



Troy Medicare Sales Agent Policies and Procedures

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Annual Certification

Agents must be licensed in the states where they sell, appointed by Troy Medicare, and are certified under the Troy Medicare Agent Certification Program prior to marketing or selling Troy Medicare products.

Certification is an annual requirement to market Individual Medicare plans during Annual Enrollment Period for January 1st effective dates **and** throughout the year. In addition, agents must complete certification annually to receive renewal compensation for existing business.

Additional training and development may be needed for Individual Medicare agents if there are significant benefit, or regulatory, changes.

Three attempts... Agents have three attempts to pass the required test associated with each training module. Failure to achieve the minimum passing score on any of the tests after three attempts will result in the agent's ineligibility to sell Individual Medicare products for the upcoming selling season.

Take and pass modules on your own... All agents are required to take and pass the certification program modules on their own behalf. An agent cannot use any outside aid or assistance on any modules or exams. This includes, but is not limited to, sharing/comparing answers, taking the exam as a part of a group and using answer keys. Agents found to have used outside aid or assistance will be subject to discipline up to and including termination of their agent agreement.

Certification support

Employed/Agents may request information about the certification process by contacting the Troy Broker Support Team at 1-833-704-8769 or brokersupport@troymedicare.com.

Requests that cannot be resolved by the Broker Support Team representative will be documented and resolved by the appropriate support staff.

Contracting

In addition to completing the annual certification requirement, prior to selling Individual Medicare products, agents must also be licensed in the applicable states and appointed with Troy. Troy also offers opportunities for qualifying Firms/Agencies. Please contact the Broker Support Unit at 1-833-704-8769 to inquire about applying for an Agency contract.

Independent agents/firm agencies

An independent agent is an individually certified, licensed and appointed agent who sells directly with Troy. A firm/agency is required to get licensed and appointed (where applicable by law) along with its principal and every agent engaging in any sales activities and in every state where these activities are taking place.

General Agents

General Agents must have down-line agents who are also individually certified, licensed and appointed with Troy.

General Agents involved in the negotiation, sale, or marketing of Individual Medicare products must have an insurance license (Health or Accident & Health, Disability, etc. as determined by each state's Department of Insurance), and line of authority to be appointed by Troy in their state of residence and in any state where they perform sales activities.

Ready to Sell Checklist

To be classified as "Ready to Sell," please ensure each step is completed in its entirety.

1. Complete certification:

- AHIP course with FWA
- Troy Product Certification including completion of required training modules

Certification will only be considered complete once a final exam for all modules has been passed. All modules must be completed within three attempts.

2. a. If new to Troy: Complete your online contract

- Complete the online contract in its entirety. Missing information will slow the license background check and delay the appointment process.
- Troy requires an active E&O policy of at least \$1,000,000 per claim and/or \$1,000,000 aggregate. Select the states in which the agent will actively market Individual Medicare plans.
- Complete an electronic W-9 for direct pay.

b. Existing agents from the previous year:

- After completing certification and credentialing for the new year, verify existing state appointments.
- Request additional appointments if needed by submitting license copies for needed appointments to brokersupport@troymedicare.com. We will also accept NIPR (PDB) print outs, or state department of insurance web prints. Please ensure that the electronic documents include the licensee's name, license number, effective date, expiration date (when applicable) and lines of insurance for which qualified.

Agent terminations

Troy is required by CMS to report the termination of any agents, and the reasons for the termination, to the state in which the agent has been appointed. The same applies for all contracted Agencies, including the reason for termination. The termination of appointment cancels the “ready to sell” status, and agents cannot market Troy plans.

Background Check and Exclusion

Troy is required to verify that our agents and employees are eligible to participate in federally funded Medicare programs and receive funds that originate from the federal government. As such, all employees and agents are checked against the OIG/GSA Exclusion databases upon hire/contracting and monthly thereafter. These checks are completed by the Troy Compliance Officer. Any employee/agent found to be listed in the database will be subject to immediate termination of employment/contract per CMS requirements. The OIG/GSA exclusion database is located at: <http://exclusions.oig.hhs.gov/>.

If you have questions regarding this policy, contact the Troy Broker Support Team at: 1-833-704-8769.

Agent Marketing/Selling Policy

Overview

Agents must be licensed in the applicable state, appointed by the Troy, and certified under the Troy Certification Program prior to marketing or selling a Troy Medicare product.

Only Troy-branded, CMS-approved marketing materials may be used with beneficiaries when discussing Troy Medicare plans. Approved marketing materials for beneficiaries are available from the Troy Broker Support Unit at 1-833-704-8769. Specific questions regarding a marketing material or marketing practice should be directed to Troy Broker Support.

Agent Training

Knowledge is power. Especially today as your clients are trying to navigate the shifting waters of our industry. Agents must participate in or complete all required training modules and are encouraged to continue the learning process by attending optional training events. Required training topics include:

- Medicare Basics
- Enrollment and Disenrollment
- Marketing and Communications Requirements and Other Regulations
- Proper topics to discuss during the marketing and sale of an MAPD plan (prior to the beginning of the enrollment process)

Topics are trained in various forums and methods to facilitate and ensure information is clear, concise and resourceful. Training materials and resources used during the training process include but are not limited to:

- Troy Agent Product Training
- Troy MA Sales Presentation
- Plan EOC, Summary of Benefits and other benefit materials
- This Sales Agent Policy and Procedure guide

Questions related to training materials should be directed to Troy's Broker Support Team.

NOTE: Troy Medicare reviews and updates our training materials to ensure information is up-to-date and in compliance with CMS Agent and Broker Training & Testing Guidelines.

Troy Product, Benefit and Coverage Information

Details of the plans offered by Troy are contained in the Agent Product Training as well as plan documents including the Evidence of Coverage (EOC) and Summary of Benefits (SB). Agents are required to familiarize themselves with these resource documents. They contain important plan features such as Medical (Part C) coverage/benefits; benefit limitations or exclusions; prior authorization/step therapy; out-of-Pocket costs (e.g., premiums, cost sharing, copays/coinsurance, maximum out-of-pocket (MOOP) limits); provider network requirements; Part D/Prescription drug coverage features including the formulary and drug tiers; coverage for Vaccines and insulin; information about Low-Income Subsidies (LIS); \$0 catastrophic coverage cost-sharing; Pharmacy networks and more.

Key Enrollment Information

Be sure you know the key facts and finer points of election periods, requirements, and the process for each of Troy's products today. It will lead to healthier choices, and relationships, with your clients.

Remember: All enrollment applications must be submitted promptly to Troy. Enrollment applications must be received by the Troy enrollment department within 48 hours of the writing agent signature date.

Election periods

For a more detailed explanation and examples of all election periods, number of elections, what to select when completing an application, election period codes, and more, contact the Troy Broker Support Team.

