Sales Partner Marketing & Communication Agency Guide For PY 2025

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Devoted's Commitment to Our Sales Partners

Devoted Health is committed to help our sales partners (i.e. "TPMOs") develop compliant marketing and communication materials. ***The purpose of this document is to provide guidance to our partners contracted with Devoted Health when developing such materials.***

The guidelines provided here apply specifically to all communication and marketing materials. It is not a comprehensive list of compliance guidelines that apply to the marketing and selling of Devoted Health products.

Sales partners must comply with Centers for Medicare & Medicaid Services (CMS), Title 42 of the Code of Federal Regulations (CFR) and any applicable state or federal laws, rules or regulations. This includes not only the content of the material, but how and when the material is used. All communications or marketing materials must include required disclaimers. All marketing materials must be submitted to CMS prior to use, pursuant to 42 CFR § 422.2261(a).

Thank you for your continued partnership! Any questions on any information provided within this guidance or with any marketing or communication materials can be directed to agencyoversight@devoted.com

HPMS User Access

Sales partners are responsible for developing multi-plan marketing materials, and submitting those materials to HPMS for approval. All sales partners creating marketing materials for multiple plans ("multiplan") must get appropriate access to CMS' Health Plan Management System (HPMS) set up with Devoted Health. If you do not yet have an active CMS user ID with access to HPMS, you must first register with CMS and obtain a CMS user ID.

See the attached CMS instructions for getting a CMS user ID and obtain access to HPMS.
https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/hpms/useridprocess

Requesting & Deleting HPMS Access:

To add CMS marketing consultant access or to add or delete contracts for existing consultant access, Devoted's Sales & Marketing team will prepare an official letter on behalf of the agency that states the users **name, CMS user ID, company name** and the contract numbers for which consultant access is needed. Again, you must first have a CMS user ID in place before Devoted can proceed with the process.

Send the following details for any user(s) in an email to Agencyoversight@Devoted.com with the subject line"Request: HPMS Access Updates"

Consultant (First & Last Name	**CMS user ID**	**Consultant Company Name**

Multiple names at the same agency can be included if they are all obtaining the same consulting access type.

Devoted will submit an access request to CMS. CMS generally completes all user access requests and deletions within 10 business days.

Devoted's Marketing Review Process

The Devoted Sales & Marketing Compliance Team is responsible for reviewing materials prior to the agencies uploading into HPMS.

- Sales Partners must submit all marketing materials to Devoted Health for pre-review/approval prior to submission in HPMS. Devoted may require a sales agency to submit communication materials for prior review and approval.
- Marketing materials must be submitted in HPMS for each plan year, and should be reviewed annually to ensure compliance with CMS regulations and guidelines.
- Materials filed for the upcoming plan year can not be used prior to October 1st (can not file materials for the upcoming plan year until June 1st).
- The third-party may not use the material for an associated contract/MCE unless the plan has opted-in.

Standardized Material Identification (SMID)

Sales Partners must use a standardized method of identification for oversight and tracking of materials received by beneficiaries.

- Marketing Materials must have an assigned Standardized material identification (SMID)**.**
- The SMID filed in HPMS must match the material ID that is published on the final version of the material.
- If the SMID changes from when the piece was initially submitted, please notify the Devoted Sales & Marketing Compliance team and let us know the old SMID and the newly revised SMID.
- There should never be more than one SMID on a single document.
- The SMID consists of the following three parts:
    a. The SMID for multi-plan marketing materials must begin with the word "MULTI-PLAN" instead of the MA organization's contract number (for example, H1234_abc123_C or MULTI-PLAN_efg456_M).
    b. A series of alpha-numeric characters (chosen at the Sales Partner's discretion) unique to the material followed by an underscore.
    c. An uppercase "C" for communications materials or an uppercase "M" for marketing materials (for example, H1234_abc123_C or H5678_efg456_M).
- The SMID is required on all materials except the following:
    a. Membership ID card.
    b. Envelopes, radio ads, outdoor advertisements, banners, banner-like ads, and social media comments and posts.
    c. OMB-approved forms/documents, except those materials specified in CFR§ 422.2267.

d. Corporate notices or forms (that is, not MA/Part D specific) meeting the definition of communications (see § 422.2260) such as privacy notices and authorization to disclose protected health information (PHI).
e. Agent-developed communications materials that are not marketing.
f. Non-English and alternate format materials, based on previously created materials, may have the same SMID as the material on which they are based.

Devoted Pre-Review Process Overview

The pre-review process will be completed by Devoted's Sales & Marketing Compliance team within 5-10 business days. Failure to submit materials to Devoted before filing in HPMS will cause delays in the approval process, and may ultimately result in Devoted choosing to opt out of materials. Please follow these steps to ensure a timely review and approval of materials:

1. Sales Partner to sends all marketing materials to Devoted for review prior to uploading into HPMS:
    a. Submit materials via email to agencyoversight@devoted.com using this submission template:
        i. Devoted Health TPMO Marketing Review Template
    b. Use one template, even if submitting multiple materials. Use ***"****Request - Marketing Materials for Pre-Review"* as your subject line.
    c. Attach the link for the marketing material.
    d. The assigned SMID needs to be listed on the material itself.
2. Devoted will review all materials for compliance with CMS regulations, and Devoted Health's guidelines. This pre-review process can take between 5-10 business days.
3. Changes and feedback:
    a. Devoted will send feedback/approval via email back to the sales partner.
    b. If Devoted has feedback/changes for the material, it is expected that the Sales Partner agrees to make changes, and/or have a discussion with Devoted regarding any suggested change(s).
        i. **Approved** - Once approved, the agency can proceed with submission into HPMS.
        ii. **Not approved** - Devoted will communicate the decision with the agency via email, and the agency can not select Devoted in the HPMS submission (Contract selection).

