Yell

Colorado
Adams
Arapahoe
Boulder
Broomfield
Denver
Douglas
Elbert
El Paso
Fremont
Jefferson

Bold = 2020 expansion counties.

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National footprint — Your opportunities

Our brands

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MA/MAPD availability by local market, state and county (continued)

Larimer
Mesa
Teller
Weld

Illinois

Adams
Alexander
Bond
Brown
Calhoun
Cass
Champaign
Christian
Clark
Clinton
Crawford
Cumberland
DeWitt
Douglas
Edgar
Effingham
Fayette
Ford

Franklin
Fulton
Greene
Iroquois
Jackson
Jasper
Jersey
Johnson
LaSalle
Livingston
Logan
Macon
Macoupin
Madison
Marshall
Mason
McDonough
McLean
Menard
Monroe
Montgomery
Morgan
Moultrie
Peoria
Perry
Piatt

Pike
Putnam
Randolph
Richland
Sangamon
Schuyler
Scott
Shelby
St. Clair
Stark
Tazewell
Union
Vermilion
Washington
Woodford

Kansas

Allen
Anderson
Atchison
Bourbon
Butler
Chase
Chautauqua
Cherokee
Coffey
Cowley
Crawford
Doniphan
Douglas
Elk
Franklin
Greenwood
Harper
Harvey
Jackson
Jefferson
Johnson
Kingman
Labette
Leavenworth
Linn
Lyon
Miami
Montgomery
Neosho
Osage
Pottawatomie
Sedgwick
Shawnee

Sumner
Wabaunsee
Wilson
Woodson
Wyandotte

Missouri

Adair
Andrew
Atchison
Audrain
Barry
Barton
Bates
Benton
Bollinger
Boone
Buchanan
Caldwell
Callaway
Camden
Cape Girardeau
Carroll
Cass
Cedar
Chariton
Christian
Clay
Clinton
Cole
Cooper
Crawford
Dade
Dallas
Daviess
DeKalb
Dent
Douglas
Franklin
Gasconade
Gentry
Greene
Grundy
Harrison
Henry
Hickory
Holt
Howard
Howell
Iron

Jackson
Jasper
Jefferson
Johnson
Knox
Laclede
Lafayette
Lawrence
Lewis
Lincoln
Linn
Livingston
Macon
Madison
Maries
Marion
McDonald
Mercer
Miller
Moniteau
Monroe
Montgomery
Morgan
Newton
Nodaway
Osage
Ozark
Perry
Pettis
Phelps
Pike
Platte
Polk
Pulaski
Ralls
Randolph
Ray
Saline
Scott
Shelby
St. Charles
St. Clair
St. Francois
St. Louis
St. Louis City
Ste. Genevieve
Stoddard
Stone
Taney
Texas

Vernon
Warren
Washington
Webster
Worth
Wright

Keystone Delaware

Kent
Newcastle
Sussex

Pennsylvania

Adams
Allegheny
Armstrong
Beaver
Bedford
Berks
Blair
Bradford
Bucks
Butler
Cambria
Cameron
Carbon
Centre
Chester
Clarion
Clearfield
Clinton
Columbia
Crawford
Cumberland
Dauphin
Delaware
Elk
Erie
Fayette
Forest
Franklin
Fulton
Greene
Huntingdon
Indiana
Jefferson
Juniata
Lackawanna
Lancaster

Lawrence
Lebanon
Lehigh
Luzerne
Lycoming
McKean
Mercer
Mifflin
Monroe
Montgomery
Montour
Northampton
Northumberland
Perry
Philadelphia
Pike
Potter
Schuylkill
Snyder
Somerset
Sullivan
Susquehanna
Tioga
Union
Venango
Warren
Washington
Wayne
Westmoreland
Wyoming
York

West Virginia

Barbour
Berkeley
Boone
Braxton
Brooke
Cabell
Calhoun
Clay
Doddridge
Fayette
Gilmer
Grant
Greenbrier
Hampshire
Hancock
Hardy
Harrison

Bold = 2020 expansion counties.

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MA/MAPD availability by local market, state and county (continued)

Jackson
Jefferson
Kanawha
Lewis
Lincoln
Logan
Marion
Marshall
Mason
McDowell
Mercer
Mineral
Mingo
Monongalia
Monroe
Morgan
Nicholas
Ohio
Pendleton
Pleasants
Pocahontas
Preston
Putnam
Raleigh
Randolph
Ritchie
Roane
Summers
Taylor
Tucker
Tyler
Upshur
Wayne
Webster
Wetzel
Wirt
Wood
Wyoming

Mid South North Carolina

Alamance
Alexander
Alleghany
Anson
Ashe
Avery
Bladen
Brunswick
Buncombe

Burke
Cabarrus
Caldwell
Caswell
Catawba
Chatham
Cherokee
Clay
Cleveland
Columbus
Cumberland
Davidson
Davie
Duplin
Durham
Edgecombe

Forsyth
Franklin
Gaston
Graham
Granville
Greene
Guilford
Halifax
Harnett
Haywood
Henderson
Hoke
Iredell
Jackson
Johnston
Lee
Lincoln
Macon
Madison
McDowell
Mecklenburg
Mitchell
Nash

Northampton
Orange
Pender
Person
Pitt
Polk
Randolph
Robeson
Rockingham
Rowan
Rutherford

Sampson
Scotland
Stanly
Stokes
Surry
Swain
Transylvania
Union
Vance
Wake
Warren
Wayne
Wilkes
Wilson
Yadkin
Yancey

South Carolina

Abbeville
Aiken
Allendale
Anderson
Bamberg
Barnwell
Beaufort
Berkeley
Calhoun
Charleston
Cherokee
Chester
Chesterfield
Clarendon
Colleton
Darlington
Dillon
Dorchester
Edgefield
Fairfield
Florence
Georgetown
Greenville
Greenwood
Hampton
Horry
Jasper
Kershaw
Lancaster
Laurens
Lee
Lexington

Marion
Marlboro
McCormick
Newberry
Oconee
Orangeburg
Pickens
Richland
Saluda
Spartanburg
Sumter
Union
Williamsburg
York

Tennessee

Bedford
Bledsoe
Bradley
Cannon
Cheatham
Cumberland
Davidson
DeKalb
Dickson
Fayette
Fentress
Franklin
Giles
Hamilton
Hardeman
Hickman
Jackson
Lawrence
Lincoln
Macon
Marion
Marshall
Maury
Meigs
Overton
Polk
Putnam
Rhea
Robertson
Rutherford
Sequatchie
Shelby
Smith
Sumner

Tipton
Trousdale
Warren
Wayne
White
Williamson
Wilson

Midlands Iowa

Adair
Allamakee
Appanoose
Benton
Black Hawk
Boone
Bremer
Buchanan
Buena Vista
Butler
Calhoun
Carroll
Cass
Cedar
Cherokee
Clay
Clayton
Clinton
Crawford
Dallas
Decatur
Delaware
Dickinson
Fayette
Fremont
Greene
Grundy
Guthrie
Hamilton
Hardin
Harrison
Henry
Howard
Ida
Iowa
Jackson
Jasper
Jefferson
Johnson
Jones

Keokuk
Linn
Louisa
Lucas
Lyon
Madison
Mahaska
Marion
Marshall
Mills
Monona
Monroe
Montgomery
Muscatine
O'Brien
Osceola
Page
Plymouth
Pocahontas
Polk
Pottawattamie
Poweshiek
Ringgold
Scott
Shelby
Sioux
Story
Tama
Union
Wapello
Warren
Washington
Wayne
Webster
Winneshiak
Woodbury
Wright

Nebraska

Adams
Buffalo
Burt
Butler
Cass
Clay
Colfax
Cuming
Custer
Dakota
Dixon

Bold = 2020 expansion counties.

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Dodge
Douglas
Fillmore
Franklin
Furnas
Gage
Greeley
Hall
Harlan
Holt
Howard
Jefferson
Johnson
Kearney
Knox
Lancaster
Madison
Nance
Nemaha
Otoe
Pawnee
Platte
Sarpy
Saunders
Seward
Thayer
Valley
Washington
Wayne
York

South Dakota

Aurora
Bon Homme
Brookings
Clay
Hutchinson
Lake
Lincoln
McCook
Minnehaha
Moody
Sanborn
Turner
Union
Yankton

Minnesota

Anoka

Brown
Carver
Chisago
Dakota
Hennepin
Isanti
Nicollet
Ramsey
Scott
Washington
Wright

New England Connecticut

Fairfield
Hartford
Litchfield
Middlesex
New Haven
New London
Tolland
Windham

Maine

Androscoggin
Aroostook
Cumberland
Franklin
Hancock
Kennebec
Knox
Lincoln
Oxford
Penobscot
Piscataquis
Sagadahoc
Somerset
Waldo
Washington
York

Massachusetts

Bristol
Essex
Hampden
Hampshire
Middlesex
Norfolk
Plymouth
Suffolk
Worcester

New Hampshire

Belknap
Carroll
Grafton
Hillsborough
Merrimack
Rockingham
Strafford
Sullivan

Rhode Island

Bristol
Kent
Newport
Providence
Washington

New York/New Jersey New Jersey

Atlantic
Bergen
Burlington
Camden
Cape May
Cumberland
Essex
Gloucester
Hudson
Hunterdon
Mercer
Middlesex
Monmouth
Morris
Ocean
Passaic
Salem
Somerset
Sussex
Union
Warren

New York

Albany
Allegany
Bronx
Broome
Cattaraugus
Cayuga
Chemung

Chenango
Clinton
Columbia
Cortland
Delaware
Dutchess
Erie
Essex
Franklin
Genesee
Greene
Hamilton
Herkimer
Jefferson
Kings
Lewis
Livingston
Madison
Monroe
Montgomery
Nassau
New York
Niagara
Oneida
Onondaga
Ontario
Orange
Orleans
Oswego
Putnam
Queens
Rensselaer
Richmond
Rockland
Saratoga
Schenectady
Schoharie
Schuyler
Seneca
St. Lawrence
Steuben
Suffolk
Sullivan
Tioga
Tompkins
Ulster
Washington
Wayne
Westchester
Wyoming

Yates

Northwest/ Mountain Idaho

Ada
Canyon
Elmore
Gem
Kootenai
Owyhee
Payette
Washington

Nevada

Carson City
Churchill
Clark
Douglas
Nye
Storey
Washoe

Oregon

Clackamas
Jackson
Josephine
Multnomah
Washington
Yamhill

Utah

Box Elder
Cache
Carbon
Daggett
Davis
Duchesne
Iron
Juab
Morgan
Rich
Salt Lake
Summit
Tooele
Uintah
Utah
Wasatch
Washington
Weber

Washington

Clark
King
Kitsap
Mason
Pierce
Skagit
Snohomish
Spokane
Thurston

Wyoming

Uinta

Ohio/Kentucky Kentucky

Anderson
Barren
Boone
Bourbon
Boyd
Bracken
Breckinridge
Bullitt
Butler
Campbell
Carroll
Carter
Christian
Clark
Edmonson
Fayette
Floyd
Franklin
Gallatin
Grant
Grayson
Greenup
Hancock
Hardin
Harrison
Hart
Henderson
Henry
Hopkins
Jefferson
Jessamine
Kenton
Knott
LaRue

Bold = 2020 expansion counties.

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Letcher
Lewis
Logan
Madison
Martin
Mason
McCracken
Meade
Montgomery
Nelson
Nicholas
Ohio
Oldham
Pendleton
Pike
Pulaski
Robertson
Rowan
Russell
Scott
Shelby
Spencer
Taylor
Trimble
Warren
Wayne
Woodford

Ohio
Adams
Allen
Ashland
Ashtabula
Athens
Auglaize
Belmont
Brown
Butler
Carroll
Champaign
Clark
Clermont
Clinton
Columbiana
Coshocton
Crawford
Cuyahoga
Darke
Defiance
Delaware

Erie
Fairfield
Fayette
Franklin
Fulton
Gallia
Geauga
Greene
Guernsey
Hamilton
Hancock
Hardin
Harrison
Henry
Highland
Hocking
Holmes
Huron
Jackson
Jefferson
Knox
Lake
Lawrence
Licking
Logan
Lorain
Lucas
Madison
Mahoning
Marion
Medina
Meigs
Mercer
Miami
Monroe
Montgomery
Morgan
Morrow
Muskingum
Noble
Ottawa
Paulding
Perry
Pickaway
Pike
Portage
Preble
Putnam
Richland
Ross

Sandusky
Scioto
Seneca
Shelby
Stark
Summit
Trumbull
Tuscarawas
Union
Van Wert
Vinton
Warren
Washington
Wayne
Williams
Wood
Wyandot

South Central New Mexico

Otero
Rio Arriba
San Miguel
Sandoval
Santa Fe
Valencia

Oklahoma

Adair
Atoka
Blaine
Bryan
Caddo
Canadian
Carter
Cherokee
Cleveland
Coal
Cotton
Craig
Creek
Custer
Delaware
Garfield
Garvin
Grady
Grant
Haskell
Hughes

Jefferson
Johnston
Kay
Kingfisher
Latimer
Le Flore
Lincoln
Logan
Love
Major
Marshall
Mayes
McClain
McIntosh
Murray
Muskogee
Noble
Nowata
Okfuskee
Oklahoma
Okmulgee
Osage
Ottawa
Pawnee
Pittsburg
Pontotoc
Pottawatomie
Pushmataha
Rogers
Seminole
Sequoyah
Stephens
Tulsa
Wagoner

Texas

Anderson
Aransas
Atascosa
Austin
Bandera
Bastrop
Bell
Bexar
Blanco
Bosque
Brazoria
Brazos
Brooks
Burnet

Caldwell
Cameron
Chambers
Cherokee
Collin
Comal
Cooke
Dallas
Denton
Dimmit
Duval
Ector
El Paso
Ellis
Fannin
Fort Bend
Galveston
Gillespie
Gonzales
Grayson
Gregg
Grimes
Guadalupe
Hale
Hardin
Harris
Harrison
Hays
Henderson
Hidalgo
Hill
Hood
Hunt
Jefferson
Jim Hogg
Jim Wells
Johnson
Kaufman
Kendall
Kenedy
Kerr
Kleberg
La Salle
Lee
Liberty
Limestone
Llano
Lubbock
Marion
Matagorda

McLennan
Medina
Midland
Montague
Montgomery
Nacogdoches
Navarro
Nueces
Orange
Parker
Polk
Potter
Rains
Randall
Rockwall
Rusk
San Jacinto
San Patricio
Smith
Somervell
Starr
Tarrant
Taylor
Tom Green
Travis
Upshur
Van Zandt
Victoria
Walker
Waller
Washington
Webb
Wharton
Willacy
Williamson
Wilson
Wise
Wood

Bold = 2020 expansion counties.

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The most common types of Medicare plans are:

- **Health Maintenance Organization (HMO) plans** — Provide coverage through a network of doctors and hospitals. Typically, you must use network providers unless it's an emergency. If you don't, your care may not be covered
- **Preferred Provider Organization (PPO) plans** — Provide coverage through a network of doctors and hospitals. In a PPO plan, you can see a doctor in or out of network. Typically, it costs more to get care out of network
- **HMO Point-of-Service (HMO POS) plans** — Provides coverage through a network of doctors and hospitals. You may be able to see a doctor out of the network for some services. The POS option provides more choice and flexibility. But some services aren't available outside the network of contracted providers
- **Special Needs Plans (SNP)** — A special type of Medicare Advantage plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid

There may be other types of Medicare plans available.

Aetna Prime HMO	Aetna Prime PPO
Offers members an affordable monthly premium with access to a network of local providers.	Offers members an affordable monthly premium with access to a network of local providers.
Members must use network providers, except in emergency or urgent care situations, or for out-of-area renal dialysis.	Members have the flexibility to choose doctors and hospitals both in and out of our Prime network, but they'll save money by using a network provider.

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*Medicare Advantage Optional Supplemental Benefits (OSBs) may be offered for an extra cost with some HMO and PPO plans. Plans vary by service area.

**Modified Open Access HMO allows members the freedom to visit network providers without a referral.

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Prime network products

We believe the future of health care is rooted in collaboration and innovation. That's why we partner closely with select groups of local care providers across the country to offer Aetna Prime network products.

These unique products offer some key advantages, including:

- Affordability — They typically offer lower premiums than others in the market
- Collaboration — We work with providers to help ensure our members get the right care at the right time
- Accountability — Both Aetna and our provider partners are accountable for performance goals that support our plans' Star Ratings and member satisfaction goals

What are Prime network plans?

Prime network plans have networks built either exclusively (i.e., HMO plans) or predominantly (i.e., PPO plans) around a select group of local care providers.

Should I describe/sell these plans any differently?

It's critical that you ask the prospect what doctors and hospitals they like to use and ensure they can continue to see those providers under the Prime product. If the person's providers are not in the network, explore alternative plan options or help member select a provider that is in network.

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Prime network products (continued)

What are these plans called?

They have several different names, based on Aetna service areas. These are the key words to look for:

Key word	Description	Plan names
Prime	"Prime" appears on the member ID card.	Aetna Medicare Advantra Butler Prime (HMO) Aetna Medicare Advantra Excelsa Prime (HMO) Aetna Medicare Advantra Washington Prime (HMO) Aetna Medicare Assure (HMO D-SNP) Aetna Medicare Assure Plus (HMO D-SNP) Aetna Medicare Assure Value (HMO D-SNP) Aetna Medicare Beaver Valley Prime (HMO) Aetna Medicare Choice (HMO-POS) Aetna Medicare Core Value (HMO) Aetna Medicare Credit Value (PPO) Aetna Medicare Elite Prime (HMO) Aetna Medicare Gold Advantage Prime (HMO) Aetna Medicare Gold Advantage Value Prime (HMO) Aetna Medicare Main Line Health Prime (HMO) Aetna Medicare PennHighlands Prime (HMO) Aetna Medicare PinnacleHealth Prime (HMO) Aetna Medicare Premier (HMO) Aetna Medicare Premier Plus (HMO-POS) Aetna Medicare Premier Preferred (HMO) Aetna Medicare Prime (HMO) Aetna Medicare Prime (HMO-POS) Aetna Medicare Prime (PPO) Aetna Medicare Prime 1 (PPO) Aetna Medicare Prime PCP Elite Plan (HMO) Aetna Medicare Prime Plan (HMO) Aetna Medicare Prime Plus Plan (HMO) Aetna Medicare Prime Premier (HMO) Aetna Medicare Prime Premier (PPO) Aetna Medicare Prime Premier Plus (PPO) Aetna Medicare Prime Value (HMO) Aetna Medicare Select (HMO) Aetna Medicare SNJ Prime Elite (PPO) Aetna Medicare Summit Select (HMO) Aetna Medicare UnityPoint Health Prime (HMO) Aetna Medicare UVA Health System Prime (HMO)

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Prime network products (continued)

How are these plans different from other Medicare Advantage plans?

These plans offer a specific local network of selected contracted providers from which members can receive care. Members of these plans do not have access to a national network, they do not have network reciprocity, and they must select providers within their plan's network in their home service area to receive health care services covered by this plan.

How can members find in-network providers?*

- For Aetna-branded plans: Use the Aetna Medicare Find a Provider site and make sure you select the specific Prime plan (don't skip this step!). Or you can find and refer to the plan's provider directory on www.aetnamedicare.com/findprovider

Note: For Aetna Medicare Connect Plus (HMO), "Connect" is part of the plan name and it appears on the member ID card. Refer to your contract for commission terms.

Where can you find more information?

Speak to your local Aetna broker manager about plan availability in your market. You can also find more information and additional resources on [Producer World](#).

*Please note: There may be other contracts with a limited network component; please always check the network provider participant through the online lookup tools.

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SilverScript PDP

SilverScript is one of America's largest Medicare PDP insurers. More than 6 million people count on us to help make their prescriptions more affordable.

Overview

SilverScript Medicare Part D prescription drug plans provide quality service and savings at a variety of premium levels. SilverScript offers convenient access through preferred and standard network pharmacies to varying levels of drug coverage.

SilverScript offers 2 stand-alone Individual Prescription Drug Plans (PDP).

2020 SilverScript PDP product portfolio:

- SilverScript Choice
- SilverScript Plus

*Effective January 1, 2019, Aetna divested all of its stand-alone Medicare Part D plans to a subsidiary of WellCare Health Plans, Inc. ("WellCare").

Helpful tools

Use the following links to find network pharmacies and formulary drug information for our Medicare plans:

SilverScript PDP:

www.silverscript.com/pricing-tool.aspx

www.silverscript.com/pharmacy-locator.aspx

Marketing materials:

SilverScript marketing materials are available via the SilverScript Agent Portal.

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SilverScript PDP (continued)

Log on to the SilverScript Agent Portal

Appointed Aetna and SilverScript agents, this is your go-to site for information, tools and reports on SilverScript PDP products. Use it to learn about products, certification and client enrollment status. You can order enrollment kits here and get sales and marketing materials. You are also able to obtain dozens of reference materials, including temporary SilverScript member ID cards to support your clients.

Log in at <https://www.SilverScriptAgentPortal.com>. Enter your Login ID and Password. Once logged in, navigate the site to become familiar with the robust functionality available to you.