There are specified election periods available for Medicare-eligible beneficiaries. The election periods include an Annual Election Period (AEP), Medicare Advantage Open Enrollment Period (MA-OEP), an Initial Coverage Election Period (ICEP), Initial Election Period (IEP), or a Special Election Period (SEP) based on specific eligibility criteria. Note: Medicare Supplement products are not restricted to the Centers for Medicare & Medicaid Services (CMS) election periods and may be enrolled throughout the year.

Annual Election Period (AEP)

AEP, which runs from October 15 through December 7, enables enrollees to change or add Prescription Drug Plans (PDPs), change Medicare Advantage 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.

Medicare Advantage Open Enrollment Period (MA-OEP)

MA-OEP, which occurs between January 1 and March 31, gives enrollees an annual opportunity to change a different MA plan or disenroll from their MA plan and return to Original Medicare. Regardless of whether the MA plan included Part D drug coverage, enrollees using the MA-OEP to disenroll from their plan are eligible for a coordinating Part D SEP, which allows them to enroll in a PDP or MA-PD during the same time frame.

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

ICEP and IEP occur when enrollees first become eligible for Medicare. These periods are for all beneficiaries becoming eligible for Medicare whether it is due to turning 65 or by becoming eligible due to a qualifying disability. Eligible enrollees can enroll into a MA plan of their choosing, including a Medicare Advantage Prescription Drug Plan (MAPD). Those already enrolled into Medicare due to disability have a second IEP upon turning 65. Note: Based upon specific eligibility criteria and election choices, ICEP and IEP may occur together or may occur separately.

Special Election Period (SEP)

An SEP allows enrollees to make an election change in accordance with applicable requirements anytime during the year, including during the period outside of the AEP. The SEPs vary in the qualifications to use them as well as the types of elections allowed. Situations such as dual-eligible status and institutionalization provide the ability to switch plans at any time during the year. All SEPs

are determined and announced by CMS.

Enrollment process — Medicare Advantage products

The enrollment application should be completed only after the agent has thoroughly explained to the enrollee the plan benefits and rules, confirmed eligibility, disclosed agent- and product-specific disclaimers, and the enrollee agrees to proceed with enrollment.

Incomplete, incorrect, or illegible enrollment applications delay or prevent processing and may result in membership in an incorrect plan and/or the inability to pay the agent commission for the sale.

Confirm Eligibility

The agent must verify and document the enrollee's coverage of Medicare Part A and Part B.

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

The enrollee must have Medicare Parts A and B at the time they enroll in an MA plan. As a best practice, the agent should verify the enrollee having Parts A and B. The following are examples of acceptable proof of eligibility:

- Copy of Medicare card
- Social Security Administration award notice
- Railroad Retirement Board letter of verification
- Statement from the Social Security Administration or Railroad Retirement Board verifying the enrollee's Medicare eligibility

Agents can verify enrollees' eligibility for the IEP or ICEP by reviewing a Social Security Administration acceptance letter showing the effective date for both Medicare Parts A and B, or the Medicare red, white and blue card.

Explain benefits, rules, and member rights

The agent must provide and explain all plan benefits, limitations, and rules thoroughly as outlined in the Summary of Benefits (SB) and Statement of Understanding, including how to access their prescription benefits (where applicable), and all required plan-specific disclaimers. To be eligible to elect an MA plan, an enrollee must be fully informed of and agree to abide by the rules of the plan that are provided during the enrollment process.

Enrollment application

The agent may proceed with enrollment only after thoroughly explaining all plan benefits, limitations, and rules to the enrollee and receiving consent to enroll from the enrollee.

The agent will ensure that all required information is provided on the enrollment application.

The agent will determine the proposed effective date based on the election period and the effective date rules. The proposed effective date will be explained and entered on the enrollment application.

A confirmation/acknowledgement letter will be sent by the Plan (Troy) 10 days within accepting

enrollment and will contain the effective date.

Once all required information has been entered onto the enrollment application and upon confirmation that the enrollee fully understands all the details of the plan and has read the Statement of Understanding, the agent will ensure that the enrollment application is signed and dated by the enrollee. If the enrollee is unable to sign their name due to blindness or illiteracy, the enrollee may sign with a mark (e.g., “X”), if it is the enrollee’s intent that the mark be their signature.

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.

After Completing the Enrollment Application

After completing the enrollment application for Troy Medicare Advantage Plans, the agent should review the following steps with the enrollee:

- Confirm the enrollee’s proposed effective date (typically the first day of the following month).
- Provide the enrollment receipt as noted in our Sales Kit
- Review the Outbound Enrollment Verification (OEV) process for Troy plans.
 - Troy sends OEV letters to 100% of all processed enrollment applications.
 - A template copy of the letter is included as an Attachment to this document.
 - In addition, Troy staff places Welcome to the Plan calls on 100% of all processed enrollment applications. These welcome calls include similar language that is contained in the OEV letter.
 - Agent should prepare the enrollee for the OEV letter and Welcome call and its purpose by explaining that:
 - The letter will be mailed directly to their mailing address after their enrollment into Troy has been processed.
 - Troy will make 3 attempts to call. If the enrollee is not reached after the third attempt, a letter will be sent. The enrollee will be asked to verify they are the intended enrollee by providing their date of birth.

The enrollee will be asked the following types of questions during the call:

1. Did the sales agent explain that you would be receiving a call to verify your enrollment?
2. Do you understand you have applied for a Medicare Advantage plan?
3. Do you understand that to enroll you must have Medicare Part A and Medicare Part B?
4. Did the sales agent fully explain your premium, benefits, copays, and coinsurances?
5. Did the sales agent review your provider information to make sure they were in-network?
6. Did the sales agent review the Summary of Benefits (SB)?
7. Did the sales agent leave their contact information? (Name, telephone, or business card.)
8. Did the sales agent give you a receipt from the enrollment application?
9. Additional questions will be asked depending upon the plan type: HMO, or HMO D-SNP plan.

10. Do you understand you must use a contracted provider to get the in-network cost shares?
11. Do you understand if you use out-of-network providers you will likely pay higher costs?
12. Did the sales agent explain the plan's drug formulary and drug tiers?
13. Did the sales agent look up your medications?
14. Do you understand you must use a Troy contracted pharmacy?

If the Enrollee does not recall enrolling or asks to disenroll, Troy staff/agent will cancel the enrollment.

If the Enrollee has questions about the plan that the OEV representative cannot answer, the Enrollee will be given the number for customer service.

Enrollment resources

The enrollment team will validate all information and forward enrollment application(s) to the Centers for Medicare & Medicaid Services (CMS).

Upon approval by CMS, the enrollee will receive a confirmation letter.

Upon approval by CMS, the enrollee will receive a membership identification (ID) card and post-enrollment Welcome kit (two separate mailings/envelopes) from Troy as well as a Welcome Kit and card from our Healthy Benefits (OTC and Healthy Foods for D-SNP benefits) partner.

