Agent Manual

CareFirst BlueCross BlueShield Medicare Advantage HMO Plans

FOR AGENTS

CareFirst Medicare Advantage

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WELCOME

Thank you for your interest in partnering with CareFirst BlueCross BlueShield (CareFirst)! We are extremely excited to offer quality care to the communities we serve through CareFirst BlueCross BlueShield Medicare Advantage Prescription Drug (MAPD) plans.

This manual will prepare our agents to market and sell our CareFirst BlueCross BlueShield Medicare Advantage plans. This guide provides essential information on product, enrollment, contracting, training, compliance, compensation and many other topics.

Please use this guide to grow and retain CareFirst BlueCross BlueShield Medicare Advantage business. This manual also sets out important compliance rules. Every agent representing our CareFirst BlueCross Blue Shield Medicare Advantage plans must comply with the Centers for Medicare and Medicaid Services (CMS) regulations and guidelines, federal and state laws, and CareFirst business rules, policies and procedures. It is important that you read and closely follow all of these rules.

We value our agent partnerships and sincerely appreciate the trust you've placed in us.

Our Medicare Sales team and Medicare Agent Sales Support team are available to assist you with any questions you may have.

ABOUT CAREFIRST

Our mission

It began with a simple idea. One of "might for right." Our not-for-profit status gives unique focus to our mission—caring more for our members than the bottom line. Today we are faced with an ever-changing landscape, but rather than avoiding change, we are committed to leading it forward. Since 1934, we have supported, invested in and built programs and partnerships that have the greatest impact on the health and wellness of those we serve, right here in our local community.

Our mission is to provide health benefit services of value to customers across our service area.

We commit to:

- Providing affordable and accessible health insurance to the plan's insured and those persons insured or issued health benefit plans by affiliates or subsidiaries of the plan
- Assisting and supporting public and private healthcare initiatives for individuals without health insurance
- Promoting the integration of a healthcare system that meets the healthcare needs of all the residents of the jurisdictions in which the nonprofit health system service plan operates

We believe all people should have access to quality, affordable healthcare. We believe in providing products and services that enable our members to take charge of their own health. We believe that by working together with our partners, providers and the local community, we will make a meaningful difference in the lives of the people we serve.

Our core values

Over 3.4 million people trust us with their health insurance. We take this responsibility seriously—we have for over 75 years.

As CareFirst BlueCross BlueShield (CareFirst), continues to transform as a company, upholding our Values and Ethics in support of our Mission will remain crucial to our success. It is through our daily conduct that each of us can thrive and be our best on behalf of the people we serve; living our Values and modeling the behaviors that form an ethical and supportive culture.

CareFirst, the mid-Atlantic region's largest healthcare insurance company, has been named by the Ethisphere Institute as one of the World's Most Ethical Companies® in 2023. This year's honor marks the eleventh consecutive year CareFirst has been recognized for its commitment to high ethical business standards and practices.

CareFirst is one of just four companies representing the healthcare insurance industry on the list of 135 organizations spanning 19 countries and 49 industries. The designation recognizes strong corporate culture, business integrity and industry leadership in accountability, transparency and corporate social responsibility.

2023 WORLD'S MOST ETHICAL COMPANIES® ETHISPHERE 11-TIME HONOREE

KEY TERMS

Take a moment to review a few key terms and acronyms which are used in this guide.

Term	Definition
Abuse	Includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge and available evidence, among other factors.
Agent Oversight Committee	CareFirst will designate a multi-disciplinary Agent/Broker Oversight Committee to oversee agent activity, selling and marketing trends, rapid disenrollment trends and corrective actions related to agents, brokers and Field Marketing Organizations (FMOs). This Committee will be responsible for ensuring that all agent-initiated enrollments are compliant with all applicable regulations and the CMS regulations.
Agent	An agent is a professional who sells an insurance company's products to consumers for a commission. An agent helps consumers select the right insurance to buy but represents the insurance company in the transaction. There are two types of insurance agents. Captive agents typically represent only one insurer. Independent insurance agents typically represent more than one insurer. Both captive and independent agents work on commission and can execute an insurance transaction from start to finish.
America's Health Insurance Plans (AHIP) National Medicare Certification	An industry-recognized certification demonstrating completion of CMS required training courses necessary to be allowed to market or sell Medicare products.
Alternate Formats	Used to convey information to individuals with visual, speech, physical, hearing and intellectual disabilities (e.g., braille, large print, audio).
Annual Election Period (AEP)	Annual Election Period occurs annually from October 15 to December 7.
Broker	A broker is a professional who represents consumers in their search for the best insurance policy for their needs. They work closely with their clients to research coverage, terms, conditions and price and then recommend the insurance policy that best fits the bill. Unlike captive and independent agents, who represent one or more insurance companies, a broker's primary duty is to the client. Since brokers don't represent insurance companies, they can't bind coverage on behalf of an insurer. They must hand over the account to an insurer or insurance agent to complete the transaction.