The screenshot shows the SilverScript Agent Portal login interface. At the top is the SilverScript logo. Below it is a white box with the heading "Welcome to the SilverScript Agent Portal". Inside this box are two input fields: "Login ID" and "Password". Below the password field is a red "Login" button. Under the button, there is a red text warning: "If you have not logged in since June 15, 2018, you will need to click on 'Forgot Password' to reset your password. Your login ID is the same as your agent/writing number." At the bottom of the box are three links: "Forgot Password", "Contact Us", and "Supported Browsers". Below the box, the footer contains the copyright notice "© Copyright 2019 SilverScript Insurance Company. All Rights Reserved." and a "CONFIDENTIAL NOTICE" stating that the website contains confidential information for authenticated users and that unauthorized use is prohibited.

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SilverScript Agent Portal: Get enrollment reports

Access your enrollment reports by logging in to the SilverScript Agent Portal at <https://www.silverscriptagentportal.com>. Navigate to Reports from the gray navigation bar and click My Clients. A grid will appear similar to what's shown here:

Plan Type	Submitted	Enrolled	Disenrolled	Denied
SilverScript Choice	281	235	41	2
SilverScript Plus	16	13	3	0

Clicking the individual numbers will display the individual client detail within each category. Principals or admins, you'll have the option to search by a particular agent or perform custom searches by organization.

Certification

- Offers a high-level look at SilverScript Individual Medicare Part D products

This course has 4 modules. If you've completed AHIP training requirements, you will only be required to complete the Part D-specific courses, as credit for the other courses will be applied to your certification profile.

SilverScript Part D training

If only contracting for PDP, only the Part D training certification is required.

- The training can be accessed at <https://www.silverscriptagentportal.com>
- Log in and go to Tools > Training and Certification
- If AHIP training was completed, credit for several courses can be applied by clicking "Transfer My AHIP Credits"
 - SilverScript certification can be completed free of charge if agents take all courses via the SilverScript Agent Portal
- At the bottom of the page, click "Launch Training" to begin. Make sure pop-up blockers are disabled as the training will open in a new window
- Required attestations are available once all prerequisite courses are completed

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SilverScript PDP (continued)

Enrollment application turnaround time

- The timely submission of enrollment applications:
 - SilverScript PDP enrollments must be entered into the SilverScript Agent Portal within 24 hours of receipt of the paper application by the agent
 - SilverScript PDP applications must be in SilverScript's possession within 24 hours of portal entry
- **For SilverScript applications, email, fax or upload through Silver Mail in the Agent Portal**
- A score of 90% or higher is required for each of the course assessments. Failure to obtain a passing score within three attempts will make you ineligible to sell SilverScript products for that plan year

SilverScript PDP enrollment materials

An initial packet of 10 enrollment kits will be mailed upon completion of the annual certification. Additional enrollment kits can be ordered through the SilverScript Agent Portal at <https://www.silverscriptagentportal.com>. Go to Resources and then Enrollment Kit Reorder. Kits can be ordered in quantities of 10; up to 100 per day. Pieces of the enrollment kits can be downloaded a la carte by going to Resources and then clicking Supply Room.

Requirements

To access the kit-ordering site, you must be ready to sell. You'll need to use your National Producer Number (NPN) to log in.

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Kit personalization

Aetna MA/MAPD: Personalization is available for free. The ordering process provides the option for entering your personal data. Kits can be personalized with up to two lines of information, with a maximum of 35 characters per line.

SilverScript PDP: No need for kit personalization for SilverScript PDP enrollment materials. All SilverScript PDP kits can be used by any ready-to-sell agent in any PDP region.

Kit limits

There is a limit on the number of kits you can order per month (allocations). If your order exceeds your monthly allocation, you may still submit the larger order. Your order will be routed to your local sales market for approval. Once approved, you will receive notification of the order status. (SSIC section: Kits must be ordered in multiples of 10. Agents have a daily maximum order limit of 100 kits.)

Order confirmation

Order history is displayed on the Enrollment Kit Reorder landing page. You can track your orders from this location.

Delivery

Orders generally ship within 1 business day after the order was placed. Kits are sent by UPS Ground Overnight shipping, and P.O. Box delivery is not available.

Description of SilverScript PDP enrollment kits:

SilverScript enrollment kits will arrive in a box of 10. Here is what is included:

- Trifolds with overview of SilverScript plans
- Plan formularies
- Scope of Appointment forms
- Plan decision guides
- Pre-enrollment checklists
- Enrollment applications
- New member reference pamphlets
- Summary of Benefits booklets
- Star Ratings sheets
- Nondiscrimination disclaimers

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SilverScript PDP (continued)

How to order

Log in to the SilverScript Agent Portal. Click “Enrollment Kit Reorder” from the Resources menu. Enrollment kits can be ordered in multiples of 10 with a maximum of 100 per day. Confirm the shipping address and number of kits requested and click “Submit Order.” Be sure to provide a complete enrollment kit (application, plan ratings and other required items) to every beneficiary. Our kits are built to help beneficiaries understand the plan and enroll. They include an enrollment form, instructions, a Summary of Benefits, plan ratings and a multilanguage insert.

The plan ratings sheet is a required component in all enrollment kits. When CMS announces Star Ratings, we'll update this page and notify you. It should happen in October. You'll then need to tear out the 2019 plan ratings page from your existing kits and insert the new 2020 plan rating page to ensure beneficiaries receive the correct information.

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SilverScript enrollment options

There are many options available

SilverScript enrollments can be submitted in a variety of ways. From paper applications to electronic enrollments, we have options that will meet all of your clients' needs.

Enrollment methods

IMPORTANT! Be sure to enter enrollments into the Agent Portal within 24 hours of receiving the paper application.

Paper application data entry	<p>All SilverScript paper applications must be entered into the Agent Portal within 24 hours of receiving the paper application.</p> <p>Log in to the Agent Portal and go to the Enrollment menu, then select the Enrollment option. From the middle of the page click CLICK HERE and follow the prompts. Once complete, you will receive a confirmation number that will need to be written on page 7 of the paper application.</p>
Send in enrollment application	<p>Within 24 hours of entering the enrollment, the paper application needs to be sent in. There are multiple methods to get us the application:</p> <p>Upload: Upload a scanned copy of the documents via the Agent Portal secure mailroom (Silver Mail) at https://www.silverscriptagentportal.com.</p> <p>Email: Send by encrypted email to enrollmentverification@cvscaremark.com</p> <p>Fax: 1-866-552-6205</p> <p>Mail: SilverScript Insurance Company Attn: Agent Processing PO Box 30002 Pittsburgh, PA 15222-0330</p>
Electronic enrollment	<p>Go paperless by utilizing the electronic enrollment. From the Agent Portal go to Enrollment and then select Electronic Application. Simply fill in the enrollment information and an email will be sent to your client. The client then opens a link from the email, which takes him/her to the electronic application. If everything looks good, the client electronically signs and the enrollment is submitted for processing.</p>
iPad enrollment	<p>If you own an iPad and have the client with you, the enrollment can be submitted directly into the iPad using the SilverScript enrollment application.</p>

Note: Agents are required to perform their own SilverScript PDP enrollment application data entry or utilize any of the other authorized SilverScript electronic application approaches.

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SilverScript Customer Care

Hours of operation: 24 hours a day, 7 days a week

Phone: 1-866-235-5660

Where can members find the enrollment form?

SilverScript: www.silverscript.com/documents-library.aspx

How do members turn in the form? After a member has filled out the PHI form, they'll need to mail it in to MSO. Aetna and Innovation Health members can also fax in the completed form. SilverScript members can fax the form to 866-552-6205. The addresses and fax number are included on the PHI form.

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Broker Services: Resources

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Making it easy to do business with Aetna

Agent/broker tools	
Aetna agent website	Aetna Producer World: https://www.aetna.com/producer/Medicare/index.html See next page.
Marketing materials	The Aetna Medicare Marketing Studio: www.aetnahub.com/MMS
Find in-network pharmacies	www.aetnamedicare.com/findpharmacy www.aetnamedicare.com/formulary
BenefitsCheckUp® site	www.benefitscheckup.org/aetna
Enrollment kits	Aetna Producer World: https://www.aetna.com/producer/Medicare/index.html
Online enrollment tool	The Ascend Virtual Sales Office app .
Reports	Access on Aetna Producer World (see “How to access reports” on next page).
Find in-network doctors, hospitals and specialists	www.aetnamedicare.com/findprovider
Consumer/member tools	
Consumer-facing website	www.aetnamedicare.com
Find in-network doctors, hospitals and specialists	www.aetnamedicare.com/findprovider

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Making it easy to do business with Aetna (continued)

Aetna Producer World

Get access to view Medicare reports

Here's how to access reports in Producer World:

Register or log in to [Aetna Producer World](#) as the principal of the firm. (If you plan to delegate Aetna Producer World tasks to others, you can do so during registration or after you complete registration.)

Then, log in. Click "Manage Profile & User Access" on the left menu, then "Principal – Manage Firm Access." Choose to give yourself Compensation privileges. This lets you view Medicare reports for all agents in your firm.

If you're the firm principal: On the "Principal – Manage Firm Access" page, you can designate up to four people with different privilege levels so they too can view Medicare reports for your firm. Your designees must first register for [Aetna Producer World](#) as an employee or agent of the firm. After choosing your designees, assign them Compensation privileges so they can see the Medicare reports. For more information, review our ["How to register in Producer World"](#) guide.

Ready-to-sell agents, log in to Producer World to access information and tools. See next page.

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Aetna Producer World (continued)

Appointed Aetna agents, this is your go-to site for information, tools, new agent onboarding, contracting and reports on Aetna Medicare (MA/MAPD) products. Use it to learn about products, compensation, certification and licensing. You can order enrollment kits here and get sales and marketing materials.

Log in or register at <http://www.aetna.com/insurance-producer.html>. Click "Log In/Register" in the top navigation bar. Click Agents/Brokers. Once logged in, click "Individual Medicare" at the top of the page to access all Individual Medicare information and materials.

The screenshot shows the Aetna Producer World interface. On the left, under the heading "Producer World® Log In", there are input fields for "User Name:" and "Password:". Below these is a yellow button labeled "SECURE LOG IN". Underneath the login fields is a link that says "Forgot Your Password Or User Name?". At the bottom left is a link that says "Register | [Your Privacy]". On the right side, under the heading "Why Register?", there is a paragraph stating: "Aetna's online service center developed to meet the informational needs of our producers, general agents and firm employees including access to:". Below this paragraph is a bulleted list: "• Get quotes", "• Find compensation information", "• Check license status", "• Set up direct deposit", "• Get reporting", and "• And more". At the bottom right of this section is a blue button labeled "REGISTER NOW". At the very bottom right, there is a link that says "About Producer World Security/Encryption".

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Reports

Log in to [Aetna Producer World](#) 24/7 to access reports on your Aetna Individual Medicare book of business. Just log in to Producer World, click “Individual Medicare” at the top of the page, then click “Access Reporting.”

You can then access the reports listed below, export them to Excel, or print and save copies for your records.

Pending enrollment report	It shows applications that are being processed or that were denied. (Once approved, applications appear on the enrollment roster report.)
Your Medicare book of business	It shows individuals enrolled in an Aetna Medicare plan, and those who terminated their policy in the past calendar year.
Month/YTD/prior year commission report	It shows the commission paid by Aetna. Detailed reports show commission by member. Summary reports show commission by product. These reports show the current month and year only. They do not show history.
Licensing reports	Use these reports to check if your license is up to date, in accordance with state law. If you manage an agency, you can view data for the producers who report to you.

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Aetna Medicare Marketing Studio (MMS)

www.aetnahub.com/MMS

Visit this site to order customizable print-on-demand Aetna Medicare marketing materials such as postcards and flyers. You need a username and password to log in. Request access through the login page.

www.benefitscheckup.org/aetna

Use this site as a one-stop shop to see if members are eligible for programs that can help cover costs for health care, prescriptions, taxes, utilities and more.

Ascend Virtual Sales Office app

Available for use on any device — including your laptop or tablet — that runs with an iPad platform (iPad 3 or newer model running on iOS 10 or higher) or a Windows 8 or later x86 processor.

Once you're ready to sell, you can request access through Aetna Producer World. After logging in, simply click "Tools" and then click the "Ascend Virtual Sales Office App" link. Click the "Request Access" radio button, verify your information and then submit your request.

<https://www.aetna.com/producer/Medicare/index.html>

These are the consumer-facing websites for all Aetna Medicare products. You can use them to find and download plan documents, such as:

- Summary of Benefits
- Star Ratings
- Formularies

Note: You may not use these sites for online enrollments.

Provider Lookup Tool

www.aetnamedicare.com/findprovider

Use this site to look up in-network doctors, hospitals and specialists for Aetna Individual Medicare plans (MA/MAPD).

Pharmacy Finder

www.aetnamedicare.com/findpharmacy

www.aetnamedicare.com/formulary

Use these sites to find in-network pharmacies for your Aetna Individual Medicare clients. Enter the ZIP code and click "Find Plans" to begin.

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Aetna Medicare Broker Services

The Aetna Medicare Broker Services Department can help answer your questions about:

- Contracting, certification and commissions
- Ready-to-sell information
- Navigation support for Aetna's Medicare website, the Aetna AHIP certification site and Aetna Individual Medicare Agent Contracting
- General questions on finding information
 - Aetna's Producer World and available reports
 - Verification of member enrollment application status, effective date of coverage, disenrollment dates and/or cancellation dates/reasons

Contracting and hierarchy assistance:

- New and returning agent contracting setup
- National distribution and strategic hierarchy onboarding, maintenance or changes
- Tax ID number changes
- Principal changes
- Payee changes
- W9/EFT setup and requirements
- State appointment requests
- Agent of Record reassignment

Additional assistance available:

- Drug/formulary lookups
- Needing a customer service phone number or fax
- Commissions inquiries, first year and renewals, true up payments, proration
- Compliance requirements
- Service areas
- General information about marketing and advertising campaigns
- Field communications
- Agent demographic changes
- Agent background reviews
- Agent terminations

The Aetna Medicare Broker Services Department

Phone: 1-866-714-9301

Email: brokersupport@aetna.com

Hours: Monday through Friday, 8 a.m. – 8 p.m. ET (5 p.m. PT)

Fax number: 1-724-741-7285

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Certification Requirements

Section 3.1



3.1 Certification Requirements

Certify to be ready to sell

Key reminders

Transferring AHIP certification

- Certification support

Be sure to bookmark
Aetna Medicare
certification site
[www.AetnaMedicare
ProducerCertification.
com](http://www.AetnaMedicareProducerCertification.com)

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Certify to be ready to sell

Aetna MA/MAPD agents and brokers must also complete market-specific training

- Full training and certification information is available on [Aetna Producer World](#)
- You can access the Aetna Medicare [certification site](#) directly

In addition to being ready to sell, you also need to attend market-specific training (online or in person) for all states and markets where you plan to sell MA/MAPD products. To sign up for market-specific training, go to www.AetnaMedicareAgentTraining.com. You are also required to attest that you agree to obtain market-specific training before you will be able to advance to the Aetna MA/MAPD product certification.

Agents and brokers marketing Aetna MA/MAPD must complete the FDR attestation

As part of Aetna's 2020 Individual Medicare certification, you are required to complete Aetna's FDR attestation. Completing the FDR attestation indicates you are compliant and understand Aetna and CMS FDR requirements. Completion of the attestation is mandatory in order for agents and brokers to access Aetna product certification. Failure to maintain compliance with the Medicare Compliance FDR requirements may result in the development of a corrective action plan, retraining and/or termination of your contract and relationship with Aetna.

[Click here for SilverScript Part D certification.](#)

Local Market Training (MST) attestation

To be ready to sell our MA/MAPD products, you must complete annual certification and contracting, licensing and appointment requirements. In addition, you must complete market-specific training for all states and markets where you plan to sell MA/MAPD and/or D-SNP products.

As part of this year's certification process, an attestation is required and must be recorded as part of the certification process to be ready to sell for 2020 Medicare Advantage plans.

Aetna Third-Party Website Usage attestation

Third-party websites are those used by contracted agents/brokers and entities to market MA/MAPD plans, or to obtain beneficiary information for the purposes of marketing or enrollment into an Individual Medicare plan. This also includes websites designed to provide agents with beneficiary leads. As part of Aetna's 2020 Individual Medicare certification, you are required to complete Aetna's Third-Party Website Usage attestation. When completing the attestation, you will indicate whether or not you or your business operates such a website. If you indicate "Yes" on the attestation, Aetna will follow up directly to obtain additional details concerning your website.

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3.1 Certification Requirements

Certify to be ready to sell

Key reminders

Transferring AHIP certification

- Certification support

Be sure to bookmark
Aetna Medicare
certification site
[www.AetnaMedicare
ProducerCertification.
com](http://www.AetnaMedicareProducerCertification.com)

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Certify to be ready to sell (continued)

Aetna D-SNP training

Aetna requires expanded training that details our Dual Eligible Special Needs Plan (D-SNP) products. All agents and brokers completing Aetna MA/MAPD certification will receive the Aetna D-SNP training.

Certification Completion Notice

Upon completion of the Aetna certification, you will receive an MA/MAPD certification completion email. The MA/MAPD certification completion email will include notification that you have completed your Aetna MA/MAPD certification for the 2020 plan year as well as direction to complete your Local Market Specific Training. Note: This notice only serves as indication that your certification requirements for Aetna MA/MAPD products have been met and does not serve as an indication that you are ready to sell. Please see “What ‘ready to sell’ means” in Section 3.3 of this guide for more information.

Ready-to-sell reminder

You must successfully complete Aetna Individual Medicare annual certification and meet all requirements prior to marketing or selling Aetna Individual Medicare products.

Certified:

A status achieved by completing the annual certification process and successfully passing the related tests.

See completing certification next page

Continued
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3.1 Certification Requirements

Certify to be ready to sell

Key reminders

Transferring AHIP certification

- Certification support

Certify to be ready to sell (continued)

Annual certification process requirements to sell Aetna Individual MA/MAPD products:

<input type="checkbox"/>	AHIP Medicare training and exam	<ul style="list-style-type: none"> This course has five modules <ul style="list-style-type: none"> If you're recertifying and you completed last year's AHIP training requirements, you can follow the recertification track of modules 4-5 only. You should still reacquaint yourself with modules 1-3 since the final exam covers all five modules The AHIP final exam requires a passing score of 90% or better within three attempts The AHIP Medicare Training costs \$125 through the Aetna certification portal. CMS FWA, General Compliance and NonDiscrimination trainings and exams follow the AHIP final exam Additional trainings required by CMS are included in the purchase of the AHIP Medicare Training
<input type="checkbox"/>	Core training and exam	<ul style="list-style-type: none"> Provides a high-level view of Aetna's Code of Conduct and Medicare Compliance program
<input type="checkbox"/>	2019CY FDR attestation	<ul style="list-style-type: none"> Attestation
<input type="checkbox"/>	Local Market Training (MST) attestation	<ul style="list-style-type: none"> Attestation
<input type="checkbox"/>	Third-Party Website attestation	<ul style="list-style-type: none"> Attestation
<input type="checkbox"/>	MA/MAPD overview training	<ul style="list-style-type: none"> Offers a high-level look at Aetna Individual MA/MAPD products
<input type="checkbox"/>	D-SNP training	<ul style="list-style-type: none"> Provides an in-depth look at Aetna's Dual Eligible Special Needs Plans (D-SNP)
	MA/MAPD/D-SNP exam	<ul style="list-style-type: none"> Completion of this exam with a 90% score or higher is mandatory for agents and brokers wishing to market Aetna MA/MAPD and/or D-SNP products
<input type="checkbox"/>	Receive completion email notification	<ul style="list-style-type: none"> Upon completion of certification, you will receive an email indicating that all steps of the Aetna 2020 MA/MAPD certification are complete

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Transferring AHIP certification

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Certify to be ready to sell (continued)

In addition to becoming ready to sell, you also need to attest when taking the Individual Medicare MA/MAPD certification that you will attend market-specific training (online or in person) for all states and markets where you plan to sell MA/MAPD products.

It's easy to sign up for training. Just go to www.AetnaMedicareAgentTraining.com. After entering your states and contact info, you can view upcoming trainings and register online. At these trainings, we'll cover 2020 plan benefits for the local service area, our provider and pharmacy networks, competitive advantages, agent tools and more.