To see a doctor prior to receiving an ID card, the enrollee can provide one of the following to the physician:

- Confirmation letter
- Copy of completed enrollment application

NOTE: Agents should inform their clients that during their plan membership, Troy keeps them up to date about their benefits and shares information by mail, email, phone, and online. When sending materials in the mail, most Troy Medicare communications are marked “Important Plan Information” on the envelope.

Enrollment denials

If CMS is unable to approve the MA enrollment application, a letter of denial is sent to the enrollee.

New Member Follow-Up Calls

The agent is highly encouraged to follow up with all new members after enrollment by placing a follow-up call. This provides the agent with an opportunity to help prevent rapid disenrollment and continue to provide exceptional service to members.

- Make an outbound call to all newly enrolled members within two to three weeks after the member's effective date.
- Confirm that the member received a member ID card and Welcome Kit.
- Allow the new member to ask any additional questions and address any key satisfaction drivers. Provide the member with customer service numbers and contact information as needed.
- 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 outbound call cannot be used to sell other products. If the member wishes to discuss alternative plan options, another call would have to be made. Verify if the Scope of Appointment you obtained previously is still valid or obtain new if necessary. If the member states they wish to disenroll/cancel during the call, the agent should instruct the enrollee to call the customer service number on the back of their member ID card to disenroll from their plan. In a professional manner, the agent should close the call.

Enrollment application cancellation, withdrawal, or disenrollment requests for CMS regulated plans

An enrollee or legal representative may request, for any reason, to cancel, after submission to Centers for Medicare & Medicaid Services (CMS), or withdraw, prior to submission to CMS, their enrollment application prior to the effective date of coverage. An enrollee's enrollment can only be canceled or withdrawn if the request is made (based on the date the telephone call or written notification is received by Troy or a Troy representative) prior to the effective date of the enrollment. Cancellations are permitted after the members' effective date only when it's the result of an OEV and is within seven days of the OEV call.

In addition, the member or legal representative may request to terminate their enrollment in a plan after the effective date.

If an enrollee requests to withdraw their enrollment application prior to the agent submitting the enrollment application, the agent must return the enrollment application to the enrollee.

A non-employee agent is not permitted to accept any requests to cancel or withdraw an enrollment application or terminate enrollment in a plan once the enrollment application has been submitted. Non-employee agents must direct all requests to cancel or withdraw enrollment applications or terminate enrollment to the Troy Customer Service Services (number located on the back of the member ID card).

An agent may neither verbally nor in writing, nor by any action or inaction, request or encourage any member to disenroll. 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 Troy Customer Service is authorized to contact disenrolling enrollees within the guidelines provided under the CMS and HIPAA privacy regulations and policies.

Customer service resources

For customer service needs of the member, the agent should refer the member to the contact information on the back of their membership identification (ID) card.

Guidelines for Marketing Medicare Products

All agents must adhere to Centers for Medicare and Medicaid Services (CMS) regulations and marketing guidelines in the delivery of their day-to-day marketing activities. It's important to be familiar with these regulations and guidelines and understand how they govern an agent's business and conduct. These guidelines apply to Medicare age-ins, as well as existing beneficiaries. This section is designed to provide an overview of both Troy's and CMS Medicare marketing guidelines. It is not intended to be all-inclusive.

Who is CMS?

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that is responsible for the administration of Medicare, Medicaid, and other federal health programs (www.cms.gov).

Agents responsibilities include:

- To adhere to CMS Medicare Marketing Guidelines, Medicare program requirements and federal regulations. This includes, but is not limited to, all of the information presented in Troy's Contract, America's Health Insurance Plan (AHIP) Certification and Product Training, Individual Troy Specific Training, Medicare Marketing do's and don'ts, Agent Manual and other CMS guidance issued for agents.
- To comply with federal and state laws and regulations related to insurers and general agents/brokers, specific to Medicare Advantage (MA) and Medicare Prescription Drug Plans (PDP).
- To prevent fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law and the False Claims Act.
- To comply with the Anti-Kickback Statute of the Social Security Act and the Civil Monetary Penalty prohibiting inducements to beneficiaries.
- To adhere to state license and appointment laws.

Staying compliant with Medicare Communications and Marketing Guidelines

Follow the complete Medicare Communications and Marketing Guidelines located at:

<https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html> and [42 CFR 422.2274](#).

Always use CMS-approved Troy sales presentations and talking points, Medicare 101 presentation and talking points, and /or Troy sales presentation video during all sales, events and presentations. These can be acquired from Troy Broker Support.

It is the agent's responsibility to make sure that all advertising material and correspondence contains the CMS-mandated specific disclaimers as outlined in the CMS marketing guidelines and/or regulations. To ensure compliance with CMS marketing rules and regulations, use only CMS-approved marketing materials approved by Troy.

Reporting of compliance questions and issues

For general compliance-related questions and reporting of suspected compliance issues, please follow the guidelines below:

- Contact our Troy Broker Support Team or the Troy Compliance Officer.
- To report suspected compliance issues or general compliance or business-related questions, please email compliance@troymedicare.com.
- Contact the [Troy Compliance and Ethics Hotline](#) to make an anonymous report.

Troy prohibits retaliation against those who report suspected or potential instances of non-compliance or fraud, waste abuse.

Additional resources

Agents are encouraged to continually access the following resources as well as contact their Troy representative or manager and compliance officer, for additional information.

Training

As noted above, Agents must participate or complete all required training modules and are encouraged to continue the learning process attending optional training events. Trainings include but are not limited to:

- AHIP certification course (five sections)
- Annual Medicare Compliance Fraud, Waste and Abuse course
- Acknowledge the Troy Medicare Code of Conduct
- Troy Medicare Product Training
- Troy-specific sales training or webinars (includes in-depth compliance and product information)

Important Links for Additional Information

- Medicare.gov: <http://www.medicare.gov/default.aspx>
- CMS.gov: <http://www.cms.gov/>
- Updated Medicare Marketing Guidelines:
<http://www.cms.hhs.gov/ManagedCareMarketing/>
- Code of Federal Regulations (Medicare Advantage Communication and Marketing Requirements)
<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V?toc=1>

Agent Monitoring

The goal of agent monitoring is to identify counseling and/or educational needs, and to ensure compliance with all CMS marketing guidelines, state requirements and Troy internal policies. Throughout the year, Troy will support and conduct internal and external monitoring activities including those activities conducted by CMS whereby they perform routine audits of all agents through field evaluations of marketing/ sales events or scheduled Personal/Individual Marketing Appointments, as well as review of administrative data. The evaluators are typically Troy sales management or designated Troy representatives, but may also include CMS representatives monitoring marketing and sales activity as part of the CMS “Secret Shopper” program. Additionally, in accordance with (but not limited to) 42 CFR 422.2274, Troy Medicare will be

conducting monitoring and oversight of agents, agencies/firms, and other individuals and entities who market and sell Troy Medicare plans. As part of this oversight and in accordance with CMS requirements, agents, agencies/firms, and other individuals and entities may be required to provide call recordings, data or other information as necessary to conduct required monitoring and oversight. This includes:

- Disclosing to Troy any subcontracted relationships used for marketing, lead generation, and enrollment, and
- Reporting to Troy monthly any staff disciplinary actions or violations of any requirements that apply to the MA plan associated with beneficiary interaction to the plan.