Term	Definition
Captive Agent	An insurance agent who only works for one insurance company. A captive agent is paid by that one company, usually with a combination of salary and commission, plus benefits. They may be a full-time employee or an independent contractor.
Centers for Medicare and Medicaid Services (CMS)	Centers for Medicare and Medicaid Services is a federal agency that administers the Medicare and Medicaid Programs. Centers for Medicare and Medicaid Services is part of the Department of Health and Human Services (HHS).
Certified	A status achieved based on completing the annual certification process training and successfully passing the related tests.
CMS Initiated Surveillance	A program implemented by CMS designed to protect Medicare beneficiaries from deceptive or high-pressure marketing tactics by private insurance companies and their agents, brokers or plan representatives in an effort to ensure compliance with marketing requirements and prohibitions.
CMS Secret Shopper Audit Program	A practice used to detect, prevent and resolve noncompliant marketing and selling activity from agents, brokers and FMOs.
Complaint Tracking Module (CTM)	Repository developed by the Centers for Medicare and Medicaid Services (CMS) as a method to capture, track and resolve complaints made against the Medicare Part C and Medicare Part D plans. CTM complaints also include sales allegations against agents.
Corrective Action	An action taken to preclude occurrences of an identified risk or to prevent recurrence of a problem.
Corrective Action Plans (CAPs)	A plan developed to resolve noncompliant activity by an individual or entity.
Disciplinary Measures	A process for dealing with job-related behavior that does not meet expected and communicated performance standards.
Downline Agent	A person or entity whose contract connects to one or more uplines or a licensed only agent.
Educational Event	Outreach activity designed with the intention of informing beneficiaries about Medicare Advantage, Prescription Drug or other Medicare programs and do not include marketing.
Field Marketing Organization (FMO)	A third-party marketing organization that has been retained to sell or promote a Plan's Medicare products on the Plan's behalf either directly or through sales agents or a combination of both.
First-Tier, Related and Downstream Entity (FDR)	Any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization (MAO) or Part D sponsor applicant to provide administrative services or healthcare services to a Medicare eligible individual under the MA program or Part D program, below the level of the arrangement between a MAO or applicant or a Part D plan sponsor or applicant and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Term	Definition
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program.
General Services Administration (GSA)	A division of the federal government maintaining a list of parties excluded from participation in government contract work.
Health Plan Management System (HPMS)	A web-enabled information system that serves a critical role in communicating updates to the ongoing operations of the Medicare Advantage and Part D programs.
Like Plan Type	PDP replaced with an MA-PD or an MA-PD replaced with a PDP.
Low-Income Subsidy Enrollees (LIS enrollees)	Enrollees who are eligible for a government program that provides monetary assistance for Part D premiums and cost sharing.
Marketing Appointments	Individual appointments designed to steer or, attempt to steer, enrollees or potential enrollees toward a plan or limited number of plans. All individual appointments between an agent and an enrollee are considered marketing/sales appointments regardless of the content discussed.
Marketing/Sales Event	Outreach activity designed to steer or attempt to steer, potential enrollees, or retention of current enrollees, toward a plan or limited set of plans.
Medicare Communications and Marketing Guidelines (MCMG)	Medicare Communications and Marketing Guidelines contains CMS' marketing requirements and related provisions for Medicare Advantage Plans (MA), Medicare Advantage Prescription Drug Plans (MAPD), Medicare Prescription Drug Plans (PDP), Employer/Union-Sponsored Group Health Plans, Medicare-Medicaid Plans (MMP) and Section 1876 Cost Plans.
Office of the Inspector General (OIG)	Within HHS—The Inspector General is responsible for audits, evaluations, investigations and law enforcement efforts relating to HHS programs and operations, including the Medicare program.
Open Enrollment Period (OEP)	Open Enrollment Period—occurs annually from January 1 to March 31—provides an additional time period for current Medicare Advantage enrollees to switch to another Medicare Advantage plan or back to Original Medicare.
Outbound Enrollment Verification (OEV)	A CMS required communication sent by Medicare Advantage plan sponsors to beneficiaries requesting enrollment when enrollment into a plan has been effectuated by an Agent, Broker, or FMO. The OEV ensures beneficiaries (i) are provided with the Plan's customer service number, (ii) receive answers any questions the applicant may have about costs, benefits, rules or any other question, and (iii) have been enrolled in their desired plan.
Outbound Enrollment Verification Cancellations	An enrollee's request to cancel or withdraw their request to enroll, for any reason, prior to or after the submission of their enrollment application to CMS. An enrollee's cancellation is permitted after the member's effective date only when it's a result of OEV communication from CareFirst and is within 7 days of receipt of that communication. This OEV cancellation is considered a rapid disenrollment.

Term	Definition
Rapid Disenrollment	When an enrollee disenrolls from a plan within the first three (3) months of continuous membership from the enrollee's effective date.
Sales Allegation	A complaint or grievance that involves potential misconduct by an agent, broker or FMO. Beneficiaries or an authorized representative can file a sales allegation as a grievance directly to CareFirst or as a complaint through CMS in the CTM or through other regulatory agencies.
Scope of Appointment (SOA)	A CMS requirement used to document an in-person, telephonic or video appointment with an enrollee to ensure that no other types of products are discussed outside of what the enrollee originally requested.
Secret Shopper	A practice used to detect, prevent and resolve noncompliant marketing and selling activity from agents, brokers and FMOs.
Star Measure C28—complaints about the health plan	The percentage of members filing complaints with Medicare about a health plan (complaints logged per 1,000 members).
Third Party Marketing Organization (TPMO)	An organization which includes all organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment. TPMOs may be a first tier, downstream or related entity (FDRs).
Unlike Plan Type	Unlike plan type means one of the following: (1) PDP replaced with an MA-PD or an MA-PD replaced with a PDP, (2) PDP replaced with a cost plan or a cost plan replaced with a PDP, (3) MA-PD replaced with a cost plan or a cost plan replaced with an MA-PD.
Upline	A firm, agency, organization or person with downline agents.
Vulnerable Enrollee	An enrollee who may be especially at-risk to unscrupulous marketing tactics and includes: beneficiaries with special needs, beneficiaries who are legally incompetent, beneficiaries with a physical or mental disability, beneficiaries who reside in Long Term Care Facilities or group homes, Dual-Eligible members and beneficiaries with limited English language proficiency.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

SELLING PLANS

CareFirst BlueCross BlueShield (CareFirst) Medicare Advantage HMO Plans

Licensing, contracting, appointment and background check

Before selling CareFirst BlueCross BlueShield Medicare Advantage Plans, agents must be licensed in Maryland and properly appointed and certified under the CareFirst BlueCross BlueShield Medicare Advantage annual certification process. CareFirst will initially verify that agents are not excluded or debarred by the HHS Office of Inspector General or by the General Services Administration from participation in any federal healthcare program (within the last three years), prior to the agent being approved to sell MA Products.

In order to successfully support our agents, we've partnered with two Field Marketing Organizations (FMOs). FMOs are experts in their field and offer the necessary support required for CareFirst BlueCross BlueShield Medicare Advantage sales activities.

The two FMOs we have partnered with are GS National and Ritter Insurance Marketing.

To become contracted with CareFirst to sell CareFirst BlueCross BlueShield Medicare Advantage Plans, agents may align with one of our contracted General Agents who will contract with one of our two Field Marketing Organizations. Or agents can align directly with one of the two FMOs. Additional information about our current General Agencies and FMOs is listed in this manual at the end under Agent Resources.

If you would like to become appointed with CareFirst, you can do so by contacting one of our contracted General Agents or by contacting one of the two FMOs. These entities will walk you through the "ready to sell" steps listed at right.

Ready to sell

Each year, Medicare sales agents must obtain "ready to sell" status with CareFirst. There are five (5) steps to achieving this status before soliciting to any Medicare prospect. Each component will be recorded and maintained with all uplines and CareFirst to ensure we are meeting all CMS requirements that are established in Section 110 of the "Medicare Communications and Marketing Guidelines." Agents will be able to verify their status through the agent's direct upline.

Agents must:

1. Pass a background check. We will perform background checks including but not limited to: Medicare Debarred and Exclusion Lists (office of Inspector General, System for Award Management and Office of Foreign Asset Control), Federal and State Criminal Search and Professional License Verification.
2. On a periodic basis, an agent background check may be required. Notification will be sent to the FMO and the agent. The agent will be given the opportunity to deny authorization of the investigation. If the agent does not grant authorization, the agent will receive a 60-day termination notice. Otherwise the background check will proceed.
3. Be licensed in Maryland for CareFirst BlueCross BlueShield Medicare Advantage.
4. Be appointed to sell with CareFirst.
5. Complete the annual Medicare AHIP Certification Exam and receive a passing score.
6. Complete the annual CareFirst product training and receive a passing score.