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Key reminders

Dual-year certification (2019–2020)

- **Beginning 7/10/19**, completion of the 2020 Aetna Individual Medicare certification also fulfills the 2019 certification requirement
- Agents who certify for MA/MAPD products must complete the FDR attestation, Market Specific Training attestation and Third-Party Website Usage attestation before completing 2020 certification
- Agents who sell Aetna MA/MAPD products must complete the market-specific training for every market in which they sell
- Agents who plan to sell Aetna MA/MAPD products must complete the D-SNP training module in addition to completing MA/MAPD Overview training module for 2020
- **You must successfully complete** the Aetna Individual Medicare annual certification process and meet all ready-to-sell requirements prior to marketing or selling Aetna Individual Medicare products
 - **Passing test score.** A minimum passing score of 90% is required for all exams within three attempts
 - **You get three attempts**
 - Aetna's initial AHIP certification registration fee is \$125; you have three attempts. You can review your attempt history on the transcript page
 - You also get three attempts each to pass the Aetna Core exam, SilverScript Part D exam and Aetna MA/MAPD/D-SNP exam. If you don't pass an exam within three attempts, you'll be locked out and will be ineligible to sell (or retest to sell) any 2020 Aetna Individual Medicare products
 - **Take the courses in order.** The tracking system requires you to finish each part of the certification before moving to the next requirement in the sequence
 - **You must take and pass modules on your own.** You cannot use any outside aid or assistance on modules or exams. This includes sharing or comparing answers, taking the exam as a group and using answer keys. If you use outside aid, you will be subject to disciplinary action, which could include termination of your Aetna appointment and contract
 - **Tracking and reporting.** On the certification site, you can see your certification history and print a certificate from the transcript page. You can also view your progress in each course
- To receive renewal commissions in January for business sold in prior years, you must complete the annual certification process by December 31, in addition to being properly licensed and appointed
- Payees must be fully contracted, licensed, appointed and certified in ALL states where they sell in order to be eligible to receive commissions

In addition, market-specific product training for the MA/MAPD plans you sell is a requirement.

See preceding page.

3.1 Certification Requirements

Certify to be ready to sell
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Transferring AHIP certification

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Transferring AHIP certification

Your existing AHIP certification will transfer to Aetna automatically upon registering for 2019 Aetna certification. To transfer AHIP certification to Aetna, you must have earned a score of 90% or better on the final exam. You must still complete the other Aetna-specific requirements to finish the Aetna Individual Medicare annual certification process. If you already paid your AHIP registration fee and transferred your AHIP certification to Aetna, you will not have to pay the \$125 AHIP registration fee again.

Certification support

Broker Services Department

- **Hours of operation:** 8 a.m. – 8 p.m. ET (5 p.m. PT), Monday through Friday
- **Toll-free number:** 1-866-714-9301
- **Fax number:** 1-724-741-7285
- **Email:** brokersupport@aetna.com

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Contracting, licensing & appointment

Section 3.2



3.2 Contracting, licensing & appointment

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For more information, contact the Broker Services Department at 1-866-714-9301

There are two types of contract agreements within the contracting system:

- **Upline agreement** — Applies to a contracted firm, agency, organization or person with downline agents
- **Producer agreement** — Applies to a writing agent who has no downline agents.
 - All writing agents have at least one upline. The upline for directly contracted agents is their local market

Key Fact: state appointments.

- Existing Aetna agents do not need to re-contract. For information on making changes to your current contract,

Distribution partners

Distribution partners must have downline agents who are individually certified, licensed and appointed with Aetna. Distribution partners must have an insurance license and line of authority to be appointed in their state of residence and in any state where they or their downline agents perform sales activities. Per each state's appointment guidelines, appointments must be active before a member policy is written or appointments must be ordered when the member policy is written.

The State License-Appointment Requirements table provides all state licensing, appointment and ordering requirements for your reference. Please click on the following link and select the State License-Appointment Requirements table in the drop-down menu:

<https://www.aetna.com/insurance-producer/become-appointed-with-aetna.html>

Distribution partners who contract with Aetna are supported every step of the way for easy onboarding that includes compliance and quality for Telebroker operations (review section 10 for details).

Speak with your National Sales Director for more on our complete onboarding processes.

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Licensed-only agents (LOAs)

An LOA is either employed by or under exclusive contract with an upline. If the employer or upline terminates an agent, the agent is deemed released from that employer's or the upline's hierarchy. The upline will send an invitation to the LOA to onboard through the Aetna Medicare contracting system.

Note: For those who prefer to refer business rather than actively sell, we offer a referral-only option.

This option allows brokers to refer business to us and earn a one-time referral fee, without completing the annual certification process.

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The contracting process

Except for certain requirements that don't apply to licensed-only agents (LOAs), completing all required contracting documents is a critical step to becoming "ready to sell" Aetna Individual Medicare products.

Step 1: Complete annual certification

Annual certification must be completed before your contract will be processed.

Step 2: Obtain a contracting invitation

Obtain a contracting invitation from your recruiter. You will use the link within the invitation to access the Medicare Producer Contracting site.

Step 3: Access the Medicare Contracting site to complete your contracting forms

- The link will guide you to register or log in to Producer World
- If we require you to submit a W-9, you will be presented with a form to complete
- Complete your Background Questionnaire and Background Authorization, and then enter banking information and sign your legal documents as applicable

Note: There is a "Quick Save" option to save your progress and exit the system if you need to return at a later time to complete your contract.

Step 4: We conduct a background investigation/regulatory review

As part of the contracting process, we perform standard background investigations and regulatory reviews that include, but are not limited to:

- National Criminal Search
- Federal Criminal Search
- County Criminal Search
- Professional License Verification
- Medicare Debarred & Exclusion Lists*

*Office of Inspector General, System for Award Management and Office of Foreign Asset Control

If the background investigation and regulatory review returns as APPROVED, we'll review your contracting case and process it if all contracting criteria are met.

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If a background investigation and/or regulatory review returns as NOT APPROVED, it will be reviewed by an internal panel to decide whether you can move forward with the contracting process or if the contract will be rejected. In the case of a rejected decision, you have the right to appeal background investigation and/or regulatory review findings. Refer to “Agent terminations” and the section titled “Agent reconsideration process” for information on how to dispute background investigation and/or regulatory review results.

Step 5: Your contract submission will be processed by the Aetna Medicare Broker Services team

Upon review and approval of your contract, you will receive an email notification stating “Your Aetna Medicare contract has been approved.”

You will be appointed as follows:

- Preappoint states = All state appointments are ordered upon approval of your contract
- JIT state(s) = Specific state appointment is ordered when first enrollment application is written in that state

Reminder: Notification of your contract approval does not mean you have achieved ready-to-sell (RTS) status. You must receive the RTS notification to market Aetna Individual Medicare products. Contact your upline for RTS status or contact the Broker Services Department at 1-866-714-9301.

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Updating demographics:

- You may update demographic information with National Insurance Producer Registry (NIPR) or your resident state Department of Insurance. Producer demographic and state license information from NIPR will update your agent record. [link to NIPR https://www.nipr.com/ccr_announcements.htm](https://www.nipr.com/ccr_announcements.htm)

Requesting additional states to market:

- If NIPR discloses a new license with the appropriate line of authority, the license will be added to your profile. Appointments to market in the newly licensed state will be ordered:
 - Preappoint states = All state appointments are ordered when the new license is disclosed
 - JIT state(s) = Specific state appointment is ordered when first enrollment application is written in that state

Updating EFT and/or W-9:

- For step-by-step instructions, refer to the [“Contract resources”](#) page on Producer World

Making a contract level change

- Visit our [“Contracting resources”](#) page on Producer World for additional information.
- Agent contract level change requests require both Top of Hierarchy and Aetna approval. In order to change your level, your upline must send you a contracting invitation. Any level change to Local Marketing Organization (LMO) level or higher requires Aetna approval

Hierarchy change guidelines

- We accept hierarchy change requests when submitted in accordance with the Transfer Release guidelines outlined [here](#)

How to add or remove a contracting level within your hierarchy

- Adding or removing a contracting level within your hierarchy requires a new onboarding invitation and case submission

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Transfer release policy

Our transfer release policy makes it easy for agents and agencies to change their upline. The *Notice of Intent/Transfer Release* document can be used as a “notice of intent” to transfer to a new upline or to initiate a transfer release. As in past years, transfers will not be permitted from October 1 – December 31.

Here’s an overview of the transfer release policy:

1. New agents/agencies must remain in their current hierarchy for three months.
2. Agents/agencies must have no production in the last three months.
3. If agent/agency has not met the previous two requirements, agents/agencies must submit a signed *Notice of Intent/Transfer Release* document to be released from their current hierarchy. Next, agent/agency must obtain a contracting invitation from their new upline and use the link in the invitation to upload the *Notice of Intent/Transfer Release* document and submit for processing.
4. **Notice of intent option:** If agent/agency is unable to obtain a transfer release from their upline, they can obtain a contracting invitation from their new upline. During the new contracting submission, they will be prompted to attach the *Notice of Intent/Transfer Release* document. The agent/agency will be transferred to the new upline after three months.

If this option is chosen:

- Agent/agency must remain under their new recruiter for a minimum of one year
 - Agent/agency can only transfer at their current level. After three months with the new recruiter, they will be eligible to change levels, provided there is room to move upward and they meet the appropriate criteria
 - All downline agents will move with agencies that request a transfer. However, after the move has been completed, those downline agents are not required to stay under the new hierarchy for one year. Instead, they may request release or submit their own notice of intent to transfer
5. **The notice of intent option cannot be used to move from a National Distribution Partner to a Direct to Market contract.**

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Upline obligations and administrative services

There are six upline contract levels

PMO	Preferred Marketing Organization
NMO	National Marketing Organization
RMO	Regional Marketing Organization
MMO	Middle Marketing Organization
GMO	General Marketing Organization
LMO	Local Marketing Organization

Obligations of uplines, all agents of upline and principal

1. Upline will, and will cause its agents to, adhere to applicable law and all of Aetna's written policies, rules and field communications about Medicare products.
2. Upline will maintain proper licensing (including agency licenses, as applicable) in accordance with applicable law in each state in which a certified agent is selling. In addition, the upline will be responsible for confirming that the principal is properly licensed in accordance with applicable law in each state in which a certified agent is selling.
3. Upline must notify Aetna if upline's, principal's or any agent's license is suspended or revoked. Such a suspension or revocation will affect ready-to-sell status of upline, principal or agent, as applicable.
4. Upline will ensure that all agents and employees of the upline perform their services in a manner that is compliant with the terms of their contract.
5. Upline will perform those services identified in Appendix C of their contract and described in this Producer Guide.

We suppress all nonprincipal LOAs from receiving our emails. Uplines share information with these individuals instead.

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Upline obligations and administrative services (continued)

The chart below indicates which administrative services are required for each contracting tier. (Please note: If the RMO, MMO, GMO or LMO is the Top of Hierarchy upline, they are responsible for the other administrative services as well.)

Uplines are required to provide certain administrative services and are compensated for such administrative services. Such administrative services may include the following:

1. Agent recruiting
2. Agent training
3. Compliance
4. Office administration related to Medicare sales/enrollment
5. Marketing

Required activity	PMO	NMO	RMO	MMO	GMO	LMO
Agent recruiting						
Identify, educate, interview and pre-qualify agents for selling and for referring.	X	X	X	X	X	X
Coordinate contracting with independent agents.	X	X	X	X	X	X
Coordinate and, if necessary, assist with appointment efforts between upline, agents and Aetna.	X	X	X	X	X	X
Ensure that principal and all agents are properly licensed, appointed and certified to sell Medicare products throughout the year and on an annual basis.	X	X	X	X	X	X
Agent training						
Coordinate and communicate all training requirements, processes, changes and deadlines.	X	X	X	X	X	X
Assist in communication of certification requirements, product training opportunities and ongoing compliance.	X	X	X	X	X	X
Provide ongoing training to agents around the proper selling, referring and servicing of Medicare products.	X	X	X	X	X	X
Ensure agents' understanding of Medicare products to help meet Medicare beneficiaries' needs and to help them make informed decisions about their health care choices.	X	X	X	X	X	X
Assist agents in navigating through Aetna's broker training portal.	X	X	X	X	X	X
Review, understand and follow the Producer Guide.	X	X	X	X	X	X
Support agent awareness and implementation of the Producer Guide.	X	X	X	X	X	X

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Upline obligations and administrative services (continued)

Required activity	PMO	NMO	RMO	MMO	GMO	LMO
Compliance						
Designate one or more employees with responsibility for assuring compliance and developing policies and procedures.	X	X	X			
Designate one or more employees with responsibility for maintaining records and reinforcing appropriate selling and referring practices.	X	X	X	X	X	X
Reinforce policy updates, compliance alerts and other communications with agents.	X	X	X			
Aid in the collection of agent responses when necessary.	X	X				
Review actionable information provided by Aetna, monitor compliance statistics, identify negative trends and take action proactively.	X	X				
Establish agent recruitment standards, including agent code of ethics.	X	X	X	X	X	X
Ensure agent and employee training, including that nonagent employees complete CMS Fraud, Waste and Abuse training annually.	X	X	X	X	X	X
Distribute Aetna's code of conduct and compliance policies, or upline's comparable code of conduct or compliance policies.	X	X	X	X	X	X
Ensure agent marketing/advertising oversight.	X	X	X	X	X	X
Facilitate annual certification procedures.	X	X	X	X	X	X
Implement complaint/inquiry handling procedures provided by Aetna.	X	X	X	X	X	X
Enforce disciplinary actions.	X	X	X	X	X	X

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Upline obligations and administrative services (continued)

Required activity	PMO	NMO	RMO	MMO	GMO	LMO
Office administration related to Medicare sales/enrollment						
Administrative support of agents (e.g., general office duties, overhead expenses including computers, copiers, etc.).	X	X	X			
Facilitate distribution and disposition of leads generated by Aetna, if any.	X	X				
Assist in the maintenance of accurate phone, email and address information for agents.	X	X	X	X	X	X
Website development and maintenance for agent support, service.	X	X				
Manage telephonic marketing in compliance with the terms of your agreement, including CMS rules regarding unsolicited telephone calls.	X	X	X	X	X	X
Facilitate agent record-keeping of scope of appointment and related enrollment materials.	X	X	X	X	X	X
Marketing oversight						
Ensure uplines' and agents' adherence to applicable law, including MCMG and related CMS guidance.	X	X	X	X	X	X
Ensure compliance with CMS and Aetna requirements for any third-party sites upline uses to generate leads (including the requirement to submit to Aetna a record of such site, which details the URL and operating entity names).	X	X	X	X	X	X
Ensure compliance with CMS and Aetna requirements with respect to any of upline's and its agents' public-facing websites (including the requirements to submit to Aetna a record of the URL and operating entity names associated with such site).	X	X	X	X	X	X
Ensure use of compliant carrier-specific and product-specific direct mail pieces.	X	X	X	X	X	X
Use lead vendors in compliance with applicable law.	X	X	X	X	X	X
Partner with local Aetna leadership to jointly market Medicare products.	X	X	X	X	X	X

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For newly contracting agents

Per CMS Communication and Marketing Guidelines (110.1), compliance with state licensure and/or appointment laws is required. Agents and brokers have the responsibility to maintain state licenses, continuing education and all other state requirements. Uplines must be contracted and have the proper licenses and appointments required by applicable law.

- Appointments for all licensed states will be processed by Aetna upon receipt of your completed contract case. Be sure to hold an active, valid license in the states you wish to sell prior to submitting your contract. Aetna will complete an NIPR bump on your behalf to verify licensing and order appointments accordingly
- For principals, please also confirm if the state appointment you are requesting requires your agency to be licensed and appointed as well. Your agency must also be licensed in that state if required by the DOI
- If you do not hold a valid license, the required class of license or appropriate appointment line of authority in the states you wish to sell, your appointment will be declined
- For a number of states, Aetna processes “Just in Time” appointments, ordering the appointments once the enrollment application is received. This allows efficiency to request the required state appointment, as long as you hold a valid license. Please refer to the link below

The **State License-Appointment Requirements table** provides all states licensing, appointment and ordering requirements for your reference. Here’s the link: <https://www.aetna.com/insurance-producer/become-appointed-with-aetna.html>

Ready-to-sell agents needing to add new state appointments:

Once contracted with Aetna, our connection to NIPR will alert us of any new state license you obtain. If that license is active and holds the proper lines of authority, Aetna will order appointments on your behalf with no further action from you.

Prior to engaging in the sale of Aetna Medicare products, producers must be ready to sell, which means certified, contracted, licensed in the applicable states and appointed by Aetna in accordance with state law. As permitted in certain states, Aetna will order appointments after the first sale.

Once we process the additional appointment request, and your ready-to-sell status is updated, you’ll get an email notification.

You can contact the Broker Services Department at **1-866-714-9301** if you have any questions.

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You must be appointed in the states where you intend to sell our Individual Medicare products, where applicable by state law. As permitted in certain states, Aetna will order appointments after the first sale.

You can check your appointment status by contacting the Broker Services Department at 1-866-714-9301. Agents will appear on the Broker Readiness Report once they become ready to sell. If you are ready to sell, you can access the Broker Readiness Report on the Medicare page on https://www.aetna.com/producer/medicare_reports/medicare_reports.html.

Active state appointments are required prior to or at time of sale, if required by state law as determined by Aetna.

The State License-Appointment Requirements table provides all state licensing, appointment and ordering requirements for your reference: https://www.aetna.com/producer/Medicare/requirements_to_sell.html

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E&O insurance program

We require all agents (AG 4 agent levels and below) to carry an Errors and Omissions (E&O) policy of at least \$1,000,000 per claim and \$1,000,000 aggregate at all times to maintain appointment with us. Upline levels LMO and above must carry an E&O policy of at least \$1,000,000 per claim and \$1,000,000 aggregate.

You will be required to attest to having the required E&O coverage amount when you first become contracted with us, through the contracting system. This is a requirement to become ready to sell.

As an Aetna Medicare agent, you're eligible to receive a discounted rate on E&O coverage through a special program administered by Gallagher MGA Insurance Services. If you have questions about the program or need assistance, you can reach a customer service representative at (877) 524-0265.

This E&O insurance program is designed to protect Aetna Medicare agents against claims arising from the sale and servicing of Life and Health insurance products, including Medicare Advantage, Medicare Supplement and SilverScript Medicare Part D. The coverage is insured by Continental Casualty Company, a member company of CNA Financial, and is rated A (Excellent) by A.M. Best.

- E&O coverage packages are available for independent agents, agencies and organizations of all sizes, including large national/regional marketing organizations
- Basic coverage starts at just \$34.17 per month with \$59.17 down or a one-time payment of \$375
- To learn more or to apply online, visit www.aetna-eo.com

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Agent termination information

When required by CMS for applicable state law, we report the termination of an agent to CMS and/or the state where an agent is appointed in accordance with applicable law. The same applies for all contracted distribution partners. When an Aetna agent is terminated, the agent cannot market our products.

Agent reconsideration process

You can request reconsideration of any adverse decision or termination action that we take against you. If you feel an action you took should have resulted in a different decision or outcome, you may dispute the decision. To do so, you must submit a formal written request for reconsideration of the original decision. Email the request to: medicarebackground@aetna.com. Or fax: 724-741-7285.

- You must include copies of all notifications provided by Aetna (corrective action, agent notes and any pertinent information, such as phone records, notes, scripts, appointment log, etc.)
- If disputing a commission payment decision as part of a complaint (e.g., commission charged back or denied), you must provide all documentation regarding the commission dispute
- If disputing a background investigation, you must provide details of the incident and supporting documentation

We'll respond to reconsideration requests within 30 days. You'll get a formal written communication outlining the reconsideration process and the final decision. It will include instructions for becoming re-appointed with us, if approved to do so.

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Ready to sell

Section 3.3



3.3 Ready to sell

What “ready to sell” means

What “ready to sell” means

DEFINITION: The term “ready to sell” means that an upline, principal or agent has completed and maintains compliance with all Aetna, CMS and applicable state law requirements for selling as specified in this document and has received a written confirmation (a ready-to-sell notice) from us specifying that the upline, principal or agent has completed all requirements and may commence selling a particular Medicare product in a particular state.

Here’s an overview of what you need to complete to be ready to sell:

To become “ready to sell” our 2020 Aetna Individual MA/MAPD and SilverScript PDP products and receive commissions, you’ll need to complete all of these requirements prior to marketing or selling:

1. **Certification:** Pass annual Medicare certification
2. **Contracting:** Active contract with Aetna Medicare
3. **Receive your ready-to-sell confirmation**
 - **For LOAs:** Your upline must also be ready to sell in the states you wish to sell

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Compensation

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In addition to the following overview, be sure to refer to your contract and the resources on Producer World. To the extent there is any conflict between the description below and the terms of your contract with Aetna, the terms of the contract apply.

Definition of compensation

Compensation includes monetary or nonmonetary remuneration of any kind relating to the sale or renewal of a policy, including, but not limited to, commissions, bonuses, gifts, prizes, awards and referral/finder's fees.

Compensation DOES NOT include:

- Payment of fees to comply with state appointment laws
- Training (outside of administrative fees)
- Certification
- Testing costs
- Reimbursement for mileage to and from appointments with beneficiaries
- Reimbursement for actual costs associated with beneficiary sales appointments, such as venue rental, snacks and materials

Overview — How we pay

The compensation year is January 1 through December 31. Also see: "Initial sales," "Renewal and replacement sales" and "Renewal commission payments." Please refer to "Compensation eligibility requirements."

The commission schedule for each agent and the administrative fee schedule for each upline is outlined in his or her contract. How much we pay is consistent with CMS requirements and the rate set in your contract.

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Compensation overview (continued)

Commission

Aetna's Medicare commission schedule for each agent and the administrative fee schedule for each upline is outlined in their contract (i.e., the "Aetna Marketing Agreement"). How much we pay is consistent with CMS requirements.

Agents are paid a commission for each member they enroll for an Aetna Medicare product in accordance with CMS requirements and the terms of their contract. We pay directly to the agent, or to the payee, as specified upon contracting. Commissions for licensed-only agent (LOA) sales pay directly to their upline for any member with an effective date greater than 1/1/15.