Agents will be monitored in these areas, including but not limited to:

- **Cancellations:** Cancellation is canceling an enrollment application before the effective date.
- **Rapid Disenrollment:** Rapid Disenrollment is disenrollment occurring within 90 days of the member's effective date with the health plan, excluding disenrollments due to death, out-of-area moves, loss of Part A or loss of Part B.
- **48-Hour Enrollment Submission:** All applications must be received by Troy or the Troy delegated enrollment entity within 48 hours of receipt by the agent.
- **Agent Complaints:** A complaint is any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) made orally or in writing, by an enrolled beneficiary. Complaints may include concerns about the service or general operations of providers and plan sponsors, including expressions of dissatisfaction with agent conduct.
- **Marketing/Sales Events & Personal/Individual Appointments:** External agent marketing/sales events and educational events must be reported to Troy in a timely manner.
- **Agent Terminations**
- **Proper Documentation and Record Retention**

Marketing Do's and Don'ts

Marketing/Sales Events:

Marketing/sales events are events designed to steer, or attempt to steer, potential enrollees toward a plan or limited set of plans. At marketing/sales events, plan representatives may discuss plan/Part D-specific information like premium, cost sharing, or benefits and/or distribute or collect applications. All one-on-one appointments with Medicare beneficiaries are considered by CMS as marketing/sales events. However, one-on-one appointments are not required to be reported to CMS. If an event is scheduled as a marketing/sales event, then requirements for marketing/sales events must be met, even if only one person is in attendance at the event. Marketing/sales events must be open to the general public and all Medicare beneficiaries, which could include current members. Marketing events are prohibited from taking place within 12 hours of an educational event, in the same location. The same location is defined as the entire building or adjacent buildings.

There are two main types of marketing/sales events – formal and informal:

Formal marketing/sales events are typically structured in an audience/presenter style with a salesperson or plan representative formally providing specific Plan/Part D Sponsor information via a presentation on the products being offered.

Informal marketing/sales events are conducted with a less structured presentation or in a less formal environment. They typically utilize a table, kiosk or a recreational vehicle (RV) that is manned by a Plan/Part D Sponsor representative who can discuss the merits of the plan's products.

At marketing/sales events, agents MAY:

- o Discuss plan-specific information (e.g., premiums, cost sharing or benefits)
Distribute health plan brochures and enrollment materials
- o Accept and perform enrollments
- o Formally present benefit information to the audience via a scripted talk, electronic slides, handouts, etc. Collect a scope of appointment form for a subsequent meeting. If a beneficiary requests a one-on-one meeting, then the beneficiary must fill out a scope of appointment form.
- o Provide educational content to the audience or passersby
- o Provide a nominal gift to attendees with no obligation. Note that the value of any giveaway, including entertainment, must be consistent with the CMS/OIG definition of nominal gift.
- o Contribute cash toward prize money to a foundation or another entity if the event is jointly sponsored. The plan cannot claim to be the sole donor of the prize and it must be clear that the prize is attached to the event and not the individual organization.
- o Provide refreshments and light snacks

At marketing/sales events, agents MUST:

- o Announce all products/plan types that will be covered during the presentation at the beginning of that presentation (e.g., HMO, PPO, PDP, Medicare Supplement, PFFS, MSA, etc.)
- o Provide prospects with all required materials in the enrollment kit
- o Only use Troy-approved sales scripts, presentations and other applicable marketing materials during the marketing/sales event. This includes talking points and/or anticipated questions and answers.
- o Provide the CMS-required TPMO disclaimer as appropriate (42 CFR 422.2267(e)(41))
- o Obtain prior express written consent from the beneficiary to share data and be contacted for marketing or enrollment purposes, as appropriate (42 CFR 422.2274(g)(4))

At marketing/sales events, agents MAY NOT:

- o Conduct health screening, health surveys or other like activities that could give the impression of “cherry picking”
- o Require beneficiaries to provide any contact information as a prerequisite for attending the event. This includes requiring an email address or any other contact information as a condition to RSVP for an event online or through mail. Agents should clearly indicate on

any sign-in sheets that completion of any contact information is optional. Use personal contact information obtained to notify individuals of raffle or drawing winnings for any other purpose

- o Use information collected for raffles or drawings for any purpose other than raffles or drawings
- o Provide meals (or have meals subsidized)

EDUCATIONAL EVENTS

With the new changes to Medicare, it's never been more important to educate beneficiaries about their options. The goal of the following guidelines is to empower agents to do so, by ensuring all events advertised as “educational,” comply with CMS requirements.

An educational event is an event designed to generally inform Medicare beneficiaries about Medicare Advantage, Prescription Drug or other Medicare programs and **does not** include marketing (i.e., the event sponsor does not steer, or attempt to steer, potential enrollees toward a specific plan or limited number of plans). Educational events may be hosted by the Plan/Part D Sponsor or an outside entity and are held in a public venue. These events cannot be held at in-home or one-on-one settings. Educational events may not include any sales activities such as the distribution of marketing materials or the distribution or collection of plan applications. Educational events must be explicitly advertised as “educational,” otherwise, they will be considered by CMS as sales/marketing events. In other words, agents may provide education at a sales or marketing event, but they may not market or sell at an educational event.

Materials distributed or made available at an educational event must be free of plan-specific information (including plan-specific premiums, copayments, or contact information) and any bias toward one plan type over another.

The following are examples of acceptable materials and activities by agents at an educational event:

- Show a banner with the plan name and/or logo displayed
- Make available promotional items, including those with plan name, logo, and toll-free customer service number and/or website. Promotional items must be free of benefit information and consistent with the CMS definition of nominal gift
- Respond to direct questions asked
- Distribute business cards
- Make available and receive beneficiary contact information, including Business Reply Cards, but not including Scope of Appointment forms

At educational events, agents **MAY NOT:**

- Discuss plan-specific premiums and/or benefits
- Distribute plan-specific materials
- Distribute, display or accept enrollment forms.
- Marketing events are prohibited from taking place within 12 hours of an educational event, in the same location. The same location is defined as the entire building or adjacent buildings.