Medicare Training and Certification—(through AHIP)

CareFirst requires all selling agents to complete the Medicare and Fraud, Waste and Abuse training through AHIP and obtain a passing score. The AHIP Certification testing is required each year in order to obtain ready to sell status for each calendar year you are selling in. If you have already completed the annual AHIP training for the calendar year you are selling for and wish to transfer the passing score, please notify your GA or FMO. If you are taking the annual AHIP certification for the first time, agents are provided three attempts to receive this passing score. You may access this testing at https://www.ahipmedicaretraining.com/ext/ahip/login.php. AHIP provides a single source access to both required Medicare and Fraud, Waste and Abuse trainings as required for your "ready to sell" status.

Below is a list of topics you will learn in the AHIP training. All costs associated with the testing are the responsibility of the selling agent.

Medicare	Fraud, Waste and Abuse (FWA)
■ The basics of Medicare fee-for-service eligibility and benefits ■ The different types of Medicare Advantage and Part D prescription drug plans ■ Eligibility and coverage ■ Nondiscrimination training ■ Marketing and enrollment under the Medicare Advantage and Part D program requirements	■ How to identify FWA ■ An overview of the industry efforts in detecting fraud ■ Legal tools to combat FWA ■ Understand both the human and financial cost of FWA ■ Review Medicare Parts C and D Fraud, Waste and Abuse and General Compliance requirements ■ Who commits FWA ■ Reporting FWA; loopholes and obligations

CareFirst BlueCross BlueShield Medicare Advantage product training

CareFirst also requires that every selling agent completes our local markets product training. You must receive a passing score upon completion of this training. Agents will be provided three attempts to pass this training. Once CareFirst completes the background check and confirms your license and appointment, agents will be provided with access to the CareFirst Product Training. Please note that the CareFirst product training will not launch until CareFirst BlueCross BlueShield Medicare Advantage plans have been fully approved by CMS each year. The approval generally occurs around late August to the beginning of September annually.

The training will be available through the CareFirst Broker Portal. Please visit www.carefirst.com/broker. Please click on the *Log In* tab across the top menu and enter the user credentials sent via e-mail to the agent's e-mail address provided. Once logged in to the Broker Portal, there will be a button for the agent to launch the CareFirst BlueCross BlueShield Medicare Advantage training at the top of the screen.

The training consists of seven (7) modules:

1. Medicare Advantage
2. CareFirst BlueCross BlueShield Medicare Advantage HMO Product Introduction
3. Product Benefits and Plan Comparison
4. Supplemental Benefits
5. Provider Network
6. Prescription Drug Coverage
7. Agent Policies and Procedures

WHEN PROSPECTS CAN ENROLL

Medicare Advantage and Prescription Drug Enrollment Periods

This information is about enrolling in Medicare Advantage Plans and Medicare Prescription Drug Plans (Part D). A prospective enrollee must have Medicare Part A and Part B to join a Medicare Advantage Plan.

Initial Enrollment Period

If this describes the prospective enrollee...	The prospective enrollee can...	At this time...
Newly eligible for Medicare because you turn 65.	Sign up for a Medicare Advantage Plan (with or without prescription drug coverage) or a Medicare Prescription Drug Plan.	During the 7-month period that starts 3 months before the month they turn 65, includes the month they turn 65 and ends 3 months after the month they turn 65. If they sign up for a Medicare Advantage Plan during this time, they can drop that plan at any time during the next 12 months and go back to Original Medicare.
Newly eligible for Medicare because they have a disability and they're under 65.	Sign up for a Medicare Advantage Plan (with or without prescription drug coverage) or a Medicare Prescription Drug Plan.	Starting 21 months after they get Social Security or Railroad Retirement Board (RRB) disability benefits. Their Medicare coverage begins 24 months after they get Social Security or RRB benefits. Their chance to sign up lasts through the 28th month after they get Social Security or RRB benefits.

If this describes the prospective enrollee...	The prospective enrollee can...	At this time...
They're already eligible for Medicare because of a disability, and they turn 65.	■ Sign up for a Medicare Advantage Plan (with or without prescription drug coverage) or a Medicare Prescription Drug Plan. ■ Switch from their current Medicare Advantage or Medicare Prescription Drug Plan to another plan. ■ Drop a Medicare Advantage or Medicare Prescription Drug Plan completely.	During the 7-month period that starts 3 months before the month they turn 65, includes the month they turn 65 and ends 3 months after the month they turn 65.
They have Medicare Part A coverage, and they get Part B for the first time by enrolling during the Part B General Enrollment Period (January 1–March 31).	■ Sign up for a Medicare Advantage Plan (with or without prescription drug coverage).	Between April 1–June 30.

Special Enrollment Periods

A prospective enrollee can make changes to their Medicare health and Medicare prescription drug coverage when certain events happen in their life, like if they move or lose other insurance coverage. These chances to make changes are called Special Enrollment Periods (SEPs) and are in addition to the regular enrollment periods that happen each year. Rules about when they can make changes and the type of changes they can make are different for each SEP. For more information about SEPs, please visit **here**.

Additional Medicare Advantage enrollment periods

Each year, an enrollee can make changes to their Medicare Advantage or Medicare prescription drug coverage for the following year during the enrollment periods defined in the following chart.

Enrollment Period	
October 15–December 7 (Changes will take effect on January 1)	**Enrollee can....** ■ Change from Original Medicare to a Medicare Advantage Plan. ■ Change from a Medicare Advantage Plan back to Original Medicare. ■ Switch from one Medicare Advantage Plan to another Medicare Advantage Plan. ■ Switch from a Medicare Advantage Plan that doesn't offer drug coverage to a Medicare Advantage Plan that offers drug coverage. ■ Switch from a Medicare Advantage Plan that offers drug coverage to a Medicare Advantage Plan that doesn't offer drug coverage. ■ Join a Medicare Prescription Drug Plan. ■ Switch from one Medicare Prescription Drug Plan to another Medicare Prescription Drug Plan. ■ Drop Medicare prescription drug coverage completely.
January 1–March 31 Medicare Advantage Open Enrollment Period Marketing is not allowed to these Individuals. Agents can respond to inquiries from individuals. (Enrollee can only make one change during this period. Changes will take effect the first of the month after the plan gets your request.)	**Enrollee can....** ■ If enrollee is in a Medicare Advantage Plan (with or without drug coverage), switch to another Medicare Advantage Plan (with or without drug coverage). ■ Disenroll from Medicare Advantage Plan and return to Original Medicare. If enrollee chooses to do so, they will be able to join a Medicare Prescription Drug Plan. ■ If enrolled in a Medicare Advantage Plan during the Initial Enrollment Period, change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without a Medicare Prescription Drug Plan) within the first 3 months you have Medicare. **Enrollee Cannot...** ■ Switch from Original Medicare to a Medicare Advantage Plan. ■ Join a Medicare Prescription Drug Plan if in Original Medicare. ■ Switch from one Medicare Prescription Drug Plan to another if in Original Medicare.