Administrative fees

We pay administrative fees to uplines who complete the Aetna Marketing Agreement for Upline Agents and Agencies (the "Upline Agreement"). Administrative fees are paid to uplines for providing administrative services, such as agent recruiting, agent training, sales compliance, office administration related to Medicare sales/enrollment, and marketing. See Section 4.1 for a complete list of upline obligations and administrative services.

For further information on CMS regulatory requirements on agent broker compensation, please go to CMS.gov under the Medicare Communications and Marketing Guidelines and look for Agent Broker Compensation. Link to the Medicare Communications and Marketing Guidelines:

<http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html>

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Initial sales

- **“Initial sale”** means beneficiaries enrolling in an Individual Medicare product, who were not enrolled in a Like Plan in the month immediately preceding their Medicare product's effective date
 - A **“Like Plan”** means a “like plan type” as described by CMS in the applicable Medicare Communication and Marketing Guidelines
 - An **“Unlike Plan”** means an “unlike plan type” as described by CMS in the applicable Medicare Communication and Marketing Guidelines

Aetna will, if permitted by law, advance the full “initial rate” set forth in your contract upon CMS confirmation that it is an initial sale.

- To the extent permitted by applicable law, the full amount of the “Initial Rate” set forth in your contract will be paid for initial sales regardless of the month in which the effective date falls (i.e., same amount will be paid if the effective date is January 1 or December 1)
- If the effective date falls after January 1 and a disenrollment occurs prior to the end of that same year, then Aetna shall recoup a prorated amount of the commission for the months that the beneficiary was not enrolled in that Individual Medicare product
- With respect to an initial sale arising from an Unlike Plan change occurring after January 1, Aetna shall pay a prorated amount of the commission for the months that the Medicare enrollee is enrolled in the Medicare product during that calendar year

We pay lifetime renewals for as long as the member remains continuously enrolled in their original Aetna MA or SilverScript PDP product.

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Renewal and replacement sales

- **“Renewal”** means a Sale to a Medicare beneficiary, when the Medicare beneficiary was enrolled in a Like Plan offered by Aetna or its affiliates in the month immediately preceding the Medicare Product’s effective date
 - For renewals, Aetna will pay based on upline’s or agent’s (as applicable) hierarchy level as of the original Aetna application received date. The “renewal rate” amount can be found on the Schedule 1 attached to your Aetna Marketing Agreement (your contract)
 - **RENEWAL TERMS:** The Schedule 1 is generally updated annually by amendment. The amount that will be paid for any particular renewal will be the “renewal rate” that is shown on the Schedule 1 in effect as of the policy effective date
 - For instance, if an agent sold an Aetna Medicare Advantage plan in October 2019, the applicable “renewal” rate for such policy will be shown on the Schedule 1, relating to 2019 policies
 - As a reminder, the “renewal rate” may be composed of an administrative fee and the amount due to the Agent of Record for the sale (subject to CMS and Aetna requirements related to plan changes). In accordance with applicable law, the commission (excluding any administrative fees) payable for the renewal cannot exceed 50% of the current year Initial Sale fair market value published annually by CMS. If such commission would exceed 50% of the current year Initial Sale fair market value, Aetna will automatically adjust the commission payment to comply with applicable law with or without notice

- Unless otherwise indicated in the Schedule 1 of your contract, the “replacement rate” is the same amount as the “renewal rate”
- We may choose, if permitted by applicable law, to pay commissions in advance of our receipt of premium from CMS. For example, if a “renewal rate” of \$200 is payable, we could pay \$16.67 per month for such renewal or pay the commission in a lump sum of \$200 in January of the renewal year

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- **“Replacement”** means a Sale to a Medicare beneficiary, when the Medicare beneficiary was enrolled in a Like Plan of someone other than Aetna in the month immediately preceding the Medicare product’s effective date
 - Replacements are payable only while your contract is in effect. For replacements, we will advance the “replacement rate” set forth on the Schedule 1 of your contract
 - If the replacement has an effective date other than January 1, a prorated amount of the replacement rate will be paid, based upon the number of months the Medicare product enrollee will be enrolled in such Medicare product within the initial calendar year. After the year in which the replacement occurs, if the Medicare product enrollee remains enrolled in a Medicare product that is a Like Plan, the replacement will become a renewal
- We may choose, if permitted by applicable law, to pay commissions in advance of our receipt of premium from CMS
- For example, if a renewal rate of \$200 is payable, we could pay \$16.67 per month for such renewal or pay the commission in a lump sum of \$200 in January of the renewal year

Please see the next page for an example of how the commission will be paid on a replacement of an MA plan under these circumstances, using \$200 as the commission rate payable for replacement. Also see examples at the end of section 5 Compensation.

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Renewal and replacement sales (continued)

Example using replacement rate of \$200

Effective date	Number of months paid	Total amount paid
1/1	12 months	\$200.00
2/1	11 months	\$183.37
3/1	10 months	\$166.70
4/1	9 months	\$150.03
5/1	8 months	\$133.36
6/1	7 months	\$116.69
7/1	6 months	\$100.02
8/1	5 months	\$83.35
9/1	4 months	\$66.68
10/1	3 months	\$50.01
11/1	2 months	\$33.34
12/1	1 month	\$16.67

EXAMPLE

The rates shown above are merely for example purposes and not a guarantee or representation of any rates set forth in the Schedule 1 in Appendix A of your contract. Commission payments are subject to chargebacks and adjustments in accordance with CMS and Aetna requirements, and the terms of your contract.

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Renewal commission payments

We process renewal commissions on or around the middle of the month; however, this is contingent upon holidays and your bank's processing time.

- Renewal payments are based on current year Schedule 1 rates. Thus, the monthly “renewal rate” may change each year. Example: A policy with a 2018 effective date will earn first year commissions based on 2018 Schedule 1 rates. If that same policy renews for 2019, the agent will earn monthly renewals based on current year (2019) Schedule 1 rates.
- We currently pay lifetime renewals for as long as the member remains continuously enrolled in their original Aetna MA or SilverScript PDP product. To receive continuous renewal payments, you must remain as the agent of record on the policy, and you must meet Aetna's annual ready-to-sell requirements

Chargebacks for rapid disenrollments and compensation recovery

Any disenrollment occurring within three months of the membership effective date is considered a “rapid disenrollment.” Rapid disenrollments are either voluntary or involuntary.

- Voluntary rapid disenrollments result in a chargeback of the full commission paid. Involuntary rapid disenrollments result in prorated commissions based on the number of months the beneficiary is active
- For voluntary or involuntary disenrollments outside the three-month rapid disenrollment period, you retain the commission earned for the length of time the policy was active. We will charge back the unearned commission and it will be reflected on the commission statement
- If we pay compensation for a sale, and a rapid disenrollment occurs thereafter, for which CMS requires compensation recovery, then the upline and its agents shall refund such compensation paid by us for such enrollee. We may deduct any compensation amounts paid to the upline or agents for a rapid disenrollment from amounts we otherwise owe to the upline or agents
- In order to not be subject to rapid disenrollment compensation recovery, the newly enrolled Medicare beneficiary must remain enrolled with us into the fourth month (e.g., if the individual enrolled with Aetna on January 1, the individual must still be enrolled with Aetna on April 1 of the same calendar year). An enrollment that occurs during the fourth quarter of a calendar year and terminates 12/31 of the same calendar year is considered a rapid disenrollment unless the termination reason indicates a plan change
- No recoupment, chargeback, refund or deduction shall be made if CMS guidance permits payment of commission for the rapid disenrollment with respect to the period that the Medicare product enrollee was actually enrolled

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Compensation eligibility requirements

Overview

To qualify for commissions, agents must:

- Not be on these reports: Office of the Inspector General (OIG) and/or the General Services Administration System for Award Management (SAM) and Office of Foreign Assets Control (OFAC). We check them initially and every month
- Complete the contract, background check, state licensing, appointment and certification process. (You will not receive commissions for applications submitted before all contracting and certification requirements are met. In addition, we may terminate your contract)
- Complete the Individual Medicare annual certification process and, in addition, agents also must take the market-specific product training for each state where they plan to sell MA/MAPD plans to receive renewal commission for policies active in the current year and meet other requirements set forth in your contract

In addition, to receive renewal commission in January for business sold in prior years, you must complete the annual certification process by December 31. NOTE: If you choose to recertify after December 31, renewal commission payments to you will resume the first month after certification is complete. You will not be eligible for any missed commission payments during your lapse period.

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Compensation eligibility requirements (continued)

Commission eligibility requirements for agent of record, payees, principals

Initial and replacement sales	Year two and beyond renewals
<ol style="list-style-type: none">1. Active agent contract with Aetna at time of sale (except for LOAs and principals)2. Complete onboarding process3. Active license in state of sale at time of sale4. Active appointment in state of sale at time of sale, if required by state law as determined by Aetna5. Must adhere to Appendix B for allowed service areas to market in6. Completed Annual Certification Process at time of sale7. If agent is LOA, direct upline must be ready to sell in state of sale	<ol style="list-style-type: none">1. Must have been eligible to receive commissions for initial sales2. Agent contract has not been terminated with cause3. Active license in state of sale on the 1st of the month that the renewal payments are generated4. Active appointment in state of sale on the 1st of the month that the renewal payments are generated5. Completed Annual Certification Process for the current renewal year by the 1st of the month that the renewal payments are generated6. If agent of record is LOA, direct upline must meet all above criteria

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Compensation eligibility requirements (continued)

Administrative fee eligibility requirements for uplines

Initial and replacement sales	Year two and beyond renewals
<ol style="list-style-type: none">1. Active agreement with Aetna at time of sale (except for principals)2. Complete onboarding process3. Active license in state of sale at time of sale*4. Active appointment in state of sale at time of sale, if required by state law as determined by Aetna*5. Agent of record must adhere to Appendix B for allowed service areas to market in6. Annual Certification Process completed prior to time of sale7. Agent of record must be eligible to receive commissions for initial sale	<ol style="list-style-type: none">1. If upline is no longer contracted, the upline cannot be in a terminated-with-cause status2. Active license in state of sale on the 1st of the month that the renewal payments are generated*3. Active appointment in state of sale on the 1st of the month that the renewal payments are generated*4. Completed Annual Certification Process for the current renewal year by the 1st of the month that the renewal payments are generated

*If upline is an agency, license and appointment are only required if mandated by state license and appointment rules.

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1099 forms

Commissions are reported via the Internal Revenue Service (IRS) 1099 process. 1099-MISC forms are postmarked to all eligible recipients by January 31 of the given year.

A 1099-MISC form will only generate to individuals and noncorporation entities if annual earnings are \$600 or above.

Documentation for earnings less than \$600 for individuals or noncorporation entities, or for any dollar amount for corporations, can be found by visiting our Producer World website and viewing Compensation Detail Reports. Note: The last statement date in December pays in January, so those earnings count toward the following tax year. (Example: A 12/21/18 statement date will count toward 2019 taxes, as payment is not generated and sent until after 1/1/19.)

For assignment of commission information, please go to the Aetna Producer World (https://www.aetna.com/producer/CompServices/documents/assignment_of_commissions.pdf).

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How termination affects compensation

This section summarizes how termination affects compensation, and the impact termination has on upline and downline hierarchy compensation. It shows how we recapture amounts you may owe Aetna if you are terminated.

Terminations without cause

If you're terminated without cause, subject to terms of our contract with you (or the upline, in the case of an LOA), we will stop paying on initial sales as of the effective date of your termination. We may continue paying renewal commissions due to you as long as you meet the requirements to receive renewal commissions that are outlined in your contract. You must still certify each year with Aetna and be properly licensed and appointed with us. Refer to your contract for details.

Note: We provide 30-day written notice for all terminations without cause.

Terminations with cause

If you're terminated with cause, it could affect your commission and commissions/administrative fees to the upline and downline.

- 1. Terminated agent** — We will stop paying commissions (initial sales and renewal) to you as of the effective date of your termination.
- 2. Downline agents** — Your downline agents will continue as contracted agents and get commissions for their sales, except as follows:
 - Your LOAs will also be terminated and no further commissions will be paid on their sales
 - If the downline agent was directly involved in sales or events that led to the termination
- 3. Upline agents** — When you have an upline hierarchy, the upline hierarchy's commissions and overrides will be impacted as follows:
 - For sales considered a contaminated sale (a sale that is not eligible for compensation), the upline hierarchy will not be paid commissions (first year or renewal) on these sales

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Recovery process for terminated agents with credit balances

Negative balances are offset by earned commissions for any new or renewal business placed with Aetna for all products.

We may contact you by mail, email or phone to ask for the amount owed. We'll work with you on a repayment plan. If we don't recover the funds, those funds may be recovered from an agent's immediate upline in the hierarchy according to the repayment plan.

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Agent of Record

Please note that in the event of an agent's death, Book of Business Reassignment requests will be reviewed by Aetna Medicare Compliance and Legal departments. For guidance or to initiate that process, please contact the Broker Services Department at 1-866-714-9301, from 8 a.m. to 8 p.m., Monday through Friday, or email us at brokersupport@aetna.com.

Member, agency or agent-initiated Agent of Record Reassignment information and procedures are as follows:

Key points:

- No Agent of Record Reassignments will be backdated
- Any agent receiving a policy or Book of Business from another agent must be confirmed ready to sell as of the date of transfer
- During a valid election period, if multiple applications are received for the same plan, the first application received and processed by Aetna will become the Agent of Record
- For agent levels AG 1 and above, a partial or complete Agent of Record or Book of Business Reassignment can only be requested by the current Agent of Record on file at Aetna
- For levels LOA7 and below, a partial or complete Agent of Record or Book of Business Reassignment can only be requested by the ready-to-sell upline
- All Agent of Record and Book of Business Reassignments must be submitted on the required Aetna template (available on Aetna Producer World, Medicare section). No agent or agency-created templates will be accepted
- All Agent of Record template documents referenced below are available on Producer World (Medicare), with the exception of third-party initiated changes. Please contact the Broker Services Department for assistance
- Instructions on how to pull a report for an existing Book of Business are available on Producer World

All AOR forms are located in Producer World. Also, be sure to review enrollment procedures in Section 9.

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Medicare “Duplicate Application Handling” policy

- **Starting October 1, 2017**, agents may no longer submit multiple applications during a valid Medicare election period for the same member, same plan with the intention of changing the Agent of Record only
- Agent of Record is documented according to the first application received and confirmed by Aetna’s Medicare Enrollment Department
- If a second application is received for the same beneficiary and for the same plan, it is considered a duplicate application and will not be processed
- The Agent of Record may only be changed by application submission if the member has elected to enroll in an entirely new plan during a valid enrollment period

Examples of scenarios are located in Producer World.

Member initiated

— can occur year-round

Member-initiated Agent of Record Reassignments will be processed as effective the first of the month, following receipt of the member’s request. We will not backdate the Agent of Record Reassignment to be effective prior to receipt of the initial request. All agents must be ready to sell in order to be an Agent of Record.

There are multiple ways that a member can request an Agent of Record Reassignment.

- This must be member-initiated. Agents should NOT submit or phone in these requests to the Broker Services Department or to Member Services on the member’s behalf

Here are the ways for the member to initiate an Agent of Record Reassignment:

1. **The member** can contact Member Services via phone by using the toll-free number located on the back of their Aetna Medicare Member ID card; OR:
2. **The member** may write a letter to the following address requesting a change to their Agent of Record:
2222 Ewing Road
Moon Township, PA 15108
3. If, upon review, the Broker Services Department finds that the receiving agent is not ready to sell, the request to change the Agent of Record will not be processed and the member will be notified.

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Agent-initiated

Agent of Record or Book of Business Reassignments

Agent-initiated Agent of Record or Book of Business Reassignments will be processed as effective the first of the month, following Aetna's receipt of all completed documents:

- **Required documentation** (available on Aetna Producer World, Medicare section):
 - *Agent-initiated Agent of Record Change Template*
 - *Aetna-approved Membership List Template*
 - *CMS-approved Member Letter*
 - This letter must be sent to every member affected by the change. Aetna requires at least one copy of a sent letter as proof of the good-faith business effort to alert membership of their change in agent
- Please submit each request with the completed documentation listed above to the Broker Services Department at brokersupport@aetna.com
- Once confirmed by the BSD, an email from brokersupport@aetna.com will be sent to the requesting agent outlining next steps. After all documents have been received, please allow at least two payout cycles to be completed before expecting commissions on the moved membership

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Third-party initiated

— death or incapacitation of an agent

Third-party initiated Agent of Record or Book of Business Reassignment request may only be made upon an agent's death or incapacitation. Third-party initiated means a person other than the current Agent of Record, or in the case of an LOA, a person other than the LOA's Upline, requests an Agent of Record change or Book of Business Reassignment.

To initiate party AOR or BOB reassignment, please contact Broker Services at 1-866-714-9301 or email brokersupport@aetna.com.

- All such cases must be reviewed by Aetna Legal and/or Agent Oversight for approval
- If approved, the request will be processed as effective the first of the month, following Aetna's receipt of all completed documents

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Retention policy

Our Agent of Record (AOR) retention policy helps ensure you earn commission for helping your existing clients change plans. Here's how it works:

- If a member enrolls in a new plan by submitting a new enrollment application directly, the existing AOR on the policy will remain. The existing agent will continue to receive commissions so long as he or she has met all ready-to-sell requirements. No special action is required
- If a member enrolls through another agent for a plan change, the new agent will become the AOR
- If a member calls Aetna telesales, the telesales representative will make the change and the original AOR will be maintained. Telesales will maintain the original AOR on the policy unless a specific request is made by the member

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(FOR ILLUSTRATION PURPOSES ONLY)

Medicare Advantage commission rates

Please note: Initial payment is based on renewal rates. Replacement and true up (Initial) rates are paid at a later date, once confirmation is received by CMS.

Hierarchy Level	National Renewal Rate (as referenced in the Schedule 1)
PMO	\$75
NMO	\$70
RMO	\$65
MMO	\$60
GMO	\$55
LMO	\$50
Agent 4	\$45

(The rates set forth above and below are merely for example purposes and not a guarantee or representation of any rates payable. For actual rates, please refer to your Schedule 1.)

Using the illustrative rates above, if an Initial Sale of a Medicare Advantage plan is made in Missouri by an agent who has been assigned a hierarchy level of Agent level 4, and the hierarchy above such agent is composed of an LMO and an NMO, the commissions payable for such sale would be as follows:

- The agent would receive a commission equal to the Medicare Advantage National “renewal rate” for Agent 4 (\$45)
- The LMO would receive an administrative fee equal to the Medicare Advantage National “renewal rate” for LMO less the Medicare Advantage National “renewal rate” for Agent 4 (\$50 – \$45 = \$5 (total amount payable to LMO))
- The NMO would receive an administrative fee equal to the Medicare Advantage National “renewal rate” for NMO less the Medicare Advantage National “renewal rate” for LMO (\$70 – \$50 = \$20 (total amount payable to NMO))

The additional amounts (i.e., administrative fees) paid to agents or agencies above the commissions paid to Agent level 4 and below are compensation for administrative services provided by such upline agents or agencies. The description of administrative services provided by such upline agents or agencies is set forth in Appendix C of your contract and the Producer Guide.

The full amount of the “Initial Rate” will be paid for Initial Sales regardless of the month in which the effective date falls (i.e., same amount will be paid if the effective date is January 1st or December 1st). Below is an example of how the Commission will be paid on an Initial Sale of a Medicare Advantage plan under these circumstances, using \$400 as the commission rate payable for Initial Sales:

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Example using an Initial Rate of \$400

Effective Date	Number of Months Paid	Total Initial Rate Paid
1/1/2019	12 months	\$ 400.00
2/1/2019	12 months	\$ 400.00
3/1/2019	12 months	\$ 400.00
4/1/2019	12 months	\$ 400.00
5/1/2019	12 months	\$ 400.00
6/1/2019	12 months	\$ 400.00
7/1/2019	12 months	\$ 400.00
8/1/2019	12 months	\$ 400.00
9/1/2019	12 months	\$ 400.00
10/1/2019	12 months	\$ 400.00
11/1/2019	12 months	\$ 400.00
12/1/2019	12 months	\$ 400.00

(The rates set forth above are merely for example purposes and not a guarantee or representation of any rates payable.)

- Please note: Initial payment is based on renewal rates. Replacement and true up (Initial) rates are paid at a later date, once confirmation is received by CMS. All commission payments remain subject to appropriate chargebacks and other adjustments in accordance with CMS and Aetna requirements as well as the terms of your contract

The additional amounts (i.e., administrative fees) paid to agents or agencies above the commissions paid to Agent level 4 and below are compensation for administrative services provided by such upline agents or agencies. The description of administrative services provided by such upline agents or agencies is set forth in Appendix C of your contract and the Producer Guide.

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Below is an example of how the commission will be paid on a replacement of a Medicare Advantage plan, using \$240 as the commission rate payable for replacement.