Guidelines for scheduling, changing or canceling marketing/sales and educational

events

Submission of event information

Agents are required to report to Troy all marketing/sales events (excluding one-on-one home appointments) that promote contracted Medicare products – as well as all educational events, health fairs and member meetings. All events must be reported to Troy prior to the event's scheduled date. All Carriers have different reporting requirements. Contact the Troy Broker Support team for your specific Troy requirements.

Agents must notify Troy if an event is canceled or changed.

Reporting an event cancellation or change

How: Agents should contact Troy Broker Support. Agents must also notify beneficiaries.

When: If canceled or changed more than 48 hours in advance... Agents must notify beneficiaries by the same means used to advertise the event. For example, if agents run an ad in a newspaper, they must issue a meeting cancellation notice in the same newspaper. A representative is not required to be present at the site.

If canceled or changed less than 48 hours in advance... A representative must be present at the site of the canceled event at the originally scheduled time, to inform attendees of the cancellation and distribute plan information. The representative must stay for 15 minutes after the scheduled start time. (Note: If the event is canceled due to inclement weather, a representative is not required to be present at the site.)

Learn more

Marketing/Sales Events in the **Medicare Communications and Marketing Guidelines** and **Code of Federal Regulations (Medicare Advantage Communication and Marketing Requirements/Beneficiary contact) 42 CFR 422.2264**

Promotional Activities

CMS defines promotional activities as activities performed by a plan, or by an individual or organization on a plan's behalf, to inform current and potential enrollees of the products available. Promotional activities include nominal gifts and are designed to attract the attention of prospective members and/or encourage retention of current members.

Generally, promotional activities include nominal gifts and are designed to attract the attention of prospective members and/or encourage retention of current members. In addition to the guidance on nominal gifts, any promotional activities or items offered by agents should adhere to the following guidelines:

Promotional items must:

- Be worth \$15 (based on the retail value of the item) or less with a maximum aggregate of \$75 per person, per year
- Be offered to all people regardless of enrollment and without discrimination
- Not be items that are considered a health benefit (e.g., a free checkup)
- Not inappropriately influence the beneficiary's selection of a provider, practitioner, or supplier of any item or service
- Not be tied directly or indirectly to the provision of any other covered item or service

- Include the CMS-required promotional give-away disclaimer as applicable (42 CFR 422.2267(e)(37))

Learn more

Nominal Gifts in the **Medicare Communications and Marketing Guidelines** and **Code of Federal Regulations (Medicare Advantage Communication and Marketing Requirements/Beneficiary contact) 42 CFR 422.2263**

Nominal gifts

You may offer gifts to potential enrollees as long as the gifts are of nominal value and provided regardless of enrollment.

The following rules must be followed when providing gifts:

- If a nominal gift is one large gift that is enjoyed by all in attendance (e.g., a concert), the total retail value must be \$15 or less when it is divided by the estimated attendance. For planning purposes, anticipated attendance may be used, but must be based on venue size, response rate, or advertisement circulation.
- Nominal gifts **may not** be in the form of cash or other monetary rebates. Cash gifts are prohibited even if their worth is less than \$15.

Note: Cash gifts **include** charitable contributions made on behalf of potential enrollees, and those gift certificates and gift cards that can be readily converted to cash, regardless of dollar amount.

Learn more

Nominal Gifts in the **Medicare Communications and Marketing Guidelines** and **Code of Federal Regulations (Medicare Advantage Communication and Marketing Requirements/Beneficiary contact) 42 CFR 422.2263**

Nominal gifts: Exclusion of meals

- Agents may not provide meals (or have meals subsidized) at sales/marketing events. Agents are, however, allowed to provide refreshments and light snacks.
- Agents must use their best judgment on the appropriateness of food products provided and must ensure that items provided could not be reasonably considered a meal and/or that multiple items are not being “bundled” and provided as if a meal.
- Meals may be provided at educational events, provided the event meets CMS’ strict definition of an educational event, and complies with the nominal gift requirement.

Learn more

Exclusion of Meals as a Nominal Gift in the **Medicare Communications and Marketing Guidelines** and **Code of Federal Regulations (Medicare Advantage Communication and Marketing Requirements/Beneficiary contact) 42 CFR 422.2263**

Personal/individual marketing appointments

Personal/individual marketing appointments are based on the comfort and familiarity of the appointment’s location or setting. They typically take place in the Medicare beneficiary’s home; however, these appointments can also take place in other venues such as a library or coffee shop, provided the appointment is set up in accordance with the **“Scope of Appointment” (SOA)**.

At least 48 hours prior to the scheduled personal marketing, the MA plan (or agent or broker, as applicable) must agree upon and record the Scope of Appointment with the beneficiary(ies), except for SOAs that are completed during the last four days of a valid election period for the beneficiary, or Unscheduled in person meetings (walk-ins) initiated by the beneficiary.

At personal/individual marketing appointments, Troy Agents MAY:

- Distribute plan materials. If not, then inform beneficiary on how to access the document through other means, e.g., mail, website)
- Discuss Troy plan options
- Review the individual needs of the beneficiary including, but not limited to, health care needs and history, commonly used medications, and financial concerns
- Provide educational content
- Provide and collect enrollment forms

At personal/individual marketing appointments, agents MAY NOT:

- Discuss plan options or products that were NOT agreed to by the Medicare beneficiary and documented in the Scope of Appointment (see Scope of Appointment information)
- Market non-health care related products (such as annuities, life insurance or VAIS)
- Ask a beneficiary for referral contact information
- Solicit/accept an enrollment request (application) for a January 1st effective date prior to the start of the Annual Enrollment Period (AEP) unless the beneficiary is entitled to a Special Election Period (SEP) or within their initial coverage election period/initial enrollment period

Learn more

Personal/Individual Marketing Appointments **Medicare Communications and Marketing Guidelines** and **Code of Federal Regulations (Medicare Advantage Communication and Marketing Requirements/Beneficiary contact) 42 CFR 422.2264**

Scope of Appointment

When conducting marketing activities, agents may not market any health care related product during a marketing appointment beyond the scope agreed upon by the beneficiary before the face-to-face individual meeting.

Agents are required to collect a Scope of Appointment (SOA) before meeting with a beneficiary for a face-to-face individual meeting to discuss MA/PDP products. A Scope of Appointment is a documented agreement between a beneficiary and a plan sponsor or agent, detailing which products may be discussed during a marketing appointment.

The **Scope of Appointment** documentation must be in writing, in the form of a signed agreement by the beneficiary. Generic and Troy Specific Scope of Appointment forms are available from Troy Broker Support.

*Note that a beneficiary cannot agree to the SOA over the phone, unless it is recorded through an approved system. In conducting marketing activities for Troy products, agents may not market any health care related product during a marketing appointment beyond the SOA agreed upon by the beneficiary and documented by the plan or representatives of the plan, prior to the appointment (48 hours in advance when practicable).