AGENT SALES TOOLS & RESOURCES

Agent Communications, Materials and Resources

This section is to introduce you to our growing library of sales information. We have multiple tools and resources to help you and your client understand the value of our CareFirst Medicare Advantage HMO plans.

Agent communications

We will regularly provide information to the agent through the FMO who will send these updates directly to their downline agents. All agents will verify that their email address is up to date with their current upline. If needed, an agent will be able to access an archive of broker communications on the CareFirst Broker Portal once obtaining login access. www.carefirst.com/broker

Resources and materials for agents

We intend to provide you with tools and resources to assist you and your clients. As resources are approved, they will be available in PDF format on our CareFirst Broker Portal:

- Permission to Contact Form
- Scope of Appointment
- Pre-sale booklet—includes benefits, cost, and enrollment forms
- Enrollment Forms (separate PDF from the pre-sale booklet)
- Prospect Facing Sales Presentations—presentations for prospect meetings that include CareFirst Medicare product offerings, general Medicare information, enrollment timelines, one/one appointments incorporating, but not limited to, CMS guidelines, O65 products offerings, and CareFirst products
- Total cost of coverage worksheet—to assist prospects in understanding total out of pocket costs including premium and coverage
- Sales Checklist—to ensure all items within the meeting are addressed with the prospect
- "What to Expect" flier—to be provided to the consumer upon completion of the application
- Top 100 Drugs" flier
- "Tier 1" Drugs at 100 day fill flier
- "The Medicare Advantage Difference: Whole Health"
- Supplemental Vendor fliers
- Nondiscrimination disclaimers
- Plan Decision Guides

This list is not all inclusive of the resources that will be made available to you.

How to bulk order agent supplies

Agents will have the option of ordering supplies online or submitting requests by a paper order form. Agents will then submit paper order forms to our Agent Support team for processing.

The online order form can be found on the broker portal under Resources.

AGENT COMPLIANCE

As a CareFirst agent representing our CareFirst Medicare Advantage plans, you must comply with the CMS regulations and guidelines, federal and state laws, and CareFirst business rules, policies and procedures.

An agent who fails to remain compliant by engaging in inappropriate or prohibited marketing activities could be at risk for potential consequences including disciplinary actions, termination and forfeiture of compensation.

We strongly encourage you to read and frequently reference the Agent Requirements in the CMS Medicare Communications and Marketing Guidelines (MCMG) in addition to the guidelines found in this manual. You can find the MCMG document at:

https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines

CMS final rule*

To address concerns and complaints regarding Third Party Marketing Organizations (TPMO), updates have been made to the communications and marketing requirements.

Agents must record all calls with beneficiaries in their entirety. The agent when conducting lead generating activities, must agree to disclose to the beneficiary that his or her information will be provided to a licensed agent for future contact. This disclosure must be provided verbally when communicating with a beneficiary through telephone; in writing when communicating with a beneficiary through mail or other paper and electronically when communicating with a beneficiary through email, online chat, or other electronic messaging platform.

Agents are required to have this displayed prominently on their website as well as marketing materials including all print and television advertising. The disclaimer is also required verbally within the first minute of a call.

Educational and sales events

Please note The following information provides CMS guidelines regarding educational events and sales events.

Educational Events

An educational event is defined as an outreach activity designed with the intention of informing beneficiaries about Medicare Advantage, Prescription Drug or other Medicare programs and does not include marketing.

All CareFirst educational events hosted by an agent must be advertised explicitly as educational, hosted in a public venue and only CareFirst approved communication materials can be distributed.

During a CareFirst educational event, an agent representing CareFirst, may:

1. Answer enrollee-initiated questions that are not specific to CareFirst BlueCross BlueShield Medicare Advantage plans, benefits or rates
2. Set up a marketing appointment
3. Distribute business cards and contact information to beneficiaries to initiate contact, including completing and collecting Scope of Appointment (SOA) forms

During a CareFirst educational event an agent representing CareFirst will not include marketing or sales activities.

*** The disclaimer is—We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1–800–MEDICARE to get information on all your options."**

Marketing/sales events

A marketing/sales event is defined as an outreach activity designed to steer, or attempt to steer, potential enrollees, or the retention of current enrollees, toward a plan or limited set of plans.

During a CareFirst marketing or sales event, an agent representing CareFirst, will:

1. Utilize talking points and presentations that have been submitted to CMS and approved prior to use
2. Clearly indicate that signing-in at the event is optional
3. As appropriate, agents will invite family members, legal representatives and or caretakers of the enrollee to attend sales and marketing meetings

During a CareFirst marketing or sales event, CareFirst, or any agent representing CareFirst, will not:

1. Include any health screening activity or other activity that may be perceived as favorable selection cherry-picking
2. Require attendees to provide contact information as a prerequisite for attending the event
3. Use contact information obtained for the purposes of a raffle or drawing for any other purpose than the raffle or drawing

Event oversight

Prior to the first event (sales or educational), the agent must complete the CareFirst "How to Run a Community Event" training.

Agents will notify CareFirst of all marketing or sales events at least seven (7) days prior to the initial advertised event. Please log on to the CareFirst Broker Portal to complete and submit the online Sales Event Form. This information will be collected by the CareFirst Events Coordinator. Agents will also notify CareFirst of all canceled or changed marketing or sales events at least 48 hours in advance of the scheduled event.

Please log on to the CareFirst Broker Portal to complete and submit the online Sales Event Cancellation Form. If an agent cannot give 48 hours advance notice, a representative will be present and inform people it has been cancelled. CareFirst will track all event information, including cancellations and changes.

Agents will:

1. Arrive early to scheduled events to ensure proper set up and greet early arrivers
2. Use CMS-approved signage
3. Announce their name and company they represent
4. Use only approved CareFirst sales presentation decks

Gifts and promotions

During a CareFirst marketing or sales event, an agent representing CareFirst may offer gifts and promotional items. Gifts and promotional items will not exceed $15, or $75 aggregate, per person, per year. Gifts and promotional items will be given to marketing or sales event attendees, regardless of whether they enroll, and without discrimination.

Agents, brokers and FMOs will ensure that gifts or promotional items will not consist of:

1. Cash
2. Monetary rebates
3. Any item perceived to be a health benefit
4. Furnished or subsidized meals or items that could be reasonably considered a meal when bundled

Non-discrimination requirements

Agents selling or marketing CareFirst BlueCross BlueShield Medicare Advantage products will not discriminate based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of healthcare, claims experience, medical history, genetic information, evidence of insurability or geographic location.