HPMS Filing

Once the Devoted Sales & Marketing Compliance team has reviewed and approved the material(s), the Sales Partner can proceed to upload and file the material in HPMS.

1. **Opt-In:** Devoted will opt-in once notification from CMS has been received.
2. **Opt-out -** Agencies are not permitted to sell Devoted products for any lead received for material in which Devoted "opted-out." Agencies must have a process in place to support opt out.

a. If Devoted does not approve the material and selects to opt out, the sales partner has a few options:
    i. Work with Devoted on necessary changes needed - once approved, the sales partner can include Devoted as an MA contract within HPMS submission; or
    ii. If a sales partner does not choose to make the Devoted requested changes, the sales partner cannot select Devoted within HPMS and are not permitted to sell Devoted products for any lead received from material in which Devoted "opted-out."
3. The sales partner can always add additional MA plans to the material in HPMS after the material has been accepted and/or approved

Note: The sales partner may not use the material for Devoted Health unless the plan has opted-in.

TV Commercial review/submission

For television commercial submissions, during Devoted's pre-review process (prior to HPMS submission), the sales partners must reply to our attestation, guaranteeing that the ad will only be broadcasted in service areas where Devoted Health Plans are available.

i. The attestation will read as follows and updated annually:
ii. *"By replying in the affirmative you are attesting that this advertisement will only be used in service areas where Devoted Health Plans are available. Our plans' 2025 service areas, as applicable, include select counties in Alabama, Arizona, Arkansas, Colorado, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Mississippi, Missouri, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, and Washington.*
iii. After the TV ad marketing material has been uploaded into HPMS, the agency must:
    1. Send us the hyperlink to the final ad for us to verify correct demographics/benefits availability within 14 days of the TV commercial being initially aired.
    2. Provide a list of corresponding service areas/zip codes.
    A delay in providing this zip code verification information, could result in Devoted opting out of materials.

Marketing vs Communications

CMS defines both marketing and communication materials. Generally, Devoted's review is limited to marketing materials, unless otherwise requested. Here is how CMS defines Communications vs Marketing:

Communications

These are activities and use of materials created or administered by the plans or any downstream entity to provide information to current and prospective enrollees. All activities and materials aimed at prospective and current enrollees, including their caregivers, are "communications" within the scope of the regulations at 42 CFR Parts 417, 422, and 423.

Marketing

"Marketing" is a subset of communication with specific intent and content. To be considered a marketing, the materials must meet both the following intent and content standards:

Intent – Materials and activities that are intended to:

- Draw attention to a MA plan or plans,
- Influence a beneficiary's decision-making process when making a MA plan selection, or
- Influence a beneficiary's decision to stay enrolled in a plan (that is, retention-based marketing)

Content – Materials and activities that include or address content regarding any of the following:

- Benefits, benefits structure, premiums or cost sharing.
- Measuring or ranking standards (for example, Star Ratings or plan comparisons).
- Rewards and incentives.

CMS now considers "marketing" any material with general widely available benefits, like dental, vision & hearing as "marketing" materials. Please make sure that you no longer include this information in your communication materials. CMS Definition of Marketing

For more details on the CMS requirements, see CMS Managed Care Marketing.

General Requirements - Development of Multi-Plan Marketing Materials

CMS permits our sales partners to submit multi-plan marketing materials directly to CMS when the marketing materials include content to support multiple (two or more) plans. For example, if the sales partner operates a website that lists several MA organizations and their cost sharing, and is used by beneficiaries to select and enroll into a plan, the sales partner may submit the website on behalf of the contracted plans.

All communication and marketing materials developed by Devoted's sales partners must comply with all CMS marketing regulations and applicable state laws. The information that follows and is included within this guide provides direction to develop materials in accordance with these requirements.

Sales Partners may not mislead, confuse, or provide materially inaccurate information to current or potential enrollees. Sales Partners must not engage in activities or create materials that could mislead or confuse Medicare beneficiaries, or misrepresent themselves or Devoted Health. Any type of deceptive advertising meant to mislead consumers in any way will not be approved by Devoted Health.

Disclaimers

CMS disclaimers are considered required content, and must be in a 12pt font, Times New Roman or equivalent.

This list does not encompass all required CMS disclaimers but displays the most commonly & frequently used Medicare Marketing disclaimers and other statements required to be included in certain scenarios.

Third-Party Marketing Organization (TPMO) Disclaimer:

If your agency sells plans on behalf of more than one MA organization, you must include the following TPMO following disclaimer on all marketing materials:

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

****For 2025, Devoted has one (1) organization and 235 PBPs****

This TPMO disclaimer must:

- Verbally conveyed within the first minute of a sales call.
- Be electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication;
- Prominently displayed on TPMO websites; and
- Included in any marketing materials, including print materials and television advertisements, developed, used or distributed.

This TPMO disclaimer is NOT required on smaller social media posts or internet search ads (e.g. “SEO”, like Google or Bing) where space does allow for that information; however, the disclaimer and all required information must be provided on the subsequent page (i.e. URL “click through”).

Federal Contracting Statement

CMS requires a Federal Contracting Statement (FCS) on all marketing materials. For CY2025, Devoted’s FCS is:

> *“Devoted Health is an HMO and/or PPO plan with a Medicare contract. Our D-SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.”*

CMS provides a few exceptions where the FCS is not required on a material:

- Banners and banner-like advertisements.
- Outdoor advertisements.
- Text messages.
- Social media.
- Envelopes.