If the beneficiary chooses to enroll in an MAPD plan, the agent must submit the Scope of Appointment to Troy along with the application. Contact Troy Broker Support for approved submission methods.

When is a Scope of Appointment form required?

- A Scope of Appointment is required before meeting with a beneficiary for a face-to-face individual meeting to discuss Troy products.
- During an appointment, if a beneficiary requests to discuss other products that were not indicated on the original Scope of Appointment, a second Scope of Appointment must be documented for the new product type and then the marketing appointment may continue.
- Agents do not need to collect a Scope of Appointment to speak with or enroll beneficiaries in a formal group setting, like an advertised meeting.
- A beneficiary may complete and sign a Scope of Appointment at a marketing/sales event for a future appointment.
- In instances where a beneficiary visits an agent's office on his/her own accord, the agent must document the Scope of Appointment prior to discussing MA or PDP products. Agents should note on the Scope of Appointment form that the beneficiary was a "walk-in".

Other Scope of Appointment guidance

- Agents cannot agree to the Scope of Appointment on behalf of the beneficiary but can confirm the appointment.
- Securing a completed Scope of Appointment form from a beneficiary may not be treated as open-ended permission for future contact with the beneficiary, and is only valid for the duration of that transaction. Scope of appointment form must be completed by the beneficiary and returned prior to the appointment.
- If it is not feasible for the Scope of Appointment form to be executed prior to the appointment, an agent may have the beneficiary sign the form at the beginning of the marketing appointment.
- If the scope of appointment form is signed the same day as the appointment, a reason for the same day scope must be written in the comments/notes section. Some examples of reasons may include: Walk-in, Requested Same Day Appointment, Requested information on additional products, Guest of (Name of Original person with whom you had an SOA for that appointment.) etc. Please have the beneficiary or attendee initial next to the reason if possible.
- Complete a SOA form for everyone attending your presentation even if they are not Medicare eligible. If they are in the room and listening, they need an SOA.

Learn more

Scope of Appointment in the **Medicare Communications and Marketing Guidelines** and **Code of Federal Regulations (Medicare Advantage Communication and Marketing Requirements) 42 CFR 422.2264 and 422.2274**

Permission-to-Contact Form / Business Reply Card

The Permission-to-Contact Form is used by agents to contact beneficiaries. The Permission-to-Contact Form must be completed prior to conducting an outbound call to a prospect. It is a separate and distinct tool from the Scope of Appointment form and is required by CMS.

If a prospect calls in to RSVP for a meeting, a Permission-to-Contact Form is not required for that meeting, but would be required for an agent to place a follow-up call to a meeting attendee.

Requests for identification numbers, bank or credit card information are prohibited. Calls or visits to beneficiaries who attended a sales or educational event are prohibited, unless the beneficiary has given express 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 may not be treated as open-ended permission for future contacts. Troy's policy for short term and using good judgment is considered to be ninety (90) days. The exception would be for leads received immediately prior to the beginning of the 10/15 AEP. In this case, agents could contact a prospect during the 10/15 – 12/7 AEP time frame.

Learn More

Marketing through Unsolicited Contacts and Telephone Contacts in the **Medicare Communications and Marketing Guidelines** and **Code of Federal Regulations (Medicare Advantage Communication and Marketing Requirements)** **42 CFR 422.2264 and 422.2274**

Contact with Medicare Beneficiaries

CMS makes a distinction between contact with beneficiaries to establish a new relationship with an agent, and contact that is with a plan member or a beneficiary where a business relationship already exists. When contacting beneficiaries to establish new relationships, consent for future contact must be limited in scope, short- term, and event-specific. The consent to contact **MAY NOT** be treated as open-ended permission for future contacts. However, for agents who are contacting their own clients, or contacting their current members, consent for each specific contact is not required to discuss plan business.

If an individual expresses they are not yet eligible for Medicare or will be qualifying for an SEP at a later date, the agent should advise the individual to contact them again when they are in their IEP or eligible for SEP if they are interested in enrolling.

Clearly requesting the caller's consent when advocating permission for a follow-up call is permissible if phrases such as "would you like" or "may we" are used when the Medicare beneficiary has a future effective date. Examples: "May we" follow up with you on (date), or "Would you like" for us to follow up with you on (date).

Telephone contact

Agents may contact their own clients and Troy may contact current members at any time to discuss plan business. Acceptable and unacceptable activities are listed in the list below.

Acceptable

- o Contact beneficiaries who submit enrollment applications to conduct quality control and agent/broker oversight activities
- o Contact their members or use third parties to contact their current members
- o Contact members to promote other plan types and discuss plan benefits
- o Contact their members to discuss educational events
- o Contact their members to conduct normal business related to enrollment in the plan

- o Call individuals who have expressly given permission for a plan or sales agent to contact them
- o Contact their members via automated telephone notification to inform them about general information such as AEP dates, flu shots, upcoming plan changes, and other important information

Unacceptable

- o Bait-and-switch strategies — making unsolicited calls about other business as a means of generating leads for Medicare plans
- o Calls based on referrals
- o Calls to former members who have disenrolled, or to current members who are in the process of voluntarily disenrolling, to market plans or products
- o Calls to beneficiaries who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call
- o Calls to beneficiaries to confirm receipt of mailed information (except as permitted with “Acceptable” contact practices)

Allowable outbound calls must comply with the following federal requirements:

- Federal Trade Commission’s Requirements for Sellers and Telemarketers
- Federal Communications Commission rules and applicable state law National Do-Not-Call Registry
- 42 CFR 422.2274

Additionally, agents must honor “do not call again” requests, and abide by federal and state calling hours.

Learn more

Telephone Contact in the **Medicare Communications and Marketing Guidelines** and **Code of Federal Regulations (Medicare Advantage Communication and Marketing Requirements)** **42 CFR 422.2264 and 422.2274**

Telephone Enrollment

Telephone enrollment activities may not include:

- Conduct outbound telephone enrollment
- Transfer outbound calls to inbound lines or telephone enrollment
- Market or enroll other lines of business as part of the telephone enrollment script
- Request or collect credit card numbers or bank account information for any purpose during the telephone enrollment call
- Use language in outbound scripts that imply that they are endorsed by Medicare, calling on behalf of Medicare, or that Medicare asked them to call the member
- Allowing agents — including third-party plan comparisons and enrollment websites that function as brokers — to assist with telephonic enrollments is prohibited unless specifically authorized by the Troy. Troy must ensure that telephonic enrollment requests are effectuated entirely by the beneficiary or his/her authorized representative and that the plan representative, sales agent, or broker is not physically present at the time of the request.

Telephone enrollment must provide confirmation of having accepted the telephone enrollment request, such as a confirmation tracking number or other tracking mechanism. Beneficiaries must have access to enrollment materials either electronically or in hard copy to ensure this information is received prior to completion of the enrollment request.