Effective Date	Number of Months Paid	Total Replacement Rate Paid
1/1/2019	12 months	\$240
2/1/2019	11 months	\$220
3/1/2019	10 months	\$200
4/1/2019	9 months	\$180
5/1/2019	8 months	\$160
6/1/2019	7 months	\$140
7/1/2019	6 months	\$120
8/1/2019	5 months	\$100
9/1/2019	4 months	\$80
10/1/2019	3 months	\$60
11/1/2019	2 months	\$40
12/1/2019	1 month	\$20

(The rates set forth above are merely for example purposes and not a guarantee or representation of any rates payable.)

Please note: All commission payments remain subject to appropriate chargebacks and other adjustments in accordance with CMS and Aetna requirements as well as the terms of your contract with Aetna.

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Illustrative examples: MA/MAPD commission rates (continued)

(FOR ILLUSTRATION PURPOSES ONLY)

Referral illustrative example

Below is an example of how the commission will be paid on a referral of a Medicare Advantage plan:

Hierarchy Level	Referral Fees for Medicare Advantage Plans
PMO	\$35
NMO	\$30
RMO	\$25
MMO	\$20
GMO	\$15
LMO	\$10
Agent 4	\$5

(The fees set forth above are merely for example purposes and not a guarantee or representation of any rates payable.)

Using the illustrative rates above, if a compensable referral for a Medicare Advantage plan is made by an agent who has been assigned a hierarchy level of Agent level 4, and the hierarchy above such agent is composed of an LMO and an NMO, the Referral fee payable for such compensable referral would be as follows:

- The agent would receive a Referral fee equal to the “Referral Fee for Medicare Advantage” for Agent 4 (\$5)
- The LMO would receive an administrative fee equal to the “Referral Fee for Medicare Advantage” for LMO less the “Referral Fee for Medicare Advantage” for Agent level 4 (\$10 – \$5 = \$5 (total amount payable to LMO))
- The NMO would receive an administrative fee equal to the “Referral Fee for Medicare Advantage” for NMO less the “Referral Fee for Medicare Advantage” for LMO (\$30 – \$10 = \$20 (total amount payable to NMO))

Please note: All commission payments remain subject to appropriate chargebacks and other adjustments in accordance with CMS and Aetna requirements as well as the terms of your Agreement.

The additional amounts (i.e., administrative fees) paid to agents or agencies above the commissions paid to Agent level 4 and below are compensation for administrative services provided by such upline agents or agencies. The description of administrative services provided by such upline agents or agencies is set forth in Appendix C of your contract and the Producer Guide.

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The Front Runner Program

Section 5



5. The Front Runner Program

The Front Runner Program

The Front Runner Program



The annual Front Runner Program

Aetna Front Runner is a rewards program for agents who excel selling our Individual Medicare products during the Annual Election Period (AEP) from October 15 – December 7. (Note: Telebrokers are ineligible.)

Criteria for the Front Runner Program is announced prior to AEP.

What Front Runners receive:

- Complimentary certification via the Aetna Medicare certification website (estimated \$175 value)
- Signage announcing your Front Runner status
- Discounts on online purchases from Staples®
- First-to-know communications on important topics
- Discounted rate on Kaplan continuing education courses online for one year

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Section 6



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Why compliance is so important

As an Aetna partner representing our Individual Medicare plans and products (MA/MAPD) and SilverScript (PDP) products, you **must** follow Aetna's policies and the Centers for Medicare & Medicaid Services (CMS) regulations and guidelines in your daily Medicare activities. You're responsible for knowing the rules and complying with them.

Potential consequences of engaging in inappropriate or prohibited marketing activities include disciplinary actions, termination and forfeiture of compensation. This is an overview of Medicare Communication and Marketing Guidelines and compliance program requirements from Aetna and CMS. It is not all-inclusive.

On May 13, 2016, the U.S. Department of Health and Human Services (HHS)/Office of Civil Rights issued a Final Rule implementing Section 1557 of the Affordable Care Act (ACA). The new regulations prohibit discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. The law establishes new protections and applies to any health programs funded by HHS, including Medicare Advantage, SilverScript Medicare Part D and the Marketplace. The law strictly prohibits discrimination on the basis of sex, pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping and gender identity. Please review the Section 1557 guidance.

Brokers for Aetna's covered programs are required to comply with the ACA Section 1557 regulations as of July 18, 2016. Any broker who engages in prohibited discrimination in connection with the marketing of an Aetna-covered program will be subject to disciplinary action including the termination with cause of his or her Producer Agreement.

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Telephone Consumer Protection Act

The Telephone Consumer Protection Act (TCPA) and other laws regulate telemarketing calls to consumers using automated systems. Completion of a TCPA attestation as part of annual certification may be required.

- “Telemarketing” means all forms of telemarketing subject to state or federal regulation including, but not limited to, telemarketing as regulated under the Telephone Consumer Protection Act, 43 U.S.C. §227. This includes use of automatic telephone dialing systems, artificial or prerecorded voice messages, SMS text messages and fax machines as well as live calls that may be subject to any applicable law, regulation or ordinance limiting, for example, the hours of such calls or contacting persons on any Do Not Call registry. (See URL information below.)
- If uplines or producers engage in telemarketing with respect to any Aetna Medicare products or services under TCPA you must:
 1. Maintain a Do Not Call list for your organization, with supporting documented procedures that ensure that on a daily basis your organization scrubs all phone numbers against federal, state and internal Do Not Call lists in accordance with applicable law
 2. Maintain records regarding compliance with call abandonment rates in accordance with all telemarketing laws and regulations that now or hereafter govern telemarketing
 3. Do not utilize any telephone number(s) to engage in telemarketing obtained without legally sufficient consent of the recipient (e.g., telephone numbers obtained via a third party)
- TCPA rules and regulations apply to outbound telephone calls to or from any individual or entity with respect to marketing any Aetna Medicare products. Therefore, Aetna-contracted selling partners must comply with all federal, state and municipal laws, regulations and administrative guidance pertaining to:
 1. The recording and/or monitoring of telephone calls
 2. Audible notice requirements regarding the recordation and/or monitoring of telephone calls (including notifying such individual or entity at the inception of the call that such calls will be recorded and monitored)
 3. Obtaining consent at the inception of such to the recordation and/or monitoring of telephone calls
 4. The storage, privacy, security and destruction of any recorded phone calls

To access the DNC Registry, go to www.telemarketing.donotcall.gov. To learn more, the FTC maintains a FAQ website for telemarketers at <https://www.ftc.gov/tips-advice/business-center/guidance/qa-telemarketers-sellers-about-dnc-provisions-tsr>.

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How to stay compliant

All of the materials mentioned below are available on [Aetna Producer World](#).

1. Remember to always refer to, and follow, the complete and current [MCMG: Medicare Communications and Marketing Guidelines](#), which you can find at: <https://www.cms.gov/medicare/health-plans/managedcaremarketing/finalpartcmarketingguidelines.html>.
2. Every time you meet with a beneficiary to discuss our MA/MAPD or SilverScript PDP products (this includes formal and individual one-on-one appointments), you must:
 - Use our CMS-approved sales presentations from beginning to end. (For informal events, use sales presentations as a reference tool)
 - Read the sales presentation notes or talking points as part of the script. NOTE: These are for your use only and are not to be shared with beneficiaries
 - Using the sales presentation video is optional. If you choose to use the video, you must use it in addition to the sales presentation deck
3. Review our [Compliance 101 Training](#) presentation. It contains high-level compliance information you need to know before selling our Medicare products.

Do's and Don'ts MCMG

Review our CMS [MCMG Do's and Don'ts](#) Agent Summary. It highlights specific rules and regulations you need to know and follow from the CMS MCMG. Print a copy and carry this portable list with you as a reference tool when selling Medicare products.



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How to report compliance and fraud, waste and abuse concerns

Medicare Marketing Code of Conduct

You're required to read and abide by the [Aetna Medicare Marketing Code of Conduct](#). It outlines prohibited activities for agents selling Medicare products. In addition, you must comply with [Aetna's Code of Conduct](#) and [Medicare Compliance Program Policies & Procedures](#) or with a comparable ethical code and program policy.

How to report compliance or fraud, waste and abuse (FWA) concerns

As an agent contracted to sell our Individual Medicare products, you're required to prevent and report suspected or actual noncompliance and/or fraud, waste and abuse (FWA).

If you prefer, you may report your concern or issue in the following ways:

- Call Ethics Line® at 1-877-287-2040, which is available 7 days a week, 24 hours a day; or
- Visit Ethics Line® on the web at www.CVSHealth.com/EthicsLine, which is available 7 days a week, 24 hours a day; or
- Confidentially report your concerns in writing to:

David Falkowski, Chief Compliance Officer
CVS Health
One CVS Drive
Woonsocket, RI 02895

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Agent Oversight

CMS holds us responsible for the actions of all agents representing Aetna Medicare plans or products. As a result, we've created a dedicated Agent Oversight team to monitor the activities of agents contracted or employed to market and sell our Medicare products.

Our Agent Oversight team has a responsibility to:

- Protect Medicare members from being misled during the marketing process
- Oversee agents to ensure they are compliant with CMS requirements
- Identify and implement corrective actions to address inappropriate behavior
- Ensure sales events are conducted in accordance with CMS requirements (e.g., attendees get accurate information and are treated well, agents arrive on time, and marketing/sales event cancellations and revisions follow guidelines)
- Ensure agencies oversee their agents and downline arrangements

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Agent monitoring

Agent Oversight routinely monitors agent performance against both CMS and internal standards. What we monitor:

- **Cancellation rates**
 - Number and percentage of enrollments canceled before the effective date of coverage
- **Rapid disenrollment rates**
 - Number and percentage of disenrollments within 90 days of the effective date (excludes disenrollments due to death, out-of-area moves, loss of Parts A or B)
- **Enrollment application turnaround time**
 - The timely submission of enrollment applications
 - Applications must be in Aetna's possession within two calendar days of receipt by the agent, broker or producer
 - Fax is the preferred method when submitting paper applications
- **Scope of Appointment (SOA) forms**
 - Appropriate and timely completion of SOA forms
 - Beneficiaries must complete the form before all individual one-on-one meetings (whether in person or by phone) to discuss MA/MAPD and/or PDP products
 - If during an individual one-on-one meeting the beneficiary wishes to discuss a product not included on the original SOA form, you must complete a new SOA for the new product line
 - SOA forms are not required to attend a formal or informal marketing/sales event
 - Forms must be CMS-approved and filled out correctly

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- **Third-party secret-shopper surveillance program of formal and informal marketing/sales events**
 - Sales activities and events conducted in accordance with CMS requirements
 - Attendees treated in a professional manner
 - Appropriate materials available
- **Complaints and marketing incidents**
 - Volume and patterns of complaints against agents
 - Monitor complaint investigation
- **Marketing/sales seminar reporting, cancellations and updates**
 - Submission of formal and informal events to Aetna
 - Submission of canceled and revised events to Aetna

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Disciplinary or corrective actions may include:

- Focused training or monitoring sessions (i.e., ride-along assessments)
- Increased surveillance
- Verbal or written warnings
- Full retraining and retesting
- Placement on an agent "watch list"
- Suspension or probationary period, with or without commissions
- Contract termination, with or without cause, and appointment termination
- Formal reporting to applicable state Departments of Insurance

Contact information

Hours of operation: Monday through Friday, 7:30 a.m. to 4:00 p.m. ET

Email: agentoversight@aetna.com

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Complaints against agents and marketing incidents

Agent complaints, grievances and CTMs are processed through the Medicare Complaints & Appeals department. The Agent Oversight team monitors agent complaints through tracking and trending.

Complaints against agents and marketing incidents include alleged or actual infractions, misrepresentations and member dissatisfaction during sales events, individual/face-to-face appointments and other interactions with Medicare beneficiaries. A full investigation is conducted in response to every complaint received and disciplinary actions imposed when needed.

Complaints are received from multiple sources including, but not limited to:

- Other Aetna departments/processes
 - Customer Service, Broker Services, Appeals and Grievances, Enrollment
- State Departments of Insurance (DOI)
- CMS, Medicare Integrity Contractor (MEDIC), federal or state representatives/agencies
- Member or member's representative

Complaint and marketing incident process

Full cooperation is required throughout the complaint process. Upon receipt of a complaint or marketing incident involving one of our Medicare agents, brokers or producers, the process below is followed:

1. Notice of investigation letter sent to the involved agent
2. Full investigation completed
3. Determination made that complaint is either founded or unfounded, with recommended disciplinary or corrective action, as noted on previous page
4. Failure to respond within the required time frame to Aetna or CMS requests for information may result in suspension or termination of an agent's, broker's or producer's ability to market, sell and receive commissions. This information is in the agent's/broker's/producer's contract with us. In the case of a licensed-only agent, language is in the upline's contract with us

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Marketing/sales events

During marketing/sales events, plan representatives may discuss plan-specific information (i.e., premiums, cost sharing and benefits), distribute health plan brochures and enrollment materials, and accept and perform enrollments.

There are two main types of marketing/sales events, and both types must be reported to Aetna. Both types follow the **same** CMS marketing guidelines.

- **Formal:** Typically in an audience/presenter format with an agent, broker or producer formally providing specific plan or product information via a presentation
- **Informal:** Conducted with a less structured presentation or in a less formal environment. Typically utilizes a table, kiosk or a recreational vehicle (RV) staffed by a plan representative who can discuss the merits of the plan's products. Beneficiaries must approach you first.

On the following pages, be sure to review:

- **Key requirements**
- **Prohibited activities**
- **Reporting sales seminars & events to Aetna**
- **Scope of Appointment**

Marketing of Allina Health | Aetna, Innovation Health and its Medicare Advantage plans, must be done separately.

Separate Scope of Appointment and Permission-to-Contact forms are required.

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Marketing/sales events (continued)

Key requirements and important notes

1. Use only our CMS-approved sales scripts, presentations and sales presentations notes/talking points during all Aetna formal marketing/sales events and personal/individual marketing appointments.
2. Formal and informal marketing/sales events do not require documentation of beneficiary agreement on a Scope of Appointment form. Do not request or obtain one. CMS views this as pressuring for personal contact information.
3. A beneficiary may complete a Scope of Appointment at a marketing/sales event for a future appointment.
4. Upon arrival to an informal or formal event, check in with the venue so they know you are on site and have the **verification form** signed at that time.
5. Do not market non-health-care-related products, such as annuities and life insurance (referred to as cross-selling) to prospective enrollees during MA/MAPD or PDP marketing/sales events.
6. All marketing/sales events must meet event requirements.
 - Exception: If only one beneficiary attends a formal event, you can discuss the MA/MAPD and/or PDP products on an individual basis (must go with attendee's preference — full presentation or informal discussion). A Scope of Appointment is not required under this exception.
7. You will not receive commission for any sale that results from an unreported marketing/sales event. Failure to report events can result in termination of your Aetna Medicare contract.
8. New agents receive marketing/sales event reporting information during their certification training. This information is also located in agent annual training/testing material, this Aetna Medicare Producer Guide and on [Aetna Producer World](#).
9. All documentation must be saved for at least 10 years and available upon request by Aetna or CMS.

You must:

1. Use one of our CMS-approved sales presentations from beginning to end every time you meet with a beneficiary during a formal marketing/sales event or an individual marketing appointment to discuss our MA/MAPD or PDP products. Read the sales presentation notes/talking points as part of the script. If you use the MAPD or PDP sales presentation video, you must use it in conjunction with the CMS-approved sales presentation.
2. Announce all products or plan types to be covered during the presentation at the beginning of the presentation (i.e., HMO, PPO, PDP, etc.).
3. When providing an enrollment form, you must also provide: 1) current Star Ratings information, 2) Summary of Benefits, with 3) Pre-Enrollment Checklist.
4. If using non-Aetna sign-in sheets, clearly write in large letters across the top "Completion of any contact information is optional."

Upon arrival to an informal or formal event, check in with the venue so they know you are on site and have the **verification form** signed at that time.

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Prohibited activities:

1. Conducting health screening, genetic testing or other like activities that give the impression of “cherry picking”
2. Requiring beneficiaries to provide any contact information as a prerequisite for attending an event. This includes requiring an email address or any other contact information as a condition to RSVP for an event online or through the mail
3. Using personal contact information for any other purpose other than to notify individuals of a raffle or drawing win
4. Comparing Aetna to another plan unless provided comparisons can be supported (i.e., by studies or statistical data), and such comparisons are factually based.
5. Providing meals to attendees. However, light snacks and refreshments are permitted
6. Asking a beneficiary for a referral
7. Soliciting or accepting an enrollment application for a January 1 effective date prior to the start of the Annual Enrollment Period (October 15 to December 7), unless the beneficiary is entitled to another enrollment period
8. Marketing or advertising Medicare plans or events for the upcoming plan year prior to October 1
9. Using absolute superlatives like “the best,” “highest ranked” or “rated No. 1” or qualified superlatives like “one of the best” or “among the highest ranked,” unless they are substantiated with supporting data
10. Claiming you or Aetna are recommended or endorsed by CMS, Medicare or the Department of Health & Human Services

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Canceling or updating events

Visit [“Seminar Reporting, Canceling or Updating Events”](#) on Producer World:

- How to report formal and informal events
- Cancellations and changes to marketing/sales events
- Canceling marketing/sales events LESS than 48 hours before the originally scheduled date and time
- Canceling marketing/sales events MORE than 48 hours before the originally scheduled date and time

Reporting marketing/sales events

Report all formal and informal marketing/sales events to us by the 18th of each month for events scheduled for the following month.

- Report all marketing/sales events (including additional events reported throughout the month) prior to advertising the event or 10 calendar days prior to the event's scheduled date, whichever is earlier
- We reserve the right to reject last-minute event submissions that do not meet CMS or our requirements

Submission of marketing/sales events must be done on the Seminar Reporting Template. The template and instructions are on [Aetna Producer World](#) under the Compliance heading, Marketing/sales and educational events drop-down menu.

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Seminar Recap Reminders

Print our Seminar Recap Reminders document from [Aetna Producer World](#) for a quick one-page summary of CMS guidelines around formal and informal marketing/sales events. Keep a copy with you to help stay compliant.

- [Seminar Recap Reminder](#)
- [Approval process for events conducted in specific locations](#)

Approval process for events conducted in specific locations

Before conducting a marketing/sales activity in health care settings (hospitals and nursing homes), residential health and assisted living facilities, or low-income and subsidized housing units, you must first obtain approval.

For details, proceed to “Approval Process for Sales & Educational Events in Specified Locations” on Producer World.



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Educational events

Educational events are designed to inform Medicare beneficiaries about Medicare Advantage, Prescription Drug or other Medicare plans or products and do not include marketing. At these events, you cannot steer or attempt to steer beneficiaries toward a specific plan or a limited number of plans.

1. DO report all educational events to Aetna.
2. You may not include any sales activities at educational events. For example, you cannot distribute marketing materials or distribute/collect plan applications. You cannot help beneficiaries complete an enrollment form or place the form in a stamped envelope for the beneficiary to mail later.
3. You must advertise these events as “educational.” Otherwise, CMS considers them marketing/sales events and they **must** be reported as such.
4. Educational events may only be held in public venues. You cannot hold them in-home or in one-on-one settings.
5. You **may** provide objective information (communication materials) at marketing/sales events but **may not** market/sell at educational events.
6. You **may not** conduct health screenings or genetic testing.
7. You may hold **enrollee/member-only educational events**, but these events may not include any enrollment or sales activities (enrollment forms are not permitted). Any marketing of these events must be done in a way that reasonably targets existing enrollees/members only (e.g., direct mail flyers) and not the mass marketplace (e.g., radio or newspaper ads). You may discuss plan-specific premiums and/or benefits and distribute plan-specific materials to enrollees/members. Events must be advertised as educational. Otherwise, they will be considered by CMS as marketing/sales events.
8. Health fairs/senior expos may be educational or marketing in nature and must comply with the educational or marketing requirements, based on the type of event. Educational health fairs/senior expos must follow CMS guidance as outlined (i.e., advertised as educational and no sales activities nor the distribution or collection of plan applications, etc.).
9. If a sign-in sheet is used for attendance, use one from [Aetna Producer World](#) under the Compliance heading, Marketing/sales and educational events drop-down menu. Any sign-in sheet must clearly have written across the top “Completion of any contact information is optional.”

Did you know? We offer a Medicare 101 presentation that you can use at educational events. Download a copy from [Producer World](#). In our Medicare Marketing Studio, you'll find several other supporting items, including a Medicare 101 brochure.

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Educational events (continued)

Enrollee/member-only educational events

You may hold enrollee/member-only educational events, but these events may not include any enrollment or sales activities (enrollment forms are not permitted). Any marketing of these events must be done in a way that reasonably targets existing enrollees/members only (e.g., direct mail flyers) and not the mass marketplace (e.g., radio or newspaper ads). You may discuss plan-specific premiums and/or benefits and distribute plan-specific materials to enrollees/members. Events must be advertised as educational. Otherwise, they will be considered by CMS as marketing/sales events.

Health fairs/senior expos

Health fairs/senior expos may be educational or marketing in nature and must comply with the educational or marketing requirements, based on the type of event. Educational health fairs/senior expos must follow CMS guidance as outlined (i.e., advertised as educational; no sales activities nor the distribution or collection of plan applications, etc.).

You may hold enrollee/member-only educational events, but these events may not include any enrollment or sales activities and they must be advertised as educational events (enrollment forms are not permitted).