Sales partners should create an FCS that fits their company. For example:

> *<Company> is a licensed representative of Medicare Advantage (HMO, PPO, and PDP) organizations that have a Medicare contract. Enrollment in any plan depends on contract renewal.*

Special Supplemental Benefits for the Chronically Ill Disclaimer (SSBCI)

This is model content through which MA organizations must:

- Convey the benefits mentioned are a part of special supplemental benefits.
- Convey that not all members will qualify.
- Include the model content in the material copy which mentions SSBCI benefits.
- Example: “The benefits mentioned are a part of a special supplemental program for the chronically ill. Not all members qualify.”

Sales Partners must also include explicit disclaimers when marketing SSBCI, ensuring beneficiaries understand that SSBCI are not available to all plan enrollees and eligibility is limited. Must include the SSBCI disclaimer in all marketing and communications materials that mention SSBCI.

There are specific format requirements which will impact TPMO advertising SSBCI:

- For print ads, must display the disclaimer in 12-point font, Times New Roman or equivalent.

- For television, online, social media, radio, or other-voice based ads, we proposed that MA organizations must either:
    - Read the disclaimer at the same pace as the organization does for the phone number or other contact information mentioned in the ad
    - Display the disclaimer in the same font size as the phone number or other contact information mentioned in the ad.
- For outdoor advertising (ODA)—must display the disclaimer in the same font size as the phone number or other contact information appearing on the billboard or other ODA.*
- The disclaimer needs to be on the ad itself (a link is not sufficient).

Accommodations Disclaimer

This is model content through which MA organizations must:

- Convey that accommodations for persons with special needs are available.
- Provide a telephone number and TTY number.
- Include the model content in disclaimer form or within the body of the material on any advertisement of invitation to all events described under § 422.2264(c).
- Example: *"For accommodations of persons with special needs at meetings call <insert phone and TTY number>."*

Star Ratings Disclaimer

This is model content through which plans must:

- Convey that MA organizations are evaluated yearly by Medicare.
- Convey that the ratings are based on a 5-star rating system.
- Include the model content in disclaimer form or within the material whenever Star Ratings are mentioned in marketing materials, with the exception of when Star Ratings are published on small objects (that is, a give-away items such as a pens or rulers).
- Disclaimer language: *"Every year, Medicare evaluates plans based on a 5-star rating system."*

Promotional Give-Away Disclaimer

This is model content. The disclaimer consists of a statement that must make clear that there is no obligation to enroll in a plan, and must be included when offering a promotional give-away such as a drawing, prizes, or a free gift.

- Example disclaimer language: *"Eligible for a free drawing, gift, or prizes with no obligation to enroll." Or, "Free gift without obligation to enroll."*

Out of Network Non-Contracted Provider Disclaimer

This is standardized content and must be included whenever materials reference out-of-network/non-contracted providers:

> *"Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call the Plan's customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services."*

CMS will not require the MA names on smaller social media posts or internet search ads (e.g. "SEO", like Google or Bing) where space does allow for that information; however, this information would be required on the subsequent page (e.g. URL "click through").

Notice of availability of language assistance services and auxiliary aids and services

This is also referred to as the Multi-language insert (MLI). The MLI must be provided with all required materials under paragraph (e) of the CFR 42 CFR 422.2267 section. For a complete list of all Required Materials, please see 42 CFR 422.2267(e)

- The MLI may be included as a part of the required material or as a standalone material in conjunction with the required material.
- When used as a standalone material, the MLI may include organization name and logo.
- When mailing multiple required materials together, only one MLI is required.
- The MLI may be provided electronically when a required material is provided electronically as permitted under paragraph (d)(2) of this section.

Here is the current version of the standardized MLI disclaimer:

> "*We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at [1-xxx-xxx-xxxx]. Someone who speaks [language] can help you. This is a free service." in the following languages: Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, and Japanese.*

Common required materials a TPMO may use:

- Plan Enrollment forms/applications
- Star ratings document
- Pre-Enrollment checklist (PECL)

Please note: Plans are responsible for creating the above materials, and should include the above MLI language. However if you utilize these materials, please ensure the above disclaimer language is included.

Names of Medicare Advantage Plans

CMS requires the names of all contracted organizations associated with this marketing to be included in the marketing material**.**

Inappropriate Requests for Health Status Information

Do not request health status information unless required for enrollment into a plan (e.g. Chronic Condition SNP) or as required by CMS as part of the "pre-enrollment checklist" review prior to enrollment. An MA organization may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an MA plan offered by the organization on the basis of any factor that is related to health status, including, but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

Ensure that any questions or other language in BRC's, plan comparisons, sales or enrollment processes or scripts, do not directly or indirectly require this information, unless necessary for enrollment in the plan.

Telephonic Script Guidance

Sales Partners must use CMS approved scripts, and scripts need to be reviewed annually and adhere to all CMS guidance.

- Sales/Pre-enrollment scripts are considered marketing and must be filed with CMS as file and use.
- The TPMO disclaimer must be conveyed within the first minute of the sales call.
- The Federal Contracting Statement must be stated on all sales/pre-enrollment calls.
- Advise that the call is being recorded and this must be conveyed to the prospect at the beginning of the call.
- Ensure all Scope of Appointment requirements are met prior to the personal marketing appointment.
- During telephonic sales presentations agents may ask, ***but not require***, the beneficiary to provide information regarding their Medicare ID number, Part A or Part B effective dates, or any other demographic or health information.
- The only information an agent needs from a beneficiary in order to provide non-beneficiary specific plan information is zip code, county, and/or state.
- If the beneficiary does not wish to disclose any of this information, the agent must continue the call and provide plan information to the beneficiary.
- The agent cannot end the call if the beneficiary does not disclose this information, as this could be seen as discriminatory.