Agents selling or marketing CareFirst BlueCross BlueShield Medicare Advantage products will not target potential enrollees from higher income areas, state or imply that plans are only available to seniors rather than to all Medicare beneficiaries, or state or imply that plans are only available to Medicaid beneficiaries unless the plan is a Dual Eligible Special Needs Plan (D-SNP) or MMP.

Agents selling or marketing CareFirst BlueCross BlueShield Medicare Advantage products will post the CareFirst Non-Discrimination Notice at all events.

Agents selling or marketing CareFirst BlueCross BlueShield Medicare Advantage products will ensure that event facilities are accessible in accordance with the Americans with Disabilities Act (ADA).

CareFirst will require all agents to make appropriate accommodations for vulnerable beneficiaries, including those with special needs, when performing sales and marketing activities. Agents must provide the following:

1. Meetings at accessible sites (have handicap spaces, don't have meetings above the 1st floor unless elevators are available)
2. Accommodations when asked, such as sign language or translation services through telephonic language line
3. Non-discrimination policies to ensure anyone requesting information can attend a meeting or meet with an agent virtually or in person

Should an event attendee not speak or understand the language of the agent selling or marketing CareFirst BlueCross BlueShield Medicare Advantage products is communicating in, the attendee will be referred to a contact number for language assistance. If a translator is requested by the enrollee or the legal representative, the agent must arrange for a translator to be present in person or via telephone.

Marketing and sales activities

All agents must obtain permission from a prospective enrollee prior to contacting them to engage in sales and/or marketing activities.

Permission to contact

All agents selling or marketing CareFirst BlueCross BlueShield Medicare Advantage products will obtain permission from a prospective enrollee prior to contacting them telephonically to schedule a sales or marketing appointment. Agents may initiate contact with a prospective enrollee who submits an online request form or via a business reply card agreeing to outreach. Agents may also initiate contact with a prospective enrollee via email and attempt to retain enrollment for a current enrollee. All email communications will include an opt-out process for the prospective or current enrollee to elect to no longer receive emails.

Marketing through unsolicited contacts

Agents selling or marketing CareFirst BlueCross BlueShield Medicare Advantage products will only make unsolicited direct contact with potential enrollees by:

Conventional mail and other print media

4. Email, provided all emails contain an opt-out function

Agents selling or marketing CareFirst BlueCross BlueShield Medicare Advantage Products will not:

1. Use door-to-door solicitation, including leaving information such as leaflets or flyers at a residence or vehicle
2. Approach potential enrollees in common areas such as parking lots, hallways, lobbies or sidewalks
3. Solicit by telephone, including text messages and leaving electronic voicemail messages

If a potential enrollee is a "no show" for a pre-scheduled marketing or sales appointment, the agent, broker or FMO may leave information at that enrollee's residence.

Marketing through telephonic contact

Agents selling or marketing CareFirst BlueCross BlueShield Medicare Advantage products will not make unsolicited telephone calls to prospective enrollees. Agents will only contact current enrollees to discuss plan business but not conduct any marketing prior to October 1 under the pretense of plan business.

Agents selling or marketing CareFirst BlueCross BlueShield Medicare Advantage products will only conduct the following specific telephonic activities:

1. Call current enrollees, including those in non-Medicare products, to discuss plan business
2. Call current MA enrollees, if they are already your current client to promote other Medicare plan types or to discuss plan benefits
3. Call beneficiaries who submit enrollment applications to conduct business related to enrollment

4. Call individuals who have given permission via business reply card, a direct email requesting a return call, or asking a customer service representative to have an agent contact them. Permission applies only to the entity from which the individual requested contact and for the duration and topic of that transaction and return phone calls or messages from individuals or enrollees (these are not considered unsolicited contacts)

Agents selling or marketing CareFirst BlueCross BlueShield Medicare Advantage products will not conduct the following types of telephonic activities:

1. Unsolicited calls about other business as a means of generating leads for Medicare plans
2. Calls based on referrals provided by CareFirst or based on other referrals without proper consent
3. Calls to market plans or products to former enrollees who have disenrolled, or to current enrollees who are in the process of voluntarily disenrolling
4. Calls to beneficiaries who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call
5. Calls to prospective enrollees to confirm receipt of mailed information unless the prospective enrollee provide consent to call back during a previous interaction, whether through a business reply card, event or telephone call

Marketing during open enrollment period (OEP)

Agents will not knowingly target or send unsolicited marketing materials to any MA enrollee or Part D enrollee during the continuous Open Enrollment Period (January 1 to March 31). Beneficiaries currently enrolled in Original Medicare do not have an OEP election period.

Agents selling CareFirst BlueCross BlueShield Medicare Advantage Plans may conduct the following activities during the continuous Open Enrollment Period:

1. 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
   - Marketing by a five-star plan regarding their continuous enrollment SEP
   - 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
2. Send marketing materials when a beneficiary makes a proactive request
3. At the beneficiary's request, have one-on-one meetings with a sales agent
4. At the beneficiary's request, provide information on the OEP through the call center
5. Include general information on their website about enrollment periods, including the Open Enrollment Period

Sales and marketing materials

All agents will only utilize sales and marketing materials that have been submitted to and approved as applicable by CareFirst and CMS (e.g., advertising, sales presentations, marketing, enrollment materials, and electronic marketing communications).

If agents create their own marketing materials, all materials that mention, or that are otherwise intended to sell, market, promote, or advertise a CareFirst plan will require CareFirst Compliance and Legal approval prior to use. This includes any materials that contain:

1. CareFirst name or brand name, logo, plan names or benefits
2. Explanations related to enrolling or membership in a CareFirst MAPD plan
3. Rules that apply to enrollees
4. Materials to be used alongside CareFirst Scope of Appointment (SOA) form
5. Mentions seminars where a sales representative will be present
6. Otherwise is used to obtain beneficiary information for marketing and/or enrollment in a CareFirst plan

All third-party websites containing any marketing content must be approved for use by CareFirst if it includes any of the information contained in #1-5 above or is used to obtain beneficiary information for marketing and/or enrollment in a CareFirst plan.

CareFirst compliance and legal approval of sales and marketing material

CareFirst Compliance and Legal will review and approve all agent or FMO created and modified member-facing materials for compliance with CMS Marketing Guidelines and CareFirst brand and marketing standards.

No agent or FMO created materials may be used until they are approved in writing by CareFirst. CareFirst will be responsible for evaluating the need for submission to CMS and, where appropriate, submit multi-lingual marketing materials created by agent, brokers and FMOs that include English and another language to CMS via the HPMS module.