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Educational events (continued)

Acceptable examples of materials and activities at educational events

- You may display a banner with a plan name and/or logo
- You may provide promotional items, including those with a plan name, logo and toll-free customer service number or website. Promotional items must be free of benefit information and be consistent with the CMS definition of nominal gift (currently defined as items worth \$15 or less based on retail purchase price of the items)
- You may provide meals as long as the event meets the CMS definition of an educational event
- You may set up a future marketing appointment through Scope of Appointment or Permission-to-contact forms
- You may distribute business cards and contact information for beneficiaries to initiate contact
- You may respond to questions asked. Responses to questions will not render the event as marketing/sales, provided the scope of your response does not go beyond the question asked

Unacceptable activities at educational events

- You may not discuss, distribute or have available plan-specific material (i.e., premium, copayment, benefit details) or demonstrate any bias toward one plan type over another
- You may not advertise an educational event and hold a marketing/sales event immediately following it in the same general location

If you have questions or concerns about educational events, contact Agent Oversight at MedicareSemi@aetna.com.

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Scope of Appointment (SOA) requirements

CMS considers **ALL** individual/one-on-one appointments discussing MA/MAPD and PDP products with beneficiaries as marketing/sales events, regardless of the venue (i.e., in-home, library, by phone). **You are** responsible for following CMS SOA guidelines when holding individual appointments in person or over the phone.

The SOA is a documented agreement between a beneficiary and an agent, broker or producer. It lists the products agreed upon for discussion prior to a one-on-one marketing appointment.

- CMS-approved SOA forms are available on [Aetna Producer World](#) under the Compliance heading, Marketing/sales and educational events drop-down menu
- CMS does not require beneficiaries to sign an SOA to attend formal or informal Medicare marketing/sales events: do not obtain one
- You can discuss various plan options, provide educational and plan materials, and provide and collect enrollment forms. Remember, **when an enrollment form is given to the beneficiary**, the following hard copy documents must also be provided: 1) current Star Ratings information, 2) Summary of Benefits, with 3) Pre-Enrollment Checklist
- SOAs must be maintained for at least 10 years and be available upon request. This includes initial and any additional SOAs obtained during the appointment

Our Scope of Appointment form lets beneficiaries select which products they want to discuss, including:

- Stand-alone SilverScript Medicare Prescription Drug Plans (Part D)
- Medicare Advantage Plans (Part C) and Cost Plans
- Dental/Vision/Hearing Products
- Supplemental Health Products
- Medicare Supplement (Medigap) Products

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You may not market any health care-related product during a marketing appointment if not agreed to before the meeting.

- You must obtain a completed SOA prior to the appointment
- A completed SOA is not open-ended permission for future contact. An SOA is only valid for the duration of that transaction/appointment

If a beneficiary requests to discuss other products not originally documented on the SOA, you must document a second SOA for the additional product type. The marketing appointment may then continue.

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You may not:

- Discuss plan options not agreed to by the beneficiary
- Ask for referrals
- Market non-health-care products such as annuities or life insurance (referred to as cross-selling)
- Solicit/accept enrollment applications for a January 1 effective date prior to the start of the Annual Election Period (AEP) unless the beneficiary is entitled to another enrollment period (i.e., Special Election Period [SEP] or within their initial enrollment period)
- Provide meals or have meals subsidized
- Market through unsolicited contacts

SOAs can be in writing on a signed, CMS-approved SOA form or as telephonic or electronic agreements.

- Signed agreements: CMS-approved SOA is available on Aetna Producer World. You must attach a copy of the signed SOA to any paper application received from individual appointments before submitting the application to Aetna.
- Telephonic agreements: Aetna's telephonic SOA is an interactive voice response system. It guides you and the beneficiary through a short series of prompts. This method requires you to document the telephonic SOA ID# on the enrollment form. And, you'll no longer need to fax SOA forms. It allows you to set up SOAs for an entire week in a matter of minutes. It also permits a conference call to set up an SOA. And, it's perfect for handling one-on-one phone conversations.
- Electronic agreements: This method is quicker than our telephonic option. You're able to send SOAs to clients by **email** or **text** through the Ascend Virtual Sales Office app. Beneficiary information you captured elsewhere in the app will autopopulate the SOA. Appointments can be confirmed digitally. You'll see confirmations in the app immediately after the beneficiary confirms. And, SOA information is stored in the Ascend app and can be easily retrieved.

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No matter which type of SOA agreement you use, you'll need to remember:

1. SOA guidelines **must** be followed.
2. SOAs **must** be obtained prior to starting one-on-one appointments outside of a formal or informal marketing sales event.

Walk-in or unexpected beneficiary

- If a beneficiary visits you or wants to attend a prescheduled, one-on-one meeting with another beneficiary, you must get an SOA. Be sure to obtain a signed telephonic or electronic SOA prior to discussing Medicare products with the unexpected attendee

Other guidance

- A beneficiary may complete an SOA at a formal or informal marketing/sales event for a future one-on-one appointment
- You may leave Medicare information at a beneficiary's residence if a prescheduled appointment at a beneficiary's residence becomes a no-show
- You cannot agree to the SOA on behalf of a beneficiary, but you can confirm the appointment

Live links to Producer World for:

- [Aetna CMS-approved SOA](#)
- [Telephonic SOA instructions](#)

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Permission-to-contact form

Aetna sales representatives and external agents must have the Permission-to-Contact form completed prior to conducting an outbound call to a Medicare prospect. The CMS-approved [Permission-to-Contact form](#) is located on [Aetna's Producer World](#) under the Marketing heading.



- The Permission-to-Contact form is a separate and distinct document from the Scope of Appointment form
- The Permission-to-Contact form is required by CMS. Forms must be maintained for at least 10 years and be available upon request
- If a prospect calls to RSVP for a meeting, a Permission-to-Contact form is not required for that meeting but would be required for a representative to place a follow-up call to a meeting attendee

Prohibited actions

- Requests for identification numbers or for bank or credit card information
- Calls or visits to beneficiaries who attended a sales event, unless the beneficiary gave permission at the event for a follow-up call (completed Permission-to-Contact form) or visit (completed Scope of Appointment form)

CMS views beneficiary consent as limited in scope and short term. Event-specific consent is not open-ended permission for future contacts.

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Contact with Medicare beneficiaries

CMS developed the following guidelines to clarify restrictions on unsolicited contact with Medicare beneficiaries.

- All types of marketing through unsolicited contact are prohibited by CMS
- Referred beneficiaries **must** contact the plan, agent, broker or producer directly
- Permission given to be contacted or called must be event-specific. Permission may not be treated as open-ended for future contacts

Outbound calls

Outbound calls **must** use only enrollment scripts and telephone scripts approved by CMS and Aetna verbatim. Outbound calls **must** comply with these federal requirements:

- Federal Trade Commission's Requirements for Sellers and Telemarketers (i.e., TCPA — Telephone Consumer Protection Act)
- Federal Communications Commission rules and applicable state law
- National Do Not Call Registry

Outbound calls must also honor Do Not Call requests and abide by federal and state calling hours.

Electronic communication

You **can** initiate contact via email to prospective enrollees and to retain enrollment for current enrollees. And, you **must** provide an opt-out process on each communication to no longer receive electronic communications. Text messaging and other forms of electronic direct messaging (e.g., social media platforms) are prohibited. (new addition)

Direct marketing

You may not market through unsolicited direct contact (cold calling). Referred beneficiaries **must** contact you or the plan directly. And, any permission given to be contacted or called isn't open-ended for future contacts. Contact **must** be event specific. (new addition)

Telephone

You may not make unsolicited telephone calls to prospective enrollees. However, you can contact your current enrollees to discuss plan business. But, you cannot market prior to October 1 under the pretense of plan business.

For detailed information on acceptable and prohibited actions, refer to the document [Contact With Medicare Beneficiaries](#) in Producer World.

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First tier, downstream and related entities

Individuals and entities that market and sell Aetna Medicare plans (MA, MAPD, SilverScript PDP) are considered first tier entities¹ and must comply with Medicare compliance program requirements.

You must review our FDR Guide and comply with the requirements.

We describe the Medicare compliance program requirements in our [First Tier, Downstream², and Related Entities³ \("FDR"\) Medicare Compliance Program Guide \("FDR Guide"\)](#). The [FDR Guide](#) also includes a toolbox of resources that may assist you in complying with the requirements.

You can always access the [FDR Guide](#) on:

- [Aetna Producer World](#) (on the Individual Medicare page, on the Compliance tab, in the first dropdown menu, under FDR Materials & Information)

You should review the [FDR Guide](#) and ensure you have internal processes in place to support your compliance with all of the requirements. By attesting that you read the Producer Guide, you are confirming: (1) You have received Aetna's educational training for FDRs, including our [FDR Guide](#), and (2) Upon request, you will submit an attestation to Aetna confirming your compliance with the Medicare compliance program requirements.

We take these responsibilities seriously. If you have questions about the Medicare compliance program requirements or if you have difficulty accessing our [FDR Guide](#), contact your Aetna account manager or email MedicareFDR@aetna.com.

¹ A first tier entity is any party that enters into a written arrangement acceptable to CMS with a Sponsor (i.e., Aetna) to provide administrative or health care services for a Medicare-eligible individual under Part C or Part D.

² A downstream entity is any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between the Sponsor and the first tier entity. These written arrangements continue down to the level of provider of both health and administrative services.

³ A related entity is any entity that is related to the Sponsor by common ownership or control and: a) performs some of the Sponsor's management functions under contract or delegation, b) furnishes services to Medicare enrollees under an oral or written agreement, or c) leases real property or sells materials to the Sponsor at a cost of more than \$2,500 during a contract period.

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CMS requires that FDRs provide general compliance and fraud, waste and abuse (FWA) training to their employees and downstream entities within 90 days of hire/contracting and annually thereafter. Effective 1/1/2016, CMS requires that FDRs use the CMS training courses to meet the training requirements. You can find CMS general compliance and FWA training modules on the [CMS Medicare Learning Network \(MLN\)](#). You can also download CMS [general compliance training](#) and [FWA training](#) and incorporate them, unchanged, into your existing trainings/systems. The courses are called:

- Medicare Parts C and D General Compliance Training
- Combating Medicare Parts C and D Fraud, Waste and Abuse Training

Note: Selling agents receive the required training as part of the Aetna Individual Medicare certification process. If you have non-agent employees or downstream contractors, ensure they receive training.

Aetna's Code of Conduct

FDRs must also distribute code of conduct and compliance program policies within 90 days of hire/contracting, when updates are made and annually. You can provide either Aetna's [Code of Conduct](#) and [Medicare Compliance Program Policies](#) or a comparable code of conduct and/or policies to all employees and downstream entities who support Aetna's Medicare Plans.

Exclusion list screening

Federal law prohibits Medicare, Medicaid and other federal health care programs from paying for items or services provided by a person or entity excluded from participation in these federal programs. Therefore, before hiring or contracting, and monthly after that, each FDR must check exclusion lists from the [Office of Inspector General \(OIG\)](#) and the [System for Award Management \(SAM\)](#). If any of your employees (including non-agent employees) or Downstream Entities is on one of these exclusion lists, you must immediately remove them from work directly or indirectly related to Aetna's Medicare plans and notify us right away.

Complete an attestation

The attestation is included on the Aetna Medicare producer certification starting July 10.

We collect attestations annually, which certify that our FDRs have received Aetna's educational training packet, including the [FDR Guide](#), and are compliant with the CMS compliance program requirements.

Continued →

6. Compliance & agent oversight

Why compliance is so important

- Telephone Consumer Protection Act
- How to stay compliant
- Do's and Don'ts MCMG

How to report compliance and fraud, waste and abuse concerns

- Medicare Marketing Code of Conduct

Agent Oversight

- Agent monitoring

Complaints against agents and marketing incidents

Marketing/sales events

- Canceling or updating events

Educational events

- Enrollee/member-only educational events
- Health fairs/senior expos

Scope of Appointment (SOA) requirements

Permission-to-contact form

Contact with Medicare beneficiaries

[First tier, downstream and related entities](#)

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First tier, downstream and related entities (continued)

What will happen if you don't comply with these requirements?

You should ensure you are compliant with all requirements outlined in the [FDR Guide](#). Throughout the year, you may receive other notifications about these requirements, including training reminders, attestation requests or audit notices. If you fail to meet these Medicare compliance program requirements or submit requested information, it may lead to development of a corrective action plan, retraining and/or termination of your contract and relationship with Aetna.

Downstream entities

You should communicate the Medicare compliance program requirements to any downstream entities you use. You must ensure downstream entities are aware of their obligations and that they comply with all of the requirements. Those entities are responsible for satisfying the requirements outlined in the [FDR Guide](#).

Make sure you maintain documentation

You are required to maintain evidence of your compliance with the Medicare compliance program requirements for no less than 10 years. Aetna or CMS may request that you provide documentation of your compliance with these requirements. Additionally, an Aetna representative may contact you to further discuss your organization's program and compliance with these requirements.

Offshore operations

If you/your organization or your downstream entities engage in offshoring of Medicare-beneficiary protected health information (PHI), submit a written request for approval by Aetna. Send requests to the Broker Services Department at brokersupport@aetna.com.

Need help?

We can assist. If you have questions about the Medicare compliance program requirements, email MedicareFDR@aetna.com or contact your Aetna account manager.

Marketing materials

Section 7



7. Marketing materials

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Before marketing or selling Aetna Individual Medicare products, you must be appropriately licensed in the state where you intend to sell, properly appointed and certified under the Aetna Individual Medicare annual certification process.

- You're required to follow all Aetna and CMS marketing requirements. You can find and review the CMS Medicare Communication and Marketing Guidelines on [Aetna Producer World](#) and www.cms.gov.
- You may only use CMS and Aetna-approved marketing materials when discussing Aetna Medicare plans. To be clear, you may only use materials that have been created by our marketing team, approved by us and, as necessary, filed with CMS by us. Note that this includes Multiplan Materials (as described in the Medicare Marketing Guidelines).
- You may not alter CMS-approved materials in any way, other than to add personal information like agent name, phone number, email or event date, when permitted, on an approved piece.
- Materials must be used as intended. For example, you can't copy a newspaper ad and mail it to beneficiaries. This is because newspaper ads are filed with CMS specifically for that purpose and are not for use as a direct mail piece. CMS has different requirements based on the type of material and how it will be used.
- Under CMS guidelines, the official marketing period for AEP for the upcoming benefit year begins October 1. You must not market or advertise Aetna products for the upcoming benefit year before October 1, even if you have marketing/sales events scheduled in early October. Once you begin marketing 2020 products, you must cease marketing 2019 products. Prior-year materials may be provided upon request, and enrollment applications may be processed.
- You may not solicit or accept an enrollment application for a January 1 effective date prior to the start of AEP on October 15 unless the beneficiary is entitled to another enrollment period.
- See the Compliance & Agent Oversight section for marketing rules and requirements for the Scope of Appointment form, Permission-to-Contact form, sales presentations and other specific marketing materials. Please direct any questions to your Aetna representative.
- Use of senior-specific designations: You are responsible for ensuring compliance with state laws pertaining to the use of "senior-specific designations" when marketing our Medicare products. For example, in New York, a senior-specific designation is a title, professional designation, credential, certification or professional description that indicates the person has expertise or training in issues specifically related to Medicare beneficiaries in their field. If you do not know whether you are in full compliance with state laws concerning the use of senior-specific designations, do not use such designations in marketing Aetna Medicare products.
- Third-party websites that market MA/MAPD and PDP must meet all applicable CMS marketing guidance, including that found in the [CMS Medicare Communications and Marketing Guidelines \(MCMG\)](#) (refer to third-party marketing and enrollment websites in the information that follows).

We give you easy access to the "need to know" Aetna and CMS Marketing compliance obligations. Use the convenient links on the left navigation bar.

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Sales presentations

You must:

- Use the appropriate CMS-approved consumer sales presentations from beginning to end every time you meet with a beneficiary to discuss our MA/MAPD or SilverScript PDP products.
- Sales presentation notes or talking points are provided for agent/broker use only and are not to be shown to beneficiaries.
- If you use the MAPD or SilverScript PDP sales presentation video, you must use it in conjunction with the CMS-approved sales presentation.

Aetna MA/MAPD and SilverScript PDP sales presentations and notes/talking points are available on [Aetna Producer World](#) under the Marketing heading.

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Your marketing resources

Find Medicare ready-to-use, CMS-approved marketing materials on [Producer World](#)

Aetna Producer World: Your online source for Aetna Medicare member and prospect marketing materials. You can download and print them from your computer. To get access, go to <http://www.aetna.com/insurance-producer.html> and click "Log In/Register." Once logged in, click "Individual Medicare" at the top to access materials.

BenefitsCheckUp®

BenefitsCheckUp® is an easy-to-use online tool that screens older adults for thousands of public and private benefits programs. It is the nation's most comprehensive, and completely free, online resource to search for benefits easily, securely and accurately. Promotional flyers are available to make it easy for you to introduce BenefitsCheckUp®.

The Aetna-branded website is <https://aetna.benefitscheckup.org/>. The streamlined questionnaire available on both websites is entirely confidential. Through the tools available on BenefitsCheckUp®, older adults and their loved ones can get information on how to apply for programs that meet their specific needs.

Aetna Medicare Marketing Studio (MMS), your personal on-demand Medicare marketing campaign hub

www.aetnahub.com/MMS

The Medicare Marketing Studio is a user-friendly, one-stop marketing portal where you can personalize, download, print or mail CMS-compliant Medicare marketing materials.

Registration is easy:

New broker/agent

Self-register at www.aetnahub.com/mms

- Go to right side of the screen under New User
- Enter your NPN as your username*
- Select password of your choosing
- Registration connects to the RTS (ready to sell) database

* If NPN is in database as RTS, you will gain automatic access to your respective states/counties.

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Your marketing resources (continued)

Aetna Medicare Marketing Studio (MMS)

Features and advantages:

- Earlier AEP Preview/Preorder Date – Our 2020 AEP materials will be available for preview and preordering two weeks earlier than last year. Key dates: 8/26/19 - studio goes dark, 9/3/19 - Studio opens for preview and pre-ordering, 10/1/19 - studio goes live for AEP
- Broker Photos on Lead Gen for 2020 AEP – We will be offering new lead gen post cards and fliers that allow for broker photos. All photos must be business professional with plain or neutral background.
- Quality vs. Quantity – Based on our review of 2018 MMS utilization, coupled with survey feedback, our 2020 AEP focus will be on quality and effectiveness of materials to help get phones to ring and prospects to attend meetings.
- Suppression File for Direct Mail – All direct mail lists purchased on MMS will suppress current Aetna Medicare members, as well as any do-not-contact requests to help improve direct mail response rates.
- CMS Compliant/Cost Effective Materials – Order with confidence as all materials are CMS compliant. Complimentary downloads, Co-op assistance and competitive direct mail and print & ship pricing.

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Using our logos

Fill out the [request form](#) on [Aetna.com](#) at “About Us.” Click “About Us Overview,” then “Contact.” You’ll need to sign off on terms and conditions to use our logo. Then you’ll need to submit a sample layout showing how you want to use the logo. We do not require a sample layout if you are including the Aetna logo on a website. Approval takes about 1–3 business days. We’ll provide comments or approval via email.

Note: We only approve requests that appropriately reflect that Aetna is among the brands you sell. We are unable to approve requests that imply exclusivity or special status to sell our products. Also, logos should **not** be combined with another logo to create duel branding.



For Allina Health | Aetna and Innovation Health logo requests, please [contact us](#). Remember to include your name, company name and email address. We will then send you a request form to complete.

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Referencing Aetna

You may reference Aetna in electronic communications as long as your Aetna representative first reviews the reference for accuracy. However, you may not show our company logos (without additional approval; see the “Using Our Logos” page), Aetna branding elements or any product-specific information.

The following are permitted:

- Electronic communications to downline agents that mention Aetna but do not include plan-specific information (e.g., information about benefits, premiums, copays, deductible, benefits, how to enroll, networks)
- Recruitment and training documents (e.g., emails, flyers)
- Materials that only indicate the products you or your company sell (e.g., HMO, PPO or PDP)

Ownership of Marks

The Aetna name, trade names, trademarks, graphics, trade devices, service marks, insignias, symbols, codes, logotypes, logos and other brand elements (collectively, the “Marks”) and any advertising materials are the property of Aetna.

You may not use any of these items without the prior written consent of Aetna and must otherwise use all such materials and Marks only in accordance with Section 7 of your contract.

Use on websites

No upline, agent or any affiliate thereof may use Aetna’s names or Marks (including logos) on any website or other online digital assets without obtaining Aetna’s prior written consent through the [request form](#) process.

If any Aetna Medicare Advantage plans or SilverScript Part D plans are marketed or mentioned on any website of an upline, agent or any affiliate thereof, the contracted upline or agent, as applicable, must obtain Aetna’s prior written consent through the process.

We send a **mandatory** compliance survey to newly contracted agencies/agents.