Customer Service Numbers

- Customer service numbers must be toll-free numbers.
- A TTY number must appear in conjunction with the customer service number in the same font size and style as the other phone numbers except as outlined below.
  Exceptions:
  - Outdoor advertising (ODA) or banner/banner-like ads.
  - Radio advertisements and radio sponsorships (e.g., sponsoring an hour of public radio).
  - In television ads, the TTY number may be a different font size/style than other phone numbers to limit possible confusion.

Email Communications

An opt-out process must be included on each communication for those who wish to no longer receive email or other electronic communications.

> *Note: Text messaging and other forms of electronic direct messaging (e.g., social media platforms) would fall under unsolicited contact and are not permitted unless there has been expressed permission.*

Lead Generation Activities

When conducting lead generation activities, TPMOs must ensure the process of obtaining leads is compliant and the lead sources must follow all CMS regulations and requirements.

Lead forms must clearly inform the beneficiary that his or her information will be provided to a licensed agent for future contact. This disclosure must be provided as follows:

- Tell the beneficiary that his/her/their information will be provided to a licensed agent for future contact. This disclosure must be provided as follows:
    - Verbally when communicating with a beneficiary through telephone.
    - In writing when communicating with a beneficiary through mail or other paper.
    - Electronically when communicating with a beneficiary through email, online chat, or other electronic messaging platform.
- Tell the beneficiary that he/she/they are being transferred to a licensed agent who can enroll them into a new plan.

TPMO Lead Collection

Beginning October 1, 2024, personal beneficiary data collected by a TPMO for marketing or enrolling them into an MA plan may only be shared with another TPMO when prior express written consent is given by the beneficiary.

Prior express written consent from the beneficiary to share the data and be contacted for marketing or enrollment purposes must be obtained through a clear and conspicuous disclosure that lists each entity receiving the data and allows the beneficiary to consent or reject the sharing of their data with each individual TPMO.

Lead Forms

Sales partners are responsible for ensuring that they are gathering and purchasing leads in a compliant manner that is consistent with Devoted Health policies and procedure, CMS guidelines, and other federal and state regulations.

- Permission to contact must be clear to the consumer that they are agreeing to give their contact information and requesting for a licensed sales agent to contact them regarding Medicare plan information.
- Lead forms, whether they are marketing or communications, must be compliant.

- If working with lead companies, ensure they are reputable, and clearly only communicate about Medicare. If contact information is required, they must advise that a licensed sales agent will call and it contains consent language as mandated by TCPA, FTC, FCC and HIPAA.

Permission to Contact

Permission to contact (PTC) must be clear to the consumer that they are agreeing to give their contact information and requesting for a licensed sales agent to contact them regarding Medicare plan information.

- If a potential enrollee provides permission to be called or otherwise contacted, the contact must be event-specific, and may not be treated as open-ended permission for future contacts.
- Permission to contact language needs to be clear and easy to read, and in a prominent location on the material.
- Language can not be buried within the disclaimer language, or in small print.

Telephone Consumer Protection Act (TCPA)

FCC guidelines stipulate when requesting information from a beneficiary agencies need to, at the minimum, disclose:

  - Calls may be made by auto dialer, text (if applicable) or robocall (if applicable)
  - Calls are for marketing purposes
  - Cellular carrier charges may apply
  - Providing permission does not impact eligibility to enroll or the provision of services
  - Can change permission preferences at any time

Websites

- Websites must be clear and easy to navigate.
- If communicating about both current year and upcoming year plans (AEP), it must be clear to which plan year the information is referencing.
- May only require users to enter zip code, county, and/or state for access to non-beneficiary specific website content.
- Websites containing any marketing content must be submitted to CMS.
- All Sales Partner websites must include the TPMO disclaimer, regardless if they are marketing or communications.

Lead generation websites

- Permission to contact must be clear
- TCPA disclaimer language is required, along with other required disclaimers.
- Agency-created websites or websites that are used by partners to obtain leads that contain lead forms need to be clear, easy to understand and navigate.
- Agencies cannot require consumers to disclose their health status, gender, or date of birth information to solicit for Medicare Advantage or Prescription Drug Plans.
- When requesting beneficiary contact/demographic information, must not require users to enter any information other than a zip code, county, and/or state for access to non-beneficiary specific website content.

Social Media

Sales partners must submit any social media (Devoted Health account) posts (e.g., Facebook, Twitter, YouTube) that meet the CMS' definition of marketing for Devoted's review and then CMS filing by the partner.

As previously mentioned, the CMS required TPMO disclaimer is NOT required on smaller social media posts, like FaceBook, Twitter or Instagram; however, the disclaimer and all required information must be on the subsequent page (i.e. URL "click through").

Marketing within Service Areas

Marketing of any benefits should be limited to those offered within a plan's service area. The exception to this "rule" is when limiting the marketing within the service area is truly unavoidable, such as advertising in a local newspaper that may be distributed outside a service area.

Medicare Advantage Organization/Medicare Names in Marketing Materials

All marketing materials must include the name of the MA and Part D organization(s) offering the products or plans, benefits, or costs identified in the materials. The name(s) must be included in the following format and each name should be bracketed individually as a variable:

- MA/Part D organization names must be in 12-point font and may not be in the form of a disclaimer or fine print.
- For television, online, or social media, the MA organization or marketing name(s) must be either read at the same pace as the phone number or must be displayed throughout the entire advertisement in a font

size equivalent to the advertised phone number, contact information, or benefits.
- For radio or other voice-based advertisements, MA organization or marketing names must be read at the same pace as the advertised phone numbers or other contact information.