Third-party agent or FMO websites used to market CareFirst products must be approved by CareFirst and cannot go live until at least five (5) days after submission to HPMS. For updates to third-party agent or FMO websites, the agent or FMO will not take down the website while making updates; however, updates will not go live until at least five (5) days after submission in HPMS.

Agents selling or marketing CareFirst BlueCross BlueShield Medicare Advantage products will include the Statement of Non-Discrimination in significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures and approved by CareFirst. Agents will accommodate alternate formats for sales, marketing and informational materials, as requested by the enrollee. CareFirst will translate sales and marketing materials into any non-English language that makes up 5% or more of the population in the sales or marketing area.

Sales activities do's and don'ts

Medicare beneficiaries should be able to understand the benefits of the Medicare plans they are presented and be able to select the plan with the healthcare coverage that best meets their personal needs. Agents and brokers play a significant role in helping Medicare beneficiaries with their coverage choices.

We encourage agents to obtain and utilize our CareFirst branded CMS approved sales presentation when meeting with your client. An embedded sales script will be available for agent use within the sales presentation but not to be shared with the client. Agents will also be provided a Personal and Individual Appointment Checklist to ensure that only appropriate content and topics are covered during the sales appointment.

Agents cannot solicit or accept enrollment applications for a January 1 effective date prior to October 15 of the preceding calendar year unless the prospective enrollee is entitled to a special enrollment period or the initial coverage election period that allows an earlier receipt date.

Scope of appointment

Plan agents cannot meet with the beneficiary without an invitation from the beneficiary. Agents can only discuss the products that the beneficiary has asked about. In order to facilitate these rules, CMS requires that a Scope of Appointment (SOA) form be completed for each appointment interaction with a beneficiary. An SOA must be obtained regardless of the location of the appointment (e.g., in-person, telephonic or assisted online enrollment) and whether a subsequent enrollment is received.

The SOA is a CMS requirement which must be completed before the meeting and is limited to the previously agreed upon healthcare related products the beneficiary requested to discuss.

The SOA provided by and utilized by CareFirst for our agents will include the following information:

1. Product types to be discussed
2. Date of appointment
3. Beneficiary and agent contact information
4. Statement stating, no obligation to enroll, current or future Medicare enrollment status will not be impacted, and automatic enrollment will not occur

If the beneficiary should ask to discuss other CareFirst BlueCross BlueShield Medicare Advantage products, the agent must execute another scope of appointment form. If you are meeting with two beneficiaries, you must obtain a Scope of Appointment form from each client.

A SOA can be obtained telephonically as long as the telephone call is recorded, documented and easily retrievable as needed. The same information listed above must be captured telephonically. Our FMO partners may offer this capability. Please check with your direct upline to learn more about this option.

Agents must retain a valid SOA along with copy of the completed application and be able to provide it no later than one calendar day when requested.

Agents are required to store all SOAs for a minimum of 10 years and provide them to CareFirst as requested. CareFirst requires the SOA be signed and dated to be considered valid. For personal or individual marketing appointments conducted via telephone, a recorded signature with date stamp is acceptable as long as the call is retrievable and retained.

CareFirst will conduct monthly audits and include SOAs in that audit to confirm adherence to CMS's Medicare Marketing Guidelines. If deficiencies are found from monthly audits, the agent will be subject to Corrective Action.

CareFirst agents and FMOs may not participate in the following:

1. Activities that mislead, confuse, or misrepresent CareFirst or its plans
2. Discriminatory marketing or selling practices
3. Offer gifts or payments to induce enrollment or solicitation of referrals
4. Solicit door-to-door marketing or selling
5. Uninitiated direct contact with beneficiaries
6. Claim endorsements or recommendations from CMS
7. Make erroneous oral or written statements or modify CMS and CareFirst approved marketing or selling materials
8. Utilize provider offices to market plans unless there is availability for all plans to market in this environment and approval has been given by CareFirst Compliance
9. Cross sell non-healthcare products during marketing or selling of CareFirst plans
10. Provide meals during marketing or sales meetings or events
11. Provide meals during marketing or sales meetings or events
12. Conduct marketing or selling activities at an educational event
13. Market or sell in areas where care is being provided
14. Provide absolute or qualified superlative statements when describing CareFirst

Enrollment

CareFirst will provide all agents with the CMS-approved CareFirst enrollment pre-sale booklet which will include the CareFirst BlueCross BlueShield Medicare Advantage enrollment form. You will have the ability to download a PDF version or submit an order through our Agent Support team for the pre-sale booklet prior to selling and marketing the plans.

All enrollment must be submitted through the agent's contracted FMO portal electronically. If a prospective enrollee provides the agent with a paper enrollment form, the agent will be responsible for keying in the enrollment into the FMO portal the day received from the prospective enrollee. If a paper enrollment form is received with missing information, the agent must make every attempt to collect the missing information within the 24-hour period. If the attempt at collecting the missing information is unsuccessful, the agent must fax the incomplete application to the FMO.

Agents will assist prospective enrollees with obtaining and completing the enrollment application. For each enrollment application, agents will verify the following has been completed:

1. Enrollee's first and last name
2. Enrollee's birth date and sex
3. Enrollee's telephone number
4. Enrollee's permanent address and mailing address if different from permanent address
5. Enrollee's permanent address will be in the United States
6. Enrollee's Medicare Number
7. Enrollee's response if they have other health or prescription drug coverage. If yes, provide name of coverage, member number of coverage and group number for this coverage. Enrollees must sign and date the enrollment application.
8. Enrollees must sign and date the enrollment application.
9. If the enrollee's authorized representative is completing the enrollment application, they must sign and date the application and complete their name, address, phone number and relationship to the enrollee.

Agents will assist enrollees with completing the below optional fields in Section 2 of the enrollment application:

10. Enrollee selects a CareFirst BlueCross BlueShield Medicare Advantage Primary Care Physician (PCP).
11. Enrollee responds to the question if they work or if their spouse works.
12. Enrollee provides email address if they wish to receive materials available for electronic delivery.
13. Enrollee may select how they wish to pay their plan premiums
14. Enrollee responds to request materials in Spanish, Braille or large print
15. Enrollee's response to race and ethnicity question.

The enrollee or their legal representative must sign the application. The authorized representative must sign and date the enrollment form and provide their name, phone number, address and relationship to enrollee.

Upon receipt of the beneficiary-completed enrollment form, the agent must:

1. Complete the "Agent Use Only" section of the enrollment form
2. Ensure proper enrollment form is being used for the given year
3. Not solicit or accept applications outside of the annual enrollment period unless the beneficiary is new to Medicare because of age or disability, or qualifies for a special enrollment period
4. Ensure the completed scope of appointment form is stored and accessible by request of CareFirst

Agents and FMOs are not permitted to share enrollee enrollment information with outside sales entities.