- As required by CMS and according to the Aetna Upline and Producer Aetna Marketing Agreements, we monitor third-party websites that market on behalf of Aetna Individual Medicare. The survey requires that Aetna-contracted individuals or entities provide all of the URLs for any public/consumer-facing marketing websites that are used to market our MA/MAPD and/or SilverScript PDP products, including those for lead-generation activities.
- The survey also verifies appropriate use of Aetna logos.
- To have your logo submitted for approval, fill out the [request form](#) on [Aetna.com](#).
- Aetna reviews survey responses using our checklist tool and advises you in the event that further action is required.
- Upon Aetna’s review of your websites, and in accordance with the CMS Medicare Communication and Marketing Guidelines, we will submit websites to CMS that require approval.

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Co-branding requirements

Co-branding requires pre-approval.* Co-branding refers to the use of the Aetna logo or other trademarked information in a marketing piece or the joint development of marketing material(s) to promote Aetna Individual Medicare (MA/ MAPD) and SilverScript (PDP) products. Marketing materials (print or other media) include advertising and marketing campaigns, events and activities.

***At all times, you must obtain Aetna's advance written approval for co-branding.**

It's a simple process. Just fill out the [request form](#) on [Aetna.com](#).

Upon approval to co-brand, all of the following requirements apply:

- It is in the best interest of Aetna and contracted agents/agencies to be jointly involved in the early stages of campaign, event or activity development so that Aetna may conduct any analysis it deems necessary and approve or disapprove of a campaign, event or activity proposal before significant resources are expended by either party in its development.
- You must coordinate directly with your upline or with your Aetna Individual Medicare sales relationship manager.
- The co-branded material is subject to Aetna and the applicable CMS filing and/or approval processes.
- Approved co-branded advertising and marketing may include permissible promotion of co-marketed educational and wellness programs for prospective or existing Aetna members.
- All promotional and outreach activities undertaken, based on approved co-branding, must comply with applicable law (including, but not limited to, the CMS Medicare Communication and Marketing Guidelines and HIPAA).
- Aetna advertising and marketing materials (print and digital) are subject to ongoing monitoring and/or audit to ensure compliance with Aetna and CMS standards and applicable law.



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Third-party marketing and enrollment websites

What is a third-party website?

Third-party websites are those used by contracted agents/brokers and entities to reference or promote MA/MAPD/PDP plans or to obtain beneficiary information for the purposes of marketing or enrollment into an Individual Medicare plan. This also includes websites designed to provide agents with beneficiary leads.

- Aetna sends out a third-party website survey to all contracted agents/brokers and entities, with mandatory rules that require those entities to complete the survey with responses that identify and explain all websites used to market or enroll in Aetna Medicare plans
- We require uplines to notify us through the survey tool if they receive leads concerning Medicare products from another entity
- If the leads are from a third-party website or entity operating a website that markets Medicare products, those website URLs must be identified on the survey
- CMS has rules regarding third-party websites and unsolicited telephone calls that apply to any sales or lead-generating service

What are the rules?

Third-party websites that market MA/MAPD and PDP must meet Aetna and all applicable CMS marketing guidance, including the **CMS Medicare Communications and Marketing Guidelines (MCMG)**. For example:

1. They cannot request health status information such as pre-existing conditions, weight and whether the beneficiary smokes. See 42 C.F.R. §422.110(a), which prohibits discrimination on the basis of medical conditions or medical history. See also 42 C.F.R. §422.2268(c) and 423.2268(c), which prohibit discriminatory marketing practices.

See our **Third-Party Website** requirements on **Aetna Producer World**. The checklist gives you the key prohibitions and requirements.

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Third-party marketing and enrollment websites (continued)

2. They cannot provide misleading information, such as identifying a Medicare Supplement plan as a Medicare Advantage plan. See 42 C.F.R. §§422.2268(e) and 423.2268(e).
3. They cannot use prohibited terminology, including unsubstantiated absolute superlatives. They must include required disclaimers.
4. Third-party leads must be compliant with applicable law.

Any website that markets Medicare products, including any sites that may provide upline leads concerning Medicare products, is subject to a formal review and approval process. We will take appropriate action if we find a noncompliant website marketing our MA/MAPD or PDP products.

Here is how we support you to be compliant:

We send a **mandatory** compliance survey to newly contracted agencies/agents.

- As required by CMS and according to the Aetna Upline and Producer Marketing Agreements, we monitor third-party websites that market on behalf of Aetna Individual Medicare. The survey requires that Aetna-contracted individuals or entities provide all of the URLs for any public/consumer-facing marketing websites that are used to market our MA/MAPD and our PDP products, including those for lead-generation activities.
- The survey will be issued after contracting and certification have been complete. Responding to the Aetna survey within 30 days from the date the survey is issued is required. Failure to respond and/or correct issues documented by Aetna may result in termination of your contract.
- The survey also verifies appropriate use of Aetna logos.
 - [Logo use request form](#)
- Aetna reviews survey responses using our checklist tool and advises you in the event that further action is required.
- Upon Aetna's review of your websites, and in accordance with the CMS Medicare Communications and Marketing Guidelines, we will submit websites to CMS that require approval.

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Submitting member/prospect materials to us for CMS approval

We recommend you take advantage of CMS-compliant marketing materials available on the [Aetna Medicare Marketing Studio](#).



If you create a Medicare marketing piece on your own that mentions Aetna or product/plan benefits, we must review and approve it before it's used. This includes direct mailers, flyers, newspaper ads, radio scripts and other marketing materials.

To get materials approved:

- Send a Word file to your upline or your Aetna broker manager for review.
- Your piece must comply with CMS Medicare Communication and Marketing Guidelines and include all required information and disclaimers. If it doesn't, we'll return it as unapproved.
- Once approved, we'll return your piece with a CMS material ID tag, which must appear on the final version.

As a last step, you must send us (by way of your broker manager) a copy of the final version for our records. For newspaper ads, you must send us a copy each time the ad appears in the newspaper.

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Enrollment

Section 8



8. Enrollment

[How to order your sales kits](#)

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- Permission-to-Contact form

How to order your sales kits

You can order Aetna MA/MAPD and SilverScript PDP enrollment kits in one place.

There is a single point of entry to order Aetna--branded kits.

You can find the link on [Aetna Producer World](#). Click "Individual Medicare" and then click "Order Enrollment Kits."

Once you access the kit-ordering site, you'll need to use your National Producer Number (NPN) to log in.

Once logged in, you will be prompted to select the plan benefit year and plan type (MA or PDP).

Requirements

To access the kit-ordering site, you must be ready to sell. You'll need to use your National Producer Number (NPN) to log in.

Kit personalization

Personalization is available for free. The ordering process provides the option for entering your personal data. Kits can be personalized with up to two lines of information, with a maximum of 35 characters per line.

Kit limits

There is a limit on the number of kits you can order per month (allocations). If your order exceeds your monthly allocation, you may still submit the larger order. Your order will be routed to your local sales market for approval. Once approved, you will receive notification of the order's status.

Order confirmation

A confirmation screen appears after you place an order. You'll get a confirmation email when your order is processed and shipped. You should allow 48 hours for processing.

Delivery

Once processed, you should get your kits within 7 –14 business days, depending on size of order and shipping location. Kits are sent by UPS Ground. Overnight shipping and P.O. box delivery are not available.

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Description of enrollment kits

Kit pages are bound in a booklet. Everything you need to enroll is in one package.

Medicare: What you need to know

- Commonly used drugs
- Summary of benefits
- Medicare Star Ratings
- How to enroll
- Scope of Appointment
- Enrollment application

Kit booklets can be personalized with your name and contact information.

In addition, formularies and plan guides are available to order on demand through the kit-ordering site.

How to order

- Log in to [Aetna Producer World](#). Click "Individual Medicare" in the top bar. Then click "Order Enrollment Kits."

For additional information on enrollment instructions, please see the Enrollment Instructions Flier on [Producer World](#).

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Enrollment kit essentials

- **Be sure to provide a complete enrollment kit (application, plan ratings and other required items) to every beneficiary.** Our kits are built to help beneficiaries understand the plan and enroll. They include an enrollment form, instructions, a Summary of Benefits, plan ratings and a multilanguage insert.
- The plan ratings sheet is a required component in all enrollment kits. When CMS announces Star Ratings, we'll update this page and notify you. It should happen in October. You'll then need to tear out the 2019 plan ratings page from your existing kits and insert the new 2020 plan ratings page to ensure beneficiaries receive the correct information.

Scope of Appointment form

You can download the form from [Aetna Producer World](#) under the Compliance heading. All one-on-one appointments with Medicare beneficiaries (whether in person or via the phone), regardless of venue (i.e., in-home, conference call, library), must follow Scope of Appointment guidance. See Section 7, Compliance and Agent Oversight, for more information about Scope of Appointment requirements and instructions for submitting the form to us.

Permission-to-Contact form

You can download the Permission-to-Contact form from [Aetna Producer World](#) under the Marketing heading. The form must be completed prior to conducting an outbound call to a prospect. It's a separate and distinct tool from the Scope of Appointment form and is required by CMS. See Section 7, Compliance and Agent Oversight, for details.

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Enrollment process: What you need to know

Section 9



9. Enrollment Process:
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 - Aetna Medicare identifier, your NPN
- E-kit
- Innovation Health, Allina, Migrating and Expansion enrollment options
- CMS “Trumping” rule
- The enrollment process: What you need to know
- Referral-only sales
- Telebroker oversight

Election periods overview

For your convenience: SEP Period Booklet link
https://www.aetna.com/producer/Medicare/documents/SW_SEPQuickReferenceGuide.pdf

Initial Coverage Election Period (ICEP) and Initial Election Period (IEP)

ICEP and IEP occur when consumers first become eligible for Medicare. These periods are for all consumers becoming eligible for Medicare, whether it’s due to turning 65 or a qualifying disability. Eligible consumers can enroll in an MA plan of their choosing, including a Medicare Advantage Prescription Drug plan (MAPD). Those already enrolled in Medicare due to disability have a second IEP when they turn 65. Based on eligibility criteria and election choices, ICEP and IEP may occur together or separately.

New to Medicare (Initial Enrollment)

			
<p>IEP</p> <ul style="list-style-type: none">• 7 months around initial eligibility• Parts A, B and D• 3-1-3	<p>Second IEP</p> <ul style="list-style-type: none">• 65th birthday• 7 months	<p>ICEP</p> <ul style="list-style-type: none">• Delay in Part B coverage• 3 months before Part B start date	<p>ICEP notes</p> <ul style="list-style-type: none">• PDP enrollment is separate• Part B awarded after effective date; requires document action

Open Enrollment Period (OEP)

OEP runs January 1 through March 31. Enrollees of Medicare Advantage plans, either MAPD or MA-only plans, are eligible to make changes. Such individuals are permitted to enroll in another MA plan or Original Medicare, with or without a Prescription Drug Plan.

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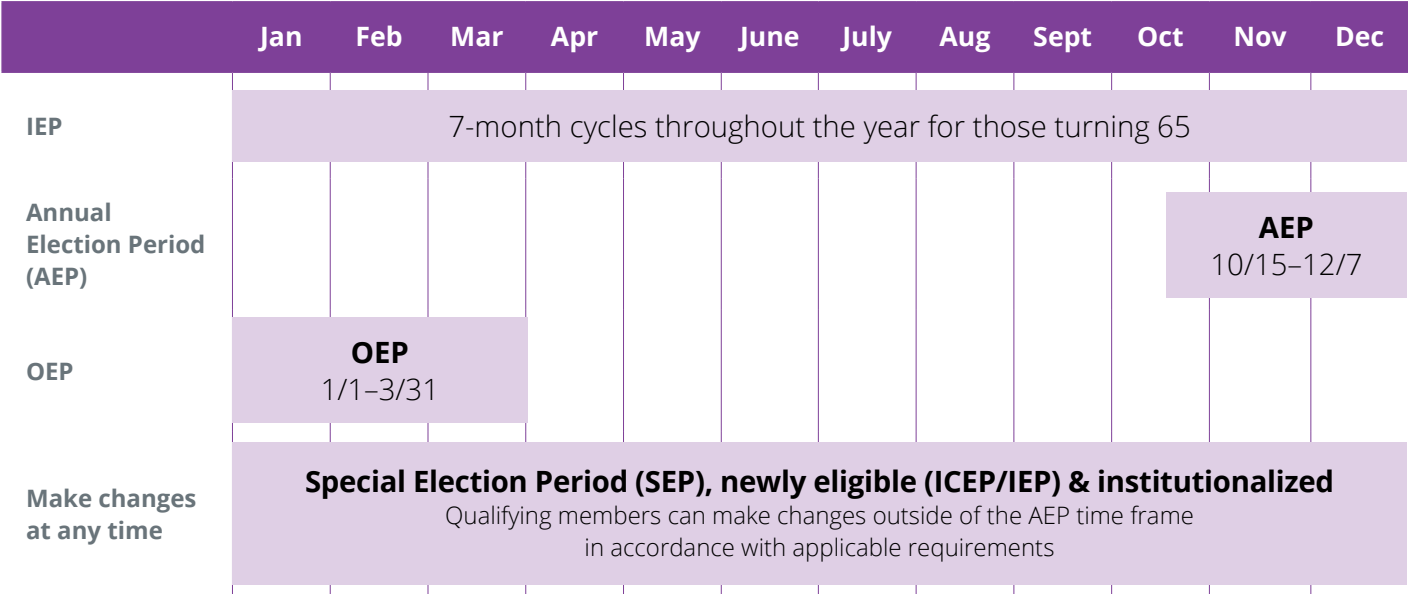
Special Election Period (SEP)

A Special Election Period lets beneficiaries change their election in accordance with requirements during certain times of the year, outside the AEP. The qualifications to use SEPs and the types of elections allowed vary. Situations such as dual-eligible status and institutionalization let beneficiaries switch plans outside the AEP. SEPs are determined and announced by CMS.

Annual Election Period (AEP)

AEP runs from October 15 through December 7. Beneficiaries can change or add a Prescription Drug plan, change Medicare Advantage (MA) plans, return to Original Medicare, or enroll in an MA plan for the first time, even if they did not enroll during their Initial Election Period.

- You can begin marketing for the upcoming benefit year on October 1. You must not market or advertise Aetna products for the upcoming benefit year prior to October 1. You must not advertise marketing/sales events to discuss subsequent-year benefits prior to October 1, even if your events are scheduled for anytime in October.
- **You may NOT accept or solicit paper enrollment forms or accept telephone or online enrollment requests prior to the start of the AEP on October 15. Any AEP applications received before October 15 will be denied, and agent commissions on these sales won’t be paid.**



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[Enrollment application
turnaround time \(TAT\)](#)

Aetna enrollment options

- Aetna Medicare identifier, your NPN

E-kit

Innovation Health, Allina,
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Enrollment application turnaround time (TAT)

A signed Medicare enrollment application must reach us within **two calendar days** of when you receive it from the beneficiary. This information is covered in your contract with us. The two-calendar-day requirement ensures sufficient time to review applications and send them to CMS for processing within the CMS-required time frame.

To ensure you meet the two-calendar-day turnaround time requirement, we encourage you to submit paper applications through the fastest and preferred method:

- **For [Aetna Medicare applications](#):** Email or fax
- **For [Innovation Health, Allina, Migrating and Expansion applications](#):** Fax

[Please refer to enrollment application turnaround time \(TAT\) on Producer World.](#)

Duplicate enrollment application

Applications received are promptly processed to CMS. If a subsequent application is received for the same plan, it is considered “duplicate” because the individual is already enrolled; therefore, the application is not processed. Also, if two applications are submitted for a member with the same agent signature date and plan selection, one of the applications will be treated as a duplicate.

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Aetna enrollment options

Online through our Ascend Virtual Sales Office app

Available for use on any device — including your laptop or tablet — that runs with an iPad platform (iPad 3 or newer model running on iOS 10 or higher) or a Windows platform (Windows 8 or later x86 processor).

Once you’re ready to sell, you can request access to the app on Producer World. After logging in, simply click “Tools” and then click the “Ascend Virtual Sales Office App” link. Click the “Request Access” radio button, verify your information and then submit your request. Please allow 2–7 days for processing.

Paper applications	
Mail	Aetna Medicare Broker Enrollment Team P.O. Box 14088 Lexington, KY 40512-4088
Fax	1-866-441-2341 or 1-888-665-6296 Please fax or mail the application to the fax number or address listed on the enrollment form. Contracts to mail or fax to Aetna address and fax numbers: H0523 H3219 H3931 H1109 H3312 H4523 H3152 H3597 H5793 Our e-kit option is a useful tool to help you enroll your clients in MA/MAPD plans. The e-kit option is available through the Ascend Virtual Sales Office app.

Aetna Medicare identifier, your NPN

In general, to ensure you receive commission for accepted enrollments, you’ll need to use:
Your National Producer Number (NPN) on Aetna Individual Medicare (MA/MAPD, PDP) applications.
You can look up your NPN on the [National Insurance Producer Registry](#) website.

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Email	<p><u>MedicareEnrollmentTransactions@aetna.com</u></p> <p>Scan and save the paper application, Scope of Appointment and any required paperwork as a single document in an approved file format. The preferred format is PDF. Other acceptable formats include .bmp, .csv, .doc, .docm, docx, .htm, .html, .jpg, .mdi, .msg, .ppt, .pptm, .pptx, .rtf, .tif, .xls, .xls, .xslm, .xlsx and .xps. Attach the file to an email message and then send it to <u>MedicareEnrollmentTransactions@aetna.com</u>.</p> <p>We recommended one applicant (and one attachment) per email. However, for greater efficiency, up to five applicants/attachments per email are allowed. Email attachments cannot exceed seven pages each. Write the name of each applicant in the subject line so that the names appear on your email confirmation. Note: The subject line cannot contain numbers and the email body cannot contain embedded images, graphics or logos.</p>
Phone	<p>You can assist a beneficiary with contacting us by phone, but telephonic enrollment requests must be initiated entirely by the beneficiary or his or her authorized representative. You cannot be physically present with the beneficiary at the time of the telephonic enrollment process. This is a CMS rule.</p>

If all requirements are met, you’ll receive an automatic email confirmation. Confirmations will include a date and time stamp from your original email, the names of the applicants you place in the subject line, and the total number of attachments sent. If all requirements are not met, you’ll receive an automatic email rejection. The email will indicate why the transaction was rejected so that you can make corrections and resubmit.

Enrollment email application requirements:

- Subject line with enrollee name only
A confirmation or rejection automated email response with the enrollee name in the subject line will be sent back to the broker/sender
- Save documents with the enrollee name only. Confirmation or rejection automated email response with the enrollee name that was saved on the document will be sent back to the broker/sender
- DO NOT use Social Security number or HICN/MBI or any type of number in subject line; automated email response will remove and default to xxxxx
- DO NOT use Social Security number or HICN/MBI or any type of number when saving documents; automated email response will remove and default to xxxxx

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E-kit

Our [e-kit option](#) is a useful tool to help you enroll your clients in MA/MAPD plans. The [e-kit option](#) is available through the Ascend Virtual Sales Office app.

Email through the e-kit function found within Ascend

Within Ascend, you can send an enrollment form and provide access to a compliant sales kit through the e-kit (email) function and still receive credit for the sale. The beneficiary is responsible for completing and submitting the enrollment form.

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Innovation Health, Allina, Migrating and Expansion enrollment options

Online through our Ascend Virtual Sales Office app

Available for use on any device — including your laptop or tablet — that runs with an iPad platform (iPad 3 or newer model running on iOS 10 or higher) or a Windows platform (Windows 8 or later x86 processor).

Once you’re ready to sell, you can request access to the app on Producer World. After logging in, simply click “Tools” and then click the “Ascend Virtual Sales Office App” link. Click the “Request Access” radio button, verify your information and then submit your request. Please allow 2–7 days for processing.

Paper applications	
IMPORTANT! Be sure to submit enrollment applications and Scope of Appointment forms directly to:	
Innovation Health/ Allina/Aetna P.O. Box 7405 London, KY 40742 Fax: 1-866-756-5514	Please fax or mail the application to the fax number or address listed on the enrollment form. Contracts to mail or fax to Innovation Health, Allina, Migrating, and Expansion address and fax number: H2829 H3219 H8649 H1608 H1692 H5325 H8597 H1100 H2663 H3959 H1609 H3928 H3239 H9431 H5302 H5522 H7149 H7301 H5337 The e-kit option is available through the Ascend Virtual Sales Office app.
Phone	You can assist a beneficiary with contacting us by phone, but telephonic enrollment requests must be initiated entirely by the beneficiary or his or her authorized representative. You cannot be physically present with the beneficiary at the time of the telephonic enrollment process. This is a CMS rule.

Aetna Medicare identifier, your NPN

In general, to ensure you receive commission for accepted enrollments, you’ll need to use:
Your National Producer Number (NPN) on Aetna Individual Medicare (MA/MAPD, PDP) applications.
You can look up your NPN on the [National Insurance Producer Registry](#) website.

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A person can't be enrolled in more than one MA product or PDP plan at a time.

If CMS gets enrollment requests from separate carriers for the same person in the same valid election period, the last application or enrollment request they get in the same election period will take effect. The carrier (and associated writing agent) that submitted the last enrollment request will get credit for the enrollment. If the enrollment requests have the same application-received date, the carrier that submitted the first enrollment request will get credit.