Inappropriate Marketing of "Savings"

CMS prohibits marketing of potential savings that most beneficiaries would not have ever have incurred. For example, savings associated with those individuals who do not have insurance, costs that dual eligibles are not responsible for, or any other costs that a Medicare beneficiary would not incur.

Any Materials that Mention Providers

Any communication or marketing material that mentions a provider and Devoted Health must be submitted to Devoted Health for review prior to use.

- Provider office materials must be filed in HPMS for approval, for a 45 day prospective review.
- Providers are prohibited from mailing marketing materials on behalf of the plan. This includes mailers that describe general plan benefits and do not mention any particular carrier.

Nominal Gifts

Gifts may be given to Medicare beneficiaries for marketing purposes so long as the total retail value is no more than $15 retail value, $75 aggregate, per person, per calendar year. Materials promoting/offering a gift must state that the gift is available with **no obligation to enroll**.

- Must be offered to all potential enrollees regardless of whether they enroll, and without discrimination.
- May not be in the form of cash or rebates.
- May not be items that are considered drug/health benefits (e.g., a free checkup), including optional mandatory supplemental benefits; may not be tied directly or indirectly to the provision of any other covered item or service.

Educational or Sales Materials

Any materials used to promote events must adhere with both CMS marketing and communication requirements, as well as the Devoted guidelines.

- Materials that include invitations to educational or sales events must clearly be advertised as 'educational' or "sales" on the material(s) itself.
- The following disclaimers must be added to the Educational or Sales Event materials:

- **Sales Events:** "For accommodation of persons with special needs at sales meetings call 1-800-338-6833 (TTY 711). A licensed sales agent will be on site with plan materials and enrollment applications."
- **Educational Events:** "For accommodation of persons with special needs at meetings call 1-800-338-6833 (TTY 711).

Important reminders for materials for sales & educational events:

- Only BRCs can be distributed at educational events.
- Scope of Appointments ("SOAs) cannot be distributed at educational events
- Sales events can not immediately follow educational events.

For more information about sales and educational event requirements, see Devoted's "Broker Manual."

Prohibited Terminology/Statements

Devoted Health prohibits agencies from distributing communications that are materially inaccurate, misleading, or otherwise make misrepresentations or could confuse beneficiaries.

All marketing materials must clearly identify who is sending the marketing material (e.g. lead generation company and/or sales partner) company and where the beneficiary will be directed. Examples of misleading content include:

- Identifying a Medicare Supplement plan as a Medicare Advantage plan;
- Creating materials or websites that look like official government notifications (i.e., tax notice formats, barcodes, perforated envelopes, official phrases, paper color, etc.)
- Using words and/or imagery that may confuse beneficiaries or cause them to believe the advertisement is coming directly from the government.
- Providing information about Original Medicare or Medicare plans that is inaccurate or unclear.

Areas of concern include:

- Company/insurance agency/broker not prominently displayed.
- Mailings/lead forms do not list a specific insurance company and request the materials be returned to Direct Mail Processing.
- Includes the American flag or imagery such as government buildings and/or symbols.
- Logos that are very similar to the Health and Human Services (HHS) logo, on websites and print materials. (Logos have featured circles with writing around the circle and a bird, wings, or other images that appear to be the same image used by the Federal

Government.)

- Websites with “Medicare” in the URL or a logo similar to the HHS logo, potentially causing a beneficiary to click on a private site when they intend to go to Medicare.gov or are seeking official Medicare information or access.
- Overuse of red, white and blue as the color scheme with no company identification to clarify you are not affiliated with Medicare or the federal government.
- Includes a company name that is similar to or includes “Medicare” or a name that may confuse consumers into believing the company is affiliated with Medicare, and does not prominently clarify that the company is a sales agency and not the government or endorsed by the government.
- Not include disclaimers, or contains hidden or very small disclaimers, including but not limited to those to clarify the company is a sales agency and not the government or endorsed by the government.

Small Font/Print Size:
According to the Federal Trade Commission 16 CFR 255.0(f), “clear and conspicuous” means that a disclosure is difficult to miss (i.e., easily noticeable) and easily understandable by ordinary consumers.

Because advertisements are targeting Medicare Advantage beneficiaries which include the senior population, it is important that disclaimers are clear and conspicuous from the perspective of older consumers, as they may have diminished visual, or cognitive processing abilities.

Use of Medicare Card Image

Sales partners that plan to use the Medicare card image on any marketing or communication piece must send the material to CMS for approval.

- The material must be sent via email to the CMS marketing mailbox at Marketing@cms.hhs.gov with an attached copy of the material that includes the card image.
- CMS suggests all pieces using the Medicare card include a disclaimer near the image that indicates they are not affiliated or endorsed by CMS, HHS, the Federal Government, etc.
- Once approved by CMS, the piece **and** the CMS approval email must be submitted to the HPMS marketing module using the SMID of the marketing piece.

Comparisons to Other Plans/Original Medicare

Do not compare Devoted Health plans to other plans/Original Medicare by name (unless substantiated by a study or statistical data) and such comparisons are factually based. *Must include footnote referencing

data/study.

- Comparison cannot be misleading or confusing to members.
- Do make disparaging comments about other plans/Original Medicare.

References to Research or Studies

Agencies may not make unsupported claims in advertising. If a statement is made that requires statistical support or documentation, current and accurate sources must be cited. Ensure that citations are either built into the text or referenced by footnote and include the date and source of the study or research.