NOTE: Enrollment and sales calls are required to be recorded in accordance with 42 CFR §§ 422.2274(g) and 423.2274(g). This includes TPMO marketing, sales and enrollment calls.

Marketing through unsolicited contacts

Prohibited activities include:

- Door-to-door solicitation, including leaving information such as a leaflet or flier at a residence or car
- Approaching beneficiaries in common areas (e.g., parking lots, hallways, lobbies, sidewalks, etc.)
- Telephonic or electronic solicitation, including leaving electronic voicemail messages, text messaging or “cold calling”
- Send direct messages from social media platforms

NOTE: Agents who have a prescheduled appointment that becomes a “no-show” may leave information at the no-show beneficiary’s residence. The prohibition on marketing through unsolicited contacts does not extend to mail and other print media (e.g., advertisements, direct mail). In addition, permission given to be called or otherwise contacted must be event-specific, and may not be treated as open-ended permission for future contacts.

Learn more

Marketing Through Unsolicited Contacts in the **Medicare Communications and Marketing Guidelines** and **Code of Federal Regulations (Medicare Advantage Communication and Marketing Requirements) 42 CFR 422.2264 and 422.2274**

Unsolicited Email

Allowed activities include:

- Emailing is allowed provided all emails contain an opt-out function*.

*Agents must always provide an option to opt-out and no longer receive email communications in all Email communication with beneficiaries.

Learn more

Marketing Through Unsolicited Contacts in the **Medicare Communications and Marketing Guidelines** and **Code of Federal Regulations (Medicare Advantage Communication and Marketing Requirements) 42 CFR 422.2264 and 422.2274**

Agent Compliance and Oversight

The Troy Compliance Department ensures that procedures are in place to oversee, manage and monitor the sales activities of any Agent/Agency that is under contract with or employed by Troy who markets and sells Medicare Advantage (MA/MAPD) Coordinated Care Plans (CCPs) and Part D Prescription Drug (PDP) products. Troy Compliance investigates, reviews, responds to and resolves all complaints and marketing incidents received involving allegations of Agent misconduct or

misrepresentation when selling contracted Medicare products. Reported CMS Medicare Marketing Guideline or regulatory infractions and prohibited Agent tactics are also investigated and resolved. Appropriate disciplinary/corrective actions are assigned based on findings of each investigation. Processes are conducted in accordance with Troy requirements and CMS regulations. Agents/Agencies are required to respond to investigations of agent misconduct within the timeframes specified during the investigation.

Disciplinary/Corrective Actions may include:

- Coaching/monitoring sessions
- Verbal/written warnings
- Focused or full retraining with testing
- Placement on Agent Watch List
- Suspension or probationary period – with or without commissions
- Contract termination – with or without cause
- Being reported to OIG/GSA and state Department of Insurance

Troy also monitors Agents' performance metrics to identify outliers and appropriate corrective actions are assigned.

Monitored Activities may include, but are not limited to:

- Cancellation Rates
- Disenrollment Rates
- Rapid Disenrollment Rates
- Turnaround Time for Submission of Enrollment Applications
- Applications **MUST** be submitted to the Carrier's within 48 hours of receipt by the Agent
- Use of Scope of Appointment Forms
- Third Party Secret Shopper Surveillance
 - Monitors sales activities, including presentations used at marketing sales events
- Complaints & Marketing Incidents (issues of inappropriate or non-compliant Agent activities) Marketing/Sales Seminar Reporting
- Reporting of Marketing/Sales Seminars Cancellations & Event Updates
- Reporting of Agent/Agencies' staff disciplinary actions or violations
- Requests for call recordings to review and monitor Agent activity
- This data is reported and reviewed on a monthly, quarterly and/or annual basis.

Should an Agent at any time experience rates that are outside of the normal thresholds, corrective actions will be taken.

Learn more

Agent Compliance and Oversight in the **Medicare Communications and Marketing Guidelines** and **Code of Federal Regulations (Medicare Advantage Communication and Marketing Requirements) 42 CFR 422.2272 and 422.2274**

Records Retention

Troy requires maintenance of sales records/files on all Medicare Sales Interactions, agents, employees and training in accordance with CMS requirements. Records are a combination of electronic data maintained by Troy and Agents and hard copy files maintained as described below. Troy maintains files on Troy employees and Agents. Troy maintains basic files for Agents authorized through a direct Troy contract. Troy monitors the maintenance of hard copy files by staff. Troy Employees and contracted Agents are required to retain the completed Scope of Appointment form, Enrollment Forms and any other supporting documentation signed or filled out by the Medicare Beneficiary, for a time of no less than 10 years. Agents and Troy Employees must also maintain copies of any BRC's, permission to contact forms, call recordings or other relevant documentation for the same period of time. The Scope of Appointment form and supporting documents (including, but not limited to, BRC's, Permission To Contact, and other materials) are retained regardless of appointment outcome and must be readily accessible to Troy upon request.

Learn more

Record Retention in the [Code of Federal Regulations \(Medicare Advantage and Prescription Drug Plans Contract Provisions\) 42 CFR 422.504\(d\) and 423.505\(d\)](#)

Beneficiary Protections

The Evidence of Coverage document not only informs members about their coverage, how and where to get their medical care and prescription drugs; it also explains the member's rights and responsibilities and how to file a complaint if they are not satisfied with a decision or treatment. It's important that Agents encourage and direct members to learn what the plan's rules are and what services are available to them by referring them to both their Summary of Benefits and Evidence of Coverage. These documents are available on the Troy website and can be sent to the member upon request. If members are confused, concerned, or just have a question, please have them contact Member Services.

Grievances and Appeals

Members who are dissatisfied or have a complaint about the plan (including, but not limited to, waiting times, customer service, quality of service, quality of care, etc.) they may contact Troy either by phone or in writing and file a grievance. For coverage decisions with which a member doesn't agree (such as a denial of coverage or a limitation/partial denial of coverage, etc.), the member may contact Troy either by phone or in writing and file an appeal. Troy follows the CMS-required timeframes and processes for handling these types of concerns. For step-by-step instructions and detailed information, please refer to the EOC.