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Before completing an enrollment application with a beneficiary

- Confirm plan eligibility and verify and document the consumer’s Medicare Part A and Part B coverage. For D-SNP plans, confirm Medicaid eligibility
- Thoroughly explain the benefits, rules and member rights. Use the Aetna CMS-approved sales presentation to ensure you’ve covered all required information
- Disclose producer- and product-specific disclaimers
- Verify that the beneficiary agrees to proceed with enrollment
- Verify that the plan the beneficiary selects is in their service area

Confirming eligibility

- To be eligible to elect an MA plan, a beneficiary must be entitled to Medicare Part A and enrolled in Part B, and continue to pay their Part B premium. The beneficiary must be entitled to Medicare Part A and Part B benefits as of the effective date of coverage under the plan. Exceptions for a Part B-only grandfathered consumer are outlined in the CMS Medicare Managed Care Manual. Part B-only consumers currently enrolled in a plan created under section 1833 or 1876 of the Social Security Act are not considered grandfathered consumers and must purchase Medicare Part A through the Social Security Administration to become eligible to enroll in an MA plan.

At the time they enroll in an MA plan, the consumer must have Medicare Parts A and B. You should always verify this. Here are examples of acceptable proof of eligibility:

- ☐ Copy of Medicare card
- ☐ Copy of Medicaid award letter for Dual-eligible Special Needs Plans
- ☐ Social Security Administration award notice
- ☐ Railroad Retirement Board letter of verification
- ☐ Statement from the Social Security Administration or Railroad Retirement Board verifying the consumer’s Medicare eligibility

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Explaining benefits, rules and member rights

You must provide and thoroughly explain all plan benefits, limits and rules as outlined in the Summary of Benefits (SB) and Statement of Understanding.

- This includes how consumers get their prescription benefits, if applicable, and all required plan-specific disclaimers.
- For **HMO** and **POS** plans, provide clear direction on Primary Care Physician (PCP) selection requirements.
- For **PPO** products, in- and out-of-network benefits must be fully described.
- To be eligible to choose an MA plan, a consumer must be fully informed of and agree to abide by the rules of the plan that are provided during the enrollment process.
- The Statement of Understanding gives the consumer the plan rules. The Statement of Understanding for the applicable plan year must be acknowledged, without modification, by the consumer or authorized representative and attached to the election form.

An important reminder: Aetna enrollment applications (MA/MAPD) include the “Proposed Effective Date.” You must:

1. Be sure that your client is aware that the effective date of the enrollment will be determined based on when the Plan receives the enrollment application request and/or election period/SEP used on the application. The effective date is determined by the Plan. Prospective members can note the proposed effective date they would like, but the Plan will make the final determination of effective date of enrollment for the Medicare Advantage plan they have selected.
 - Make sure your client understands that they cannot be effective with a plan prior to their Part A and Part B effective date.
2. Confirm their proposed effective date (typically the first day of the next month).

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Completing the enrollment application

You may proceed with the enrollment only after thoroughly explaining all plan benefits, limitations and rules to the consumer and receiving consent from them.

- Ensure that all required information is provided on the application
- Ensure the MBI is entered in the correct format:
 - #, A, # or A, #, A,# or A,#,A,A, #, #
 - # = Numbers 0–9
 - A = Alpha character (excludes: S, L, O, I, B and Z)
- If the applicant is using a Special Election Period to enroll, make sure you complete the Enrollment Checklist portion of the enrollment forms to confirm your client’s eligibility to enroll
 - **During AEP 10/15–12/7, if your client wants an effective date other than 1/1, a SEP must be provided. If a SEP is not provided, the member could be enrolled for a 1/1 effective date**
- Provide a phone number for the applicant
- Be sure that the applicant is aware that the effective date of the enrollment will be determined based on when the Plan receives the enrollment application request and/or election period/SEP indicated on the application. The prospective member can note the proposed effective date they would like, but the Plan will make the final determination of effective date of enrollment for the plan the applicant has selected
- Ensure that the application is signed and dated by the applicant
 - If an authorized representative signs the enrollment application, the record of attestation of authority must be maintained as part of the record of the enrollment election and must include contact information
- Agent is required to sign and date page 8 of the application. This information is used to determine the receipt date of the application by Aetna

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- Upon submission of your client’s enrollment application, they will receive an Outbound Enrollment Verification letter which is required by CMS for any agent/broker sale. Upon acceptance of the enrollment with CMS, they’ll receive a Confirmation of Enrollment letter. If there is any key data missing or unclear information on the application that prohibits submission to CMS, your client may receive a phone call from the enrollment processing team to obtain the missing data. They may also receive a Request for Information letter indicating what is needed in order to complete the application, along with a date for returning this information. If the information is not received in time to complete the enrollment process, the application will be denied. CMS may reject the enrollment if your client already has employer group health coverage. Your client will receive a call as well as a letter indicating that we need confirmation that they wish to enroll in the plan. If the confirmation is not received prior to the expiration of the time frame (30 days), the application will be denied.

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Referral-only sales

If you participate in the referral program, you must comply with the program requirements below.

1. You may only leave approved referral materials with qualified individuals.

For a referral on an MA plan, a qualified individual is an eligible Medicare beneficiary who meets the following requirements:

- Has both Medicare Parts A and B
- Resides in an Aetna Medicare Advantage service area
- Is qualified to enroll in a Medicare Advantage plan
- Has a relationship with the agent
- Has expressed interest in a Medicare Advantage plan
- Understands that he or she must contact Aetna by phone or on the website

For a referral on a SilverScript PDP plan, a qualified individual is an eligible Medicare beneficiary who meets the following requirements:

- Is entitled to Medicare benefits under Part A or enrolled in Medicare Part B
- Resides in a SilverScript Medicare Part D service area
- Is qualified to enroll in a SilverScript Medicare Part D plan
- Has a relationship with the agent
- Has expressed interest in a SilverScript Medicare Part D plan
- Understands that he or she must contact Aetna by phone or on the website

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2. You must adhere to CMS Medicare regulations and guidelines and all state insurance laws:

- You can't engage in sales presentations or market the Aetna MA/MAPD or the SilverScript PDP plans being referred to the qualified individual
- You may only confirm the client is a qualified individual, provide the client with Aetna referral materials, and inform the client they're responsible for contacting Aetna about enrolling in a Medicare plan
- The referring agent must only use Aetna CMS-approved materials
- The referring agent cannot contact the client for follow-up on Aetna MA/MAPD or SilverScript PDP plans

3. You are prohibited from soliciting referral clients through cold calling, door-to-door visits or other actions prohibited under state or federal law. You must have an existing relationship with the Medicare beneficiary or qualified individual.

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Telebroker oversight

Medicare distribution telebroker

- Upon contracting, you receive a Telesales Amendment

Speak with your dedicated Aetna National Sales Director for complete onboarding and training details

Oversight

- As First Tier, Downstream and Related Entities (FDR), Telebrokers are subject to CMS regulatory requirements for enrollment applications of Aetna MA/MAPD and SilverScript PDP, including annual oversight
- The agency principal must be confirmed Ready to Sell
 - All Telebrokers must be confirmed ready to sell, including completion of Annual National Telebroker Product Training
- Annual oversight audits are performed on all Telebrokers

Annual audit requirements

- Collaboration between Telebroker Operations, Aetna Medicare Sales Director and the Aetna Audit Team to ensure timely completion of annual audits
- Operational review — A review of Telebroker operational policies and procedures to ensure compliance with all regulatory requirements and contractual obligations
 - The auditors ensure the existence of effective monitoring and oversight protocols of the Telebrokers.
 - Completion of Aetna’s TeleSales Operational Review Questionnaire (ORQ)
 - » Submission of applicable policies and procedures
- Performance review — Sampling of entities call recordings to validate sales agent licensing and script adherence
 - Submission of report of all telephonic enrollment applications completed during current AEP (10/15/YYYY – 12/7/YYYY)
 - » A random sampling of telephonic enrollment applications will be selected for audit
 - » The Telebroker submits recordings for selected sample
 - Sales agent licensing
 - » Confirm Sales Agent licensing for resident and plan state
 - » Confirm Health Plan Appointment

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Telebroker oversight (continued)

- Aetna; Allina; Innovation Health
 - Script adherence
 - » Telebroker must use CMS-approved sales and enrollment scripts
 - » If Telebroker uses their own script, they must provide that script to Aetna with proof of CMS approval
 - » Must submit copies of CMS-approved scripts for applicable AEP period
 - » Operational and/or Performance Deficiencies are documented as Corrective Actions in the Final Audit Report, and the Telebroker will be placed on corrective action

Note: Under the terms of your Aetna contract, telebroker partners are required to disclose to Aetna any complaints or compliance issues they have identified internally as well as respond to any complaints that are received through Aetna.

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Member experience

Section 10



10. Member experience

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After submitting the application

What happens after your client enrolls?

Your clients will hear from us approximately 14 days after their enrollment form has been received and accepted. Prior to this date, we recommend that you and your client review the handy checklist that is included in their pre-enrollment Sales Kit.

Material name	Description
Plan confirmation/ Acceptance letter/ RFI/Denial/Rejection	<p>Encourage your clients to complete all required fields on the enrollment application to ensure their timely and accurate enrollment with our plan.</p> <p>We're not able to submit to the Centers for Medicare & Medicaid Services (CMS) enrollment applications if required information is missing or incomplete. Our enrollment processing team will make an attempt to contact your client to obtain the missing data. Your clients may also receive a Request for Information (RFI) letter indicating what is needed in order to complete the application and a time to return this information. If the information is not received in time to complete the enrollment process, the application will be denied.</p> <p>CMS may reject the enrollment if your client has employer group health coverage. Your client will need to confirm their intent to enroll in the Individual Medicare Advantage plan. They will receive a call as well as a letter with instructions. If the confirmation is not received prior to the expiration of the time frame of 30 days, the application will be denied.</p> <p>We'll send an acceptance letter to your clients once CMS accepts their enrollment. This letter will include information to help them understand how use their plan. In the event that CMS is unable to approve the enrollment request, your client will receive a letter of denial or a letter of rejection into the plan.</p>
Monthly plan premium	Remind your client about the premium payment option they chose on their enrollment application.

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Material name	Description
Member ID card	<p>After we've received confirmation from CMS that the member can be enrolled in the plan, we'll mail them materials.</p> <ul style="list-style-type: none">• Member ID Card• Evidence of Coverage (EOC)• Directory notice (insert)• Formulary (drug list)
Prescription drug Transition of Care	<p>It is critical to review clients' current medications against the plan's formulary to confirm coverage. Also review special coverage rules (e.g., prior authorization, step therapy, quantity limits) prior to enrolling them in a plan. <i>One of the leading reasons for members to disenroll from their plan is that one or more of their current drugs are not covered by their plan.</i> Transition prescription fills let members get one-time, short-term coverage for prescription drugs that are not on their plan's formulary or that have coverage rules. Members are encouraged to work with their providers to see if changing to another drug that is on the plan's formulary is right for them. Or they should work with their provider to request a coverage determination. The provider will need to show that the member meets the criteria for one of our coverage rules.</p> <p>Even with approval, sometimes the prescription is only covered at a Tier 4 cost-share. This means the member will pay more for the drug than if they switched to an alternative drug that's covered on their plan's formulary.</p> <p>Transition prescription fills are not for new prescriptions. Members can only get transition prescription fills for drugs they were taking before switching plans or before their plan changed its coverage.</p>
Health needs assessment (Reminder, this applies to Medicare Advantage only)	<p>We'll contact your clients to learn about their health history. The information won't affect their enrollment in the plan.</p>

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Material name	Description
Doctor visit (Reminder, this applies to Medicare Advantage only)	Be sure to remind your client to see their doctor to take advantage of the annual health care services available to them. Remind them to list their current PCP on the enrollment form. Even if members choose a PPO plan that does not require them to select a PCP, it is helpful for us to know who they see to coordinate their care.
Medical transition of care (Reminder, this applies to Medicare Advantage only)	Our transition of care program works to get members the care they need. New members should let us know if they're getting active treatments from or have an upcoming surgery scheduled with a doctor that's not in our network. For us to cover their care, they need to complete a Transition of Care form. There are time frames for which we need to receive the information, so it's important they connect with us as soon as possible.

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We encourage you to follow up with a welcome call to new members you help to enroll. Making this call within the first month of the member's effective date ensures your clients are off to a good start using their coverage. During your conversation, you should verify the following, based on their specific plan:

- The PCP we have on file and printed on their member ID card is the PCP they normally see. If not, offer to help them find a network PCP OR direct them to Member Services to update their information
- They understand what action to take if their current prescription drugs are not on the plan's formulary or have coverage rules
- They are clear on their plan premium payment options (e.g., paying an LEP monthly plan premium, paying the Part B premium, etc.). If the member is on a SSA payment, share that it could take up to three months for this option to go into effect. And that they should pay any premium notices they get from the plan until they receive confirmation that a SSA was set up
- [For members with direct-to-member reimbursement for dental/vision/hearing benefits] That they understand how their DMR benefits work and what information is required to request the reimbursement
- [For members with a Part B Give Back] That the member understands it could take up to 90 days to see the Part B reflected in their Social Security check
- Allow the new member to ask any additional questions
- Ask the new member to give your contact information to their friends and relatives so you can help them the same way you helped the new member.

This is a service call, and you cannot use this call to sell products. Allow the new member to ask any questions about their current plan and how to best use it. If the member wishes to discuss alternative plan options, you will need to separate topics and call the member back.

If the member states they wish to disenroll, remind them that most Medicare beneficiaries have specific time frames to enroll in or disenroll from a plan. Instruct the member to call us at the number on their member ID card to learn about any disenrollment options.

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National Committee for Quality Assurance

What the NCQA means for you and your Aetna clients

The National Committee for Quality Assurance (NCQA) is a private, nonprofit organization. It's dedicated to improving health care quality.

Like the Good Housekeeping Seal, the NCQA seal is a widely recognized symbol of quality. To display the seal, we had to pass a rigorous, comprehensive review. And each year, we have to report on our performance to keep our NCQA accreditation. The seal is a reliable way for your clients to know that we're well-managed and we deliver high-quality care and service.

How we share NCQA-required information

The NCQA requires us to share certain information with our members. This information can help them get the most out of their health care plan. For example: We have to let them know how we decide which treatments to cover and why we review their use of some services. This information and other NCQA-required information appears in the plan's Evidence of Coverage.

To learn more about the NCQA, visit their website at <http://www.ncqa.org>.

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An enrollment can only be canceled or withdrawn if the request is made (based on the date the telephone call or written notification is received) prior to the effective date of the enrollment.

If your client requests to withdraw their enrollment application prior to you submitting their enrollment application, you must still submit the enrollment application to us.

You may not accept any requests to cancel or withdraw an enrollment application or terminate enrollment in a plan. Instead, you must direct all requests to cancel or withdraw enrollment applications or terminate enrollment to the same location where the application was originally submitted or to Member Services, which is the number on the member ID card.

An agent may not request or encourage any member to disenroll (neither verbally nor in writing, nor by any action or inaction).

Furthermore, an agent is not permitted to make additional contact with a member or legal representative who requests to cancel or withdraw their enrollment application or disenroll from the plan. Only Member Services is authorized to contact members within the guidelines provided under the privacy regulations and policies.

Reminder: If an enrollment application is received and it has incorrect information or certain information can't be validated, it could be placed in the Predenial process. The Predenial process differs from the Missing Information process.

An application can be denied for the following reasons:

- Plan selection is not available
- No valid Election Period/SEP
- Applicant incorrectly checked YES to the ESRD question

If an application is put into the Predenial process, the enrollment team will attempt to contact the applicant to correct or validate the information over the phone. If the enrollment team cannot obtain the necessary information, the application will be denied. If the application is denied, the applicant will have to submit a new application.

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For help with any plan-related questions, members should contact our Member Services team at the phone number on their member ID card.

Aetna Member Services

Hours of operation: 8 a.m. to 8 p.m., 7 days a week

Phone: Differs by plan. Shown on the member's ID card

Allina Health

Hours of operation: 8 a.m. to 8 p.m., all time zones, 7 days a week

Phone: 1-833-570-6671

Innovation Health

Hours of operation: 8 a.m. to 8 p.m., all time zones, 7 days a week

Phone: 1-855-249-1282

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Members who want to have someone speak with a representative on their behalf can complete an Authorization for Release of Protected Health Information form. This allows us to talk to their representative about:

- Their benefits and coverage
- Their claims
- Their bills

Designating full control of a member's account (power of attorney)

Members can send in a Power of Attorney or Personal Representative form to give full control of their account to another individual. This designated person then has the same ability as the member to obtain information or make changes to the account.

Members can request a form from Member Services, complete it and send it in to us. Or, members can send us power of attorney information from the court, requesting that we assign a designated person permission to act on their behalf.

Members can now grant brokers permission to call Member Services on their behalf

Using the Protected Health Information (PHI) form, members can now give brokers permission to call Member Services (MSO) on their behalf.

What is the PHI form?

It's an optional form members can complete to give permission to a family member, caretaker or their broker to call Member Services on their behalf.

When members list a broker on the PHI form, the broker's name will now be added to the member's record. As a result, when brokers call into Member Services for their members, Member Services can first verify that the broker has the right authorization before answering any questions.

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Here's just some of the rules for using the PHI form:

1. Only the member can initiate and fill out the form.
2. Members need to submit one form per person they wish to have on their account.
3. It can take up to 30 days to process the PHI form. The member will need to provide permission by phone to MSO to release their information until it has been processed.

Be sure to review the PHI form rules.

Where can members find the form?

Aetna and Innovation Health: www.aetnamedicare.com/forms.

How do members turn in the form? After a member has filled out the PHI form, they'll need to mail it in to MSO. Aetna and Innovation Health members can also fax in the completed form. The addresses and fax number are included on the PHI form.

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Your clients can find what they need online

We offer online tools to help guide your clients on their health journey. Whether accessing a member ID card, finding a network pharmacy or looking up medications, we've got your clients covered. There are two primary online tools to help your clients. The first is our Medicare website, which has your clients' plan information. The second is the secure member website, which contains your clients' personal information.

AetnaMedicare.com

Use it to:

- See a plan's formulary, or list of prescription drugs we cover
- View a plan's EOC
- View flu shot benefits
- Find forms like mail-order delivery, prescription drug claims forms and more
- Find a network doctor, hospital or pharmacy

Secure Member Website

Use it to:

- Check your claims
- View or request a new member ID card
- Sign up to receive certain communications by email
- Access wellness tools and available discount programs
- See your electronic Explanation of Benefits (EOB) statements

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Member engagement programs

Medicare Advantage members may receive letters or phone calls promoting wellness programs. This includes health risk assessments and Healthy Home Visits.

These programs are part of members' plan benefits and available free of charge. They're voluntary and confidential. If your clients have any questions about any of them, they should call Member Services at the number on their member ID card.

Member Meetings:

In certain markets, we invite members to attend a member meeting during AEP. At these meetings, we review new benefits and answer member questions.

Welcome Member Meetings:

At the beginning of the year, we host local meetings to ensure members understand their benefits so that they can get the most out of them. At these educational meetings, members can learn about their plan and get answers to their questions.

Welcome Calls:

New members are called after AEP and throughout the year. During these calls, our retention agents review the member's plan benefits and answer any questions the member may have.

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Member engagement programs (continued)

Resources For Living

Resources For Living is a unique, exciting program exclusively for your MA/MAPD clients/our members and their caregivers. Resources For Living is available for all Aetna brands. What are the benefits of this program? It's a complimentary research and referral service that connects members and caregivers with local resources, services and activities that can help meet their daily needs. The program offers:

- Personalized research on a variety of topics like senior housing, adult day care, home-delivered meals, transportation not covered by the medical plan, community activities and more
- Referrals, resources and educational materials
- Help finding caregiver support options, household services and assistance for emergency needs

There's no cost to contact RFL. Your clients decide which services they want to use. If they choose services that have costs associated with them, like home cleaning, they'll need to pay those costs.

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Healthy Home Visits

This program is available to Medicare Advantage members at no charge and is an opportunity to talk to a trained health care professional about their unique needs in the comfort of their home. Medicare Advantage members will be contacted by phone or mail from an Aetna outsourced company. The in-home health evaluation takes about an hour, and Medicare Advantage members can have a caregiver or family member present as well. Participation in this program is highly recommended and is simply another way we can help members take the best possible care of their health and well-being. The program doesn't take the place of regular doctor visits. Instead, it's another resource for members to ask questions and get answers about the things that matter most about their health. This program does not affect Medicare Advantage members' health care coverage in any way.

During the in-home health evaluation:

- The Medicare Advantage member talks one on one with a licensed health care professional and asks any questions they may have about their health and medical conditions
- The visiting in-home health care professional will suggest a personalized list of topics to discuss with the Medicare Advantage member's primary care physician
- Medicare Advantage members may be referred to other programs available through Aetna to help manage long-term health

Health Risk Assessments

This program is available to Medicare Advantage members who are not targeted for an in-home health assessment. They receive outreach through Care Management to participate in a Health Risk Assessment (HRA) survey, which is delivered through email and IVR outbound call channels. The HRA survey questions align with our member engagement messaging and include subjects like Health Goals, Behavioral Health and Social Determinates of Health. The purpose of the Medicare HRA survey is to identify those members who are at high medical risk, particularly for inpatient care. High-risk members are referred to a Nurse Care Manager for further assessment and, if needed, active case management.

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