- Agencies may not make superlative statements such as "the best" or "highest ranked" or "number one" unless these statements can be validated. If you can't support it, you can't state it.
    - If a "highly rated" statement is used, need to include the following substantiation language, *"XX% of the plans offered through <Agency> are highly rated. Highly rated is considered 4 and above out of 5 stars. Medicare evaluates plans based on a 5-Star rating system. Star Ratings are calculated each year and may change from one year to the next."*

Claims of Endorsement

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

"Partnership" or "Alliance"

Avoid words like "partnership" or "alliance" in reference to the relationship between Devoted Health and the agency/agent or Devoted Health and a vendor.

Endorsements / Testimonials

If member testimonials are used, must use actual members who are currently active in the plan they are endorsing. Testimonials must also include the name of the plan in which the member is enrolled ("Devoted Health"). Must add required disclaimer language: "Real Devoted Health Member." (only the first time we "see" the member if they appear multiple times, such as in a TV ad).

- Ensure the member has given consent for quotes to be used in the particular medium, such as on a website.
- If an individual is paid to endorse or promote the plan or product, this must be clearly stated (e.g., "paid endorsement").
- If an individual, such as an actor, is paid to portray a real or fictitious situation, the ad must clearly state

it is a “Paid Actor Portrayal.”

- Any endorsement or testimonial that is made by a healthcare provider (even if another individual quotes the provider) must be discussed with and reviewed by Devoted Health prior to use. Providers can not be paid or compensated for testimonials in any way.
- Any claim made in an endorsement or testimonial must be substantiated.
- An endorsement or testimonial cannot use negative testimonials about other Plans/Part D Sponsors.

Language Rules & Restrictions

Use Correct Terminology to Describe Agents

It is acceptable to use the following terms:

- Licensed Sales Agent
- Licensed Sales Representative
    - *Note: “Medicare Expert” may not be used as it can be misleading, implying the agent may have additional knowledge/skill above licensing requirements that can’t be verified. Using the word Medicare in the title may also make it seem as if we’re endorsed by Medicare***.**
- If an agent’s phone number or one that will route to sales is included, must clearly indicate before the number that it will direct callers to a “licensed sales agent”.

Refrain from using the term “Senior”

- Never state or imply plans are only available to seniors rather than to all Medicare beneficiaries.” as it may imply that people with Medicare are only eligible due to aging in (65+); CMS views the use of the term “senior” in some contexts as potentially discriminatory against those who have Medicare due to a qualifying disability.
- Use “People with Medicare” or “Medicare eligible” or “older Americans”, as this is the preferred terminology.
- CMS uses the term Medicare Beneficiary, not Medicare Recipient..

Superlatives and Absolute Language

- Do not use unsubstantiated absolute or qualified superlative language, such as “best”, “greatest,” “#1” or “outstanding”.
- Do not use absolute language such as “guarantee” or “promise” (these are only examples).
- Use of superlatives, unless sources of documentation or data supportive of the superlative is also referenced in the material. Such supportive documentation or data must reflect data, reports, studies, or

other documentation that applies to the current or prior contract year.
    - Including data older than the prior contract year is permitted provided the current and prior contract year data are specifically identified.

Describing Medicare

- When comparing Original Medicare to MAPD, it must be more specific than just “Medicare”.
- It is preferable to describe it as “Medicare Part A and Part B.”
- The term “Original Medicare” can also be used.

Acceptable Use of the word “Free”

- When describing gifts/services like, “Free Medicare Plan Comparison”, need to include “no obligation to enroll” language. (At a minimum disclaimer language is needed).
- It is preferred to have this language in proximity to the FREE reference. If there are space issues, may use an asterisk with the language notated at the bottom in a footnote.
- Do not use the term “free” to describe a zero dollar premium, reduction in premiums (including Part B buy-down), reduction in deductibles or cost-sharing, low-income subsidy (LIS), or cost sharing for individuals with dual eligibility.
    - *It is only permissible to use the term “free” with respect to plan benefits when describing mandatory, supplemental, and preventive benefits provided at a zero-dollar cost sharing for all members.*

Use of Qualifying Language

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

Words/phrases to avoid

- Entitled (can only be used when discussing Original Medicare)
- Any Affordable Care Act reference
- Customized” or “personalized” should not be used when describing Medicare plans or benefits
- Do not market any federal programs in order to obtain MA/MAPD leads (I.e., Medicare Savings

Program, Food Stamps, etc.)

Acceptable Words and Terms to use at the end of AEP

Approved phrases to communicate at the end of AEP (Annual Election Period) that doesn't create false sense of urgency include:

- Don't delay
- Enroll now
- Now's the time
- The time is now
- Don't Miss Out
- Get the answers you need
- AEP is ending soon (may only be used within 2 weeks of 12/7)
- AEP ends on 12/7

Scare and High-Pressure Tactics

- Avoid using language to create undue fear or anxiety in members/prospects, such as "beware of some plans whose copays could bust your budget", etc.
- Avoid words that would cause a false sense of urgency, such as "Act now, or you may lose your benefits!" etc.
- Avoid repetitive phrases, certain font/colors, and/or punctuation that may communicate this to a potential enrollee.
    - Examples may include **"URGENT!!!", "OPEN IMMEDIATELY", or "TIME SENSITIVE"** used on a materia. This may, but not always, be used with fonts that are in all caps, oversized and red.
    - One specific example, provided by a Medicare beneficiary, is a postcard with the beneficiary-named address with ''Medicare Notice'' in large, (sometimes red) bold letters at the top along with ''Personal & Confidential'' and ''Important Medicare Information.