Learn More

Please visit our website at the following links to learn more about:

- <https://www.troymedicare.com/member-rights-and-responsibilities>
- <https://www.troymedicare.com/privacy-policy>
- <https://www.troymedicare.com/non-discrimination-notice>
- <https://www.troymedicare.com/your-coverage-rights>
- <https://www.troymedicare.com/disenrollment-rights-and-responsibilities>

Troy Broker Support Team

If Agents don't have the information they need when they need it, your hands are tied. That's why Troy's

Broker Support Team is dedicated to Troy Medicare Agents. One phone number brings Agents a team trained to answer questions about Medicare products regarding:

- Products and benefits commissions
- Licensing, appointment, certification
- Enrollment status
- Enrollment materials and more

Contact information

Phone: 1-833-704-8769

Email: brokersupport@troymedicare.com

Hours: 9:00AM - 5:00PM Monday through Friday EST

Appendix A: Associated References

Content	Reference(s)
Original Medicare Basics	42 CFR- Subpart A General Provisions
Medicare Advantage Basics	42 CFR Part 422 • Subpart A—General Provisions • Subpart B—Eligibility, Election, and Enrollment • Subpart C—Benefits and Beneficiary Protections Medicare Managed Care Manual (MMCM) Ch. 1 MA Enrollment and Disenrollment Guidance
Part D Basics	42 CFR Part 423 • Subpart A—General Provisions • Subpart B—Eligibility and Enrollment Medicare Prescription Drug Benefit Manual (PDBM) Ch. 1 & 3
1876 Cost Plans	42 CFR Part 417; MMCM Ch. 17 D Cost Plan Enrollment and Disenrollment Instructions
Extra Help	42 CFR Part 423 • Subpart P—Premiums and Cost-sharing Subsidies for Low Income Individuals • Subpart S—Special Rules for States-Eligibility Determinations for Subsidies and General Payment Provisions Medicare Prescription Drug Benefit Manual Chapter 13 - Premium and Cost-Sharing Subsidies for Low-Income Individuals
Election Periods	42 CFR §422.62- Election of coverage under an MA plan 42 CFR §423.38- Enrollment periods MA Enrollment and Disenrollment Guidance Section 30
Enrollment and Disenrollment Process	42 CFR Part 422; Subpart B—Eligibility, Election, and Enrollment 42 CFR Part 423; Subpart B—Eligibility and Enrollment MA Enrollment and Disenrollment Guidance
Beneficiary Protections	42 CFR Part 422; Subpart C—Benefits and Beneficiary Protections 42 CFR Part 423; Subpart C – Benefits and Beneficiary Protections Medicare Managed Care Manual Ch. 17f Benefits and Beneficiary Protections; Medicare Prescription Drug Benefit Manual Ch. 5 (Benefits and Beneficiary Protections)
Part C Organizational Determinations and Appeals, Part D Coverage Determinations and Redeterminations, and Grievances	42 CFR Part 422; Subpart M—Grievances, Organization Determinations, and Appeals 42 CFR Part 423; Subpart M—Grievances, Coverage Determinations, Redeterminations, and Reconsiderations Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
Overview of Marketing	42 CFR Part 422; Subpart V—Medicare Advantage Marketing Requirements 42 CFR Part 423; Subpart V—Marketing Requirements

Content	Reference(s)
Marketing Event Requirements	42 CFR Part 422; Subpart V—Medicare Advantage Marketing Requirements §422.2264 Beneficiary Contact 42 CFR Part 423; Subpart V—Marketing Requirements §423.2264 Beneficiary Contact
Overview of Marketing Materials Requirements	42 CFR §422.2260 - 422.2267 42 CFR §423.2260 - 423.2267
Agent/Broker Compensation	42 CFR §422.2274- Agent, broker, and third-party requirements 42 CFR §423.2274- Agent, broker, and third-party requirements
Marketing Event Type	42 CFR Part 422; Subpart V—Medicare Advantage Marketing Requirements §422.2264 (c) Events with beneficiaries 42 CFR Part 423; Subpart V—Marketing Requirements §423.2264(c) Events with beneficiaries

Appendix B: CMS Recommended Discussion Topics - Applicable to Troy plans

Consistent with §§ 422.2274(c)(12) and 423.2274(c)(12), plans must ensure that all agents and brokers (employed, captive, and independent) discuss the following CMS-developed list of items during the marketing and sale of an MA or Part D plan, prior to the beginning of the enrollment process:

1. Review the beneficiary-specific information:
 - a. What kind of health plan does the beneficiary wish to enroll in?
 - b. Are the beneficiary's current providers (primary care and specialists) in-network?
 - c. Is the beneficiary's current pharmacy in-network? If not, explain that they will need to choose a new pharmacy.
 - d. Are the beneficiary's prescriptions on the formulary? If not, explain that they may have to pay the full price of the prescription.
 - e. Does the beneficiary require hearing, dental, and/or vision coverage?
 - f. Does the beneficiary have any other healthcare needs, such as durable medical equipment or physical therapy?
 - g. Is the beneficiary's preferred hospital in-network? If not, explain that they will need to pick a new one.
 - h. Are there other preferred facilities that need to be in-network?
 - i. Does the beneficiary have any other specific healthcare needs?
2. Review premiums, including Part B premium, If applicable, review current premium vs. another plan premium.
3. Review beneficiary cost sharing such as deductibles, copays, and coinsurances. Go over inpatient hospital copay, and any other copays for services/items the beneficiary needs.
4. Discuss the costs/limitations on dental, vision, and hearing.
5. Review coverage for out-of-network providers and services (e.g., except in emergency or urgent situations, plan does not cover services by out-of-network providers (i.e., doctors who are not listed in the provider directory)).
6. Review coverage outside the United States.
7. Explain the potential effect that enrolling in this plan will have on other, current coverage, which may in some cases mean that the beneficiary is disenrolled from their current health coverage (e.g., another MA plan, Medigap). Explain that this is not a hearing/dental/vision "rider" but a full plan.
8. Explain that the plan operates on a calendar year basis, so benefits may change on January 1 of the following year.
9. Explain that the Evidence of Coverage provides all of the costs, benefits, and rules for the plan.
10. Review how to file a complaint.
11. Review needs to have Medicaid to qualify for a D-SNP.
12. Inform beneficiary of their right to cancel this enrollment as well as the specific date on which cancellation may occur.

Outbound Enrollment Verification

{DATE}

{Member ID:}

Dear {MEMBER NAME}:

Thank you for your interest in {Troy Medicare (HMO) or Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)}. You are receiving this letter because we received your request to enroll in {Troy Medicare (HMO) or Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)}, which is a Medicare Advantage Plan.

Enrolling in {Troy Medicare (HMO) or Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)} means that you will be getting your Medicare coverage through {Troy Medicare (HMO) or Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)} and payment for your healthcare services will be processed through {Troy Medicare (HMO) or Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)}. Your enrollment request has been submitted to Medicare for final review.

{Troy Medicare (HMO) or Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)} is a Medicare Advantage Plan with both medical and prescription drug coverage. It is not Original Medicare and is not a Medigap or Medicare supplemental insurance plan.

If you have any questions, please call {Troy Medicare (HMO) or Troy Medicare for Dual-eligible Beneficiaries (HMO D-SNP)} at 1 (888) 494-TROY (8769). TTY users should call 711. During the months of April through September, we are available Monday through Friday from 8:00 am to 8:00 pm EST. During the months of October through March, we are available from 8:00 am to 8:00 pm EST, seven (7) days a week.

Thank you again for choosing Troy Medicare!