When an enrollee is unable to complete an enrollment request due to a disability or literacy issue, the agent will follow state laws when considering how to obtain the proper enrollment signatures. When agents question how to proceed, they will reach out to the CareFirst Sales Management Team for guidance.

Agents must submit completed enrollment applications to the FMO the day they are received from the enrollee. The preferred method of enrollment submission is electronically via the FMO's broker portal. For enrollees who submit enrollment requests to agents, the application date is the date the Agent or Broker receives (accepts) the enrollment request and not the date the CareFirst receives the enrollment request from the Agent or Broker. For purposes of enrollment, receipt by the Agent or Broker employed by or contracting with CareFirst, is considered receipt by the plan, thus all CMS required timeframes for enrollment processing begin on this date.

Enrollment via telephone

Enrollees may request to enroll over the phone when they make a call to their agent or during an outbound call from their agent. Telephone enrollment activities are CMS regulated and must remain CMS compliant. There are different requirements for telephone contact, sales scripts, recording and maintaining calls and other sales activities associated with telephonic enrollment.

An agent will speak with their FMO regarding any telephonic enrollment capabilities to ensure all CMS guidelines are strictly adhered to.

Outbound enrollment verification

CareFirst will complete Outbound Enrollment Verification (OEV) for all agent effectuated enrollments, in writing to the enrollee within 15 calendar days of receipt of the enrollment request from the enrollee. Translation of the letter will be provided if requested.

The OEV letter will be documented, dated and will:

a. Verify the enrollee's enrollment is accurate
b. Ensure the Enrollee fully understands the benefits and premium of the selected plan as indicated in the CareFirst Plan Benefit Package
c. Ensure the Enrollee understands that the provider network can change at anytime and for the most up-to-date information refer them to the Plan's website or to contact CareFirst customer service.
d. Provide the CareFirst customer service number for the Enrollee to use to contact the plan for any questions regarding costs, benefits, rules, or any other questions about the CareFirst plan, and
e. Provide contact information in the event the Enrollee wants to cancel the enrollment.

CareFirst will ensure that OEV communications address enrollment into the CareFirst plan and provide a customer service number for enrollee questions regarding costs, benefits, rules or any other question about the CareFirst plan.

CareFirst will not permit agents or FMOs to be part of the OEV communication. CareFirst will track and trend OEV cancellations and complaints and take appropriate follow up actions, as required. OEV processes will stop if CareFirst is notified that enrollee is ineligible to enroll in the plan or if enrollee has cancelled the enrollment.

Rapid disenrollment and outbound enrollment verification cancellations

Agents, brokers and FMOs must strive to continuously reduce the rapid disenrollment rate of CareFirst members through enrolling each enrollee into a plan that best meets their particular needs and ensuring that all plan features, benefits and provider network restrictions are clearly explained to beneficiaries before the time of enrollment. Additionally, CareFirst will recover any compensation paid to an agent, broker and FMO for members that rapidly disenroll or cancel enrollment during Outbound Enrollment Verifications (OEVs) as required by CMS.

A rapid disenrollment applies when an enrollee makes any plan change (regardless of Parent Organization) within the first three (3) months of enrollment. CareFirst will recover, and chargeback, any compensation paid to an agent, broker or FMO when an enrollee rapidly disenrolls from the plan.

In the event a cancellation is made based on an Outbound Enrollment Verification and compensation has been paid to the agent, broker or FMO, that compensation will be recovered.

Outbound Enrollment Verification cancellations will count toward rapid disenrollment numbers.

CareFirst will not recover compensation based on rapid disenrollment when the enrollee enrolled with an effective date of October 1, November 1 or December 1 and subsequently changes plans during the annual election period for an effective date of January 1 of the following year.

CareFirst will not recover compensation because of rapid disenrollment in the following CMS-approved circumstances:

1. Other creditable coverage (e.g., employer plan)
2. Moving into or out of an institution
3. Gains/drops employer/union sponsored coverage
4. Plan termination, non-renewal or CMS imposed sanction
5. To coordinate with Part D enrollment periods or State Pharmaceutical Assistance Program
6. Becoming LIS or dual (Medicare and Medicaid) eligible
7. Dual eligible beneficiaries moving from an MA-PD to MMP
8. Qualifying for another plan based on special needs
9. Due to an auto, facilitated or passive enrollment
10. Death
11. Moves out of the service area
12. Non-payment of premium
13. Loss of entitlement or retroactive notice of entitlement
14. Moving to a five-star plan or from an LPI plan into a plan with three or more stars

The CareFirst Agent/Broker Oversight Team will monitor rapid disenrollment and cancellation rates for agents, brokers and FMOs. Any agent, broker or FMO that exhibits a pattern of rapid disenrollment or cancellations will be reviewed for corrective action.

AGENT OVERSIGHT

Agent oversight committee

CareFirst regularly monitors and oversees agent activities and responds to any sales allegations or complaints against an agent. We have established a multi-disciplinary Agent Oversight Committee to oversee agent activity.

The Agent Oversight Committee will be responsible for review and oversight of agent activities such as:

1. Proper licensing and appointment of individuals per individual state requirements
2. Reporting to state where agent is appointed if an agent is terminated, including the reason for termination, if state law requires
3. Proper annual agent recertification of individuals according to CMS requirements
4. Agent background checks are performed after a gap year in agent recertification.
5. Reporting to CMS all enrollments made by an unlicensed agent and report for-cause terminations
6. Training and testing meets CMS requirements
7. Appropriate submission of marketing materials to CMS
8. Completion of Scope of Appointment (SOA) forms for all marketing appointments
9. Rapid disenrollment and outbound verification cancellation reports
10. Agent and broker related Complaint Tracking Modules (CTMs) and grievances,
11. Secret shopper and/or ride along audit results
12. Agent and broker related corrective actions and disciplinary measures
13. Appeals made by agents and brokers in response to corrective action and disciplinary measures
14. Sales allegation reports.
15. Sales and marketing compliance data
16. Reviews oversight trends
17. Vendor selection and terminations

Sales grievances and allegations

A Sales Allegation is a complaint or grievance that involves potential misconduct by an agent, broker, or FMO. Beneficiaries or an authorized representative can file a sales allegation as a grievance directly to CareFirst or as a complaint through CMS in the Complaint Tracking Module (CTM) or through other regulatory agencies.