General Election Period Requirements for Marketing & Communication Materials

When submitting materials in HPMS, please indicate the selling period(s) that the material will be used in the marketplace.

Annual Election Period (AEP)

In order to ensure that beneficiaries are not misled or confused about Original Medicare open enrollment versus MA/PDP fall open enrollment and the January – March Open Enrollment Period (OEP), the following terms are acceptable to use when describing AEP:

- "Annual Enrollment Period"
- "Medicare Annual Election Period."
- "Fall Open Enrollment Period"
- It must be clear in the context of the piece as a whole that the piece is referring to the AEP when a person can enroll in a Medicare Advantage or Prescription Drug Plan.

Open Enrollment Period (OEP)

Agencies are prohibited from knowingly targeting or sending unsolicited marketing materials to any MA enrollee or Part D enrollee during the continuous Open Enrollment Period (OEP) (January 1 to March 31).

- Be careful in not appearing to be marketing during OEP.
    - "Switching" language must not be used during the OEP.
    - Specifically calling out the OEP, or outlining the options a member has during the Open Enrollment Period would likely be considered marketing the OEP by CMS.
    - Any materials used during OEP that only focus on the ability to switch - instead of focusing on the ability to enroll through the use of ICEP and other SEP's, would not be allowed.

During the OEP, agency partners/agents may:

- Conduct marketing activities that focus on other enrollment opportunities including but not limited to:
    - Marketing to age-ins (who have not yet made an enrollment decision);
    - 5-star plans marketing the continuous enrollment SEP; and
    - Marketing to dual-eligible and LIS beneficiaries who, in general may make changes once per calendar quarter during the first nine months of the year.
- Send marketing materials when a beneficiary makes a proactive request;
- At the beneficiary's request:
    - Have one-on-one meetings with a sales agent; and/or
    - Provide information on the OEP through the call center.

During the OEP, agency partners/agents may <u>not</u>:

- Send unsolicited materials advertising the ability/opportunity to make an additional enrollment change or referencing the OEP;

- Specifically target beneficiaries who are in the OEP because they made a choice during Annual Enrollment Period (AEP) by purchase of mailing lists or other means of identification;
- Engage in or promote agent/broker activities that intend to target the OEP as an opportunity to make further sales; or
- Call or otherwise contact former enrollees who have selected a new plan during the AEP.

It is important to consider the intent of any material prior to including information about the OEP:

- Materials that specifically call out the OEP, or outline the options a member has during the Open Enrollment Period would likely be considered marketing the OEP by CMS.
- If creating advertisements that will be used during OEP, necessary qualifiers must be included that speak to those who may be aging in, new to Medicare, losing coverage, or other SEP qualifying event, so as not to violate the prohibition of knowingly targeting or sending unsolicited marketing material during the Open Enrollment Period (OEP).

Rest of Year (ROY) and Special Election Periods (SEP)

When marketing Medicare plans outside of AEP to the general public, only a small percentage of members/prospects will be aging-in, recently moved, or have other SEP qualifying conditions. Therefore, be careful not to mislead members/prospects into believing they could change their respective plans outside of AEP. Agencies cannot market for an upcoming plan year prior to October 1.

When marketing during ROY, materials **must:**

- Materials that discuss a beneficiary's enrollment eligibility need to be clear that the piece is describing eligibility for a Special Election Period, or to "enroll in the plan".
- Marketing materials that appear to be marketing towards the general public and include a call to action such as "Call now to get the benefits you deserve" could be considered misleading and may be opted out of by Devoted Health.
- All advertisements used during ROY must include on the materials:
    - Necessary qualifiers that speak to those who may be aging in, new to Medicare, losing coverage, or other SEP qualifying event - ; OR
    - If the qualifier is not clearly stated within the marketing material, the call to action must be that they are calling to see if they are eligible to enroll, call to learn more, or "call to see if you qualify" for a special election period.
    - A disclaimer explaining that: "Enrollment in the described plan type may be limited to certain times of the year unless you qualify for a Special Enrollment Period."

Branding & Logo Requests

Any sales partner who would like to use the Devoted logo must submit the Devoted Health Logo & Publication Request Form

- The following items are required in order to process the request: Agency Name, Material Type, (I.E. Flier, website, etc.), Target Audience, Market Area and Verbiage.
- An email communication will be sent to the sales partner and their Market Sales Leader advising of the status of the request (i.e. approved or denied).
    A. Approvals - All approvals will include the specific Logo attached as a pdf.
    B. Denials - If denied, the email will explain the reason for denial.

Marketing New/Expansion Markets /New Plans

Use the following guardrails to develop agent and beneficiary facing communications related to Devoted expansions of both service areas and new plans:

Medicare Beneficiary Facing	
Prior to 10/1 WITH CMS approval in expansion areas:	
CAN	**CANNOT**
• Use the "Devoted Health Plans" logo with prior approval. • Conduct communication activities only, e.g., describe Devoted Health Plans brand, e.g., messaging "Devoted Health Plan offers complete, coordinated, custom care…", "All-in-one healthcare with Devoted Health Plan", and similar corporate branding statements. • Make available and receive beneficiary contact information via Devoted Health Plans permission to contact forms only.	• Use the Devoted Health or Devoted Health Plans logo without prior approval. • Engage in marketing activities for upcoming plan year prior to 10/1. As defined by CMS in the Medicare Communications and Marketing Guidelines, marketing content includes plan benefits, benefits structure, premiums, or cost sharing; measuring or ranking standards such as Star Ratings or plan comparisons; or rewards and incentives. • State or imply that Devoted Health Plans will be offering plans in any specific market for the following contract year prior to 10/1 as this could be interpreted as marketing for the upcoming plan year which is prohibited prior to 10/1 (e.g., "Devoted Health Plans will be expanding to Alaska in 2025"). • Make available Scope of Appointment forms prior to 10/1.

Prior to 10/1 WITHOUT CMS approval in expansion areas:	
CAN	**CANNOT**
• Use the “Devoted Health” logo with prior approval. • Conduct communication activities only, sharing the Devoted Health brand (e.g., messaging “Hope to see you soon!, “Devoted Health will continue our incredible growth in future years”).	• Use the “Devoted Health” logo without approval. • Use the “Devoted Health **Plans**” logo. • Engage in marketing activities for upcoming plan year prior to 10/1. As defined by CMS in the Medicare Communications and Marketing Guidelines, marketing content includes plan benefits, benefits structure, premiums, or cost sharing; measuring or ranking standards such as Star Ratings or plan comparisons; or rewards and incentives. • State or imply that Devoted Health Plans will be offering plans in any specific market for the following contract year prior to 10/1 as this could be interpreted as marketing for the upcoming plan year (e.g., “Devoted Health will be expanding to Alaska in 2025”) • Collect Devoted Health Plan permission to contact/Business Reply Cards or Scope of Appointment forms.

Agent/Broker Facing	
Prior to 10/1 <u>WITH</u> CMS approval in expansion areas: *To use on Business 2 Business materials clearly directed to agents/brokers for recruitment and educational purposes.*	
CAN	**CANNOT**
• Use the Devoted Health **Plan** logo on agent/broker-only facing materials (e.g., email, snail mail) and must include the following disclaimer language (please refer to the DH disclaimer library) ○ *Confidential. **<u>For <broker/provider> use only. Not for distribution to Medicare beneficiaries.</u>** To enroll in a Devoted Health plan you must meet certain eligibility requirements and reside in the plan's CMS-approved service area. Our plans' <2024> service areas, as applicable, include select counties in <Alabama, Arizona, Colorado, Florida, Hawaii, Illinois, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, and Texas>. <2025> service area depends on CMS contract approval.* *Note: If communicating about upcoming plan year information (prior to 10/1) need to also include: **Any dissemination of Devoted Health Plans information for the upcoming plan year prior to 10/1 is strictly prohibited.***	• Use the Devoted Health or Devoted Health **Plan** logo without prior approval. • Engage in marketing activities for upcoming plan year prior to 10/1. As defined by CMS in the Medicare Communications and Marketing Guidelines, marketing content includes plan benefits, benefits structure, premiums, or cost sharing; measuring or ranking standards such as Star Ratings or plan comparisons; or rewards and incentives. • Posting Devoted Health Plans marketing content (e.g., benefits, benefit structure, premiums, cost sharing, Star Ratings, rewards, incentives, etc) in a site accessible to the public. • Post **public facing** communications directed to agents/brokers on social media for recruitment purposes mentioning expansion areas for the upcoming plan year prior to 10/1. (e.g., Devoted Health will be expanding to Alaska in 2025) • Posting upcoming plan year expansion areas in public sites accessible to Medicare beneficiaries.

• Post communications clearly directed to agents/brokers on social media for recruitment purposes **without mentioning CMS approved expansion areas** e.g., "Devoted Health Plans is expanding in PY 2025! Register for this broker-only event today!", "Get an exclusive look at what Devoted Health Plans has to offer. Register for this broker-only event today!" ○ Note: Specific expansion areas and plan benefit information for upcoming plan year can only be provided to agents/brokers via a link to a closed site that can only be accessed by agents/brokers. **Service areas and benefits for upcoming plan year may not be made publicly available prior to 10/1.** • Provide agents/brokers upcoming plan year information, including expansion areas via email, and/or mail only and must include the the following disclaimer language (please refer to the DH disclaimer library) • *Confidential. **For <broker/provider> use only. Not for distribution to Medicare beneficiaries.** To enroll in a Devoted Health plan you must meet certain eligibility requirements and reside in the plan's CMS-approved service area. Our plans' <2024> service areas, as applicable, include select counties in <Alabama, Arizona, Colorado, Florida, Hawaii, Illinois, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, and Texas>. <2025> service area depends on CMS contract approval.*	

Note: If communicating about upcoming plan year information (prior to 10/1) need to also include: ***Any dissemination of Devoted Health Plans information for the upcoming plan year prior to 10/1 is strictly prohibited.*** • **Service areas and benefits for the upcoming plan year may not be made publicly available prior to 10/1.**	

References

- Final Rule (CMS-4201-F) Effective September 20, 2024: https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit

- Code of Federal Regulations (CFR), Title 42 (*Public Health*), Chapter IV (*HHS*), Subpart B (*Medicare*), Part 422 (*Medicare Advantage Program*), Subpart V (*Medicare Advantage Communications Requirements)*: See §§ 422.2260, 422.2261, 422.2262, 422.2263, 422.2264 and 422.2274 42 CFR 422.2267(e)(34) https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422#subpart-V

- Centers for Medicare and Medicaid Services (CMS), Medicare Managed Care Manual, Medicare Communications and Marketing Guidance (MCMG) https://www.cms.gov/medicare/health-plans/managedcaremarketing/finalpartcmarketingguidelines

- Centers for Medicare and Medicaid Services (CMS), Chapter 2 of the Medicare Managed Care Manual. https://www.cms.gov/medicare/eligibility-and-enrollment/medicaremangcareeligenrol

- Office of Civil Rights (OCR) Section 1557 of the Affordable Care Act. https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html