Sales allegations can be avoided by not participating in the following:

1. Activities that mislead, confuse, or misrepresent CareFirst or its plans
2. Discriminatory marketing or selling practices
3. Offer gifts or payments to induce enrollment or solicitation of referrals
4. Solicit door-to-door marketing or selling
5. Uninitiated direct contact with beneficiaries
6. Claim endorsements or recommendations from CMS
7. Make erroneous oral or written statements or modify CMS and CareFirst approved marketing or selling materials
8. Utilize provider offices to market plans unless there is availability for all plans to market in this environment and approval has been given by CareFirst Compliance
9. Cross sell non-healthcare products during marketing or selling of CareFirst plans
10. Provide meals during marketing or sales meetings or events
11. Conduct marketing or selling activities at an educational event
12. Market or sell in areas where care is being provided
13. Provide absolute or qualified superlative statements when describing CareFirst

CareFirst's Agent Oversight Team will conduct a thorough investigation of all sales allegations and grievances from prospective members and enrolled members. A sales allegation or sales grievance may be received by CareFirst through member call centers, written/electronic

correspondence, the CMS Complaint Tracking Module (CTM) or surveillance, a state Department of Insurance, the CareFirst Executive Inquiry process or via other method of communication to a CareFirst associate or delegated vendor. The CareFirst Appeals and Grievances team will work with the Agent Oversight Team to triage, investigate and respond to all grievances that are received based on CMS defined resolution timeline requirements.

CareFirst will contact the agent and/or FMO in question to solicit a response regarding any sales allegations or grievances made toward the agent. The agent and/or FMO must respond in writing to CareFirst's request within five (5) business days, or sooner if the nature of the allegation or grievance requires, including any accompanying documentation and call recordings needed.

The agent, and/or FMO involved will have no contact with the complainant during the investigation period. The Agent Oversight Committee will review the allegation or grievance and the agent's and/ or FMO's response to determine if the sales allegation or grievance was substantiated.

The Agent Oversight Team will then determine if corrective actions are required.

An agent could be suspended for a limited duration to enable CareFirst to conduct due diligence investigations.

The CareFirst Agent Oversight Committee and the Appeals and Grievances Committee will provide a written response back to the complainant upon the conclusion and resolution of the sales allegation or grievance.

Secret shopper audits

CareFirst, or a third-party vendor, will conduct secret shopper audits on agents to help detect, prevent and resolve noncompliant sales and marketing activity. CareFirst will develop evaluation criteria to monitor an agent's sales and marketing activities, based on CMS guidance. CareFirst will randomly select agents to be included in the secret shopping audit activities. Agents which CareFirst observes patterns of noncompliance or receives complaints will be added to the secret shopper audit list. Secret shopping audit activities will be conducted in accordance with the agreed upon evaluation criteria and include public sales/ marketing events and in-person or individual marketing appointments. However, during the COVID-19 pandemic where events and in-person appointments are discouraged, secret shopper activities may limited to oversight of virtual events.

The Secret Shopper audit team will provide a report of all deficiencies and results noted during secret shopper audit and the findings will be reviewed by CareFirst and the agent will be notified. The agent will be requested to provide in writing any substantiation and supporting documentation in support of the audit. The CareFirst Agent Oversight Committee will determine if corrective action, termination and/or reporting to CMS are required. CareFirst will work directly with the FMO responsible for the agent or broker in question to implement corrective actions. CareFirst may suspend an agent from servicing CareFirst during an investigation of any sales allegations identified by the Secret Shopper audit. If termination of the agent is required, the termination will be completed as stated below in the Corrective Action guidelines.

CMS may notify CareFirst of a deficiency noted as a result of a CMS Initiated Surveillance activity. All deficiencies reported by CMS to CareFirst from CMS Initiated Surveillance will be reviewed by the CareFirst Medicare Sales Director and the CareFirst Agent/Broker Oversight Committee. The CareFirst Medicare Sales Director will request relevant information from the Agent, Broker, or FMO in question. The Agent, Broker, or FMO will respond to request(s) with all required information and documentation. The CareFirst Medicare Sales Director will report the results from any investigation of a deficiency identified by a CMS Initiated Surveillance to the CareFirst Medicare Compliance Officer and the CareFirst Agent/Broker Oversight Committee. The CareFirst Medicare Compliance Officer will determine if Corrective Action, suspension, termination, and/or reporting to CMS are required. The CareFirst Medicare Sales Director, or his/her designee, will work directly with the Agent, Broker, or FMO in question to implement corrective actions.

Corrective action

Corrective actions related to agents are initiated in response to actual or potential operational, performance, and compliance risk, issues or problems. These issues may include, but are not limited to:

1. Late application submissions
2. Agents not following CMS Medicare Marketing Guidelines when interacting with clients during one-on-one appointments, events, telephonic enrollment inquiries, etc.
3. Performance issues that present risk to CareFirst
4. High rapid disenrollment rates

Methods by which issues could be raised:

1. CMS Notice of Noncompliance
2. CMS Audit finding
3. Routine monitoring of agent operations
4. CareFirst Auditing of agent operations
5. Self-reporting by agent
6. Request of the Medicare Compliance Officer
7. A call to the Compliance Hotline

Corrective actions may also be initiated in response to sales-related allegations received as a grievance from a prospective or existing member, through CTM, a state Department of Insurance, the Executive Inquiry process or other method of communication to a CareFirst associate or delegated vendor.

The CareFirst Medicare Sales Director in coordination with the CareFirst Sales Management Team and the applicable agent and/or FMO will investigate the matter and conduct a root cause analysis. The root cause analysis will be used to identify the central issues that led to the actual or potential operational or compliance issue. Once the CareFirst Medicare Sales Director and the CareFirst Sales Management Team identify the existence of an actual operational or compliance issue or problem, they are required to promptly notify the CareFirst Medicare Compliance Officer of the matter. The CareFirst Medicare Compliance Officer, in consultation with Legal, if applicable, will promptly determine if CMS needs to be notified of operational or compliance issue or problem. If required to notify CMS, the CareFirst Medicare Compliance Officer will report the operational or compliance issue or problem.

The CareFirst Medicare Sales Director and the CareFirst Medicare Compliance Officer will determine if corrective actions are required based on the operational or compliance risk, issue, or problems. The CareFirst Medicare Sales Director will coordinate with the CareFirst Medicare Compliance Officer, and the applicable agent and/or FMO to draft a corrective action plan (CAP) that addresses each cause of the operational or compliance issue or problem. The CAP may include, but is not limited to:

1. Revisions to training and education programs
2. Retraining of agents, brokers or FMOs
3. Updated process steps or workflows
4. New or modified agent, broker or FMO policies and procedures
5. Enhancement to equipment or systems
6. Changes to team size, scope, or responsibilities
7. Enhancement of controls
8. Disciplinary action, up to and including, termination of the agents

The CareFirst Sales Management Team will monitor the progress, next steps and potential resolutions. The CareFirst Medicare Compliance Committee will make the final determination whether to allow additional time for remediation and/or if disciplinary action or termination is required. Where approved by the CareFirst Medicare Compliance Committee, an agent's disciplinary action if applicable, up to and including termination will be imposed in accordance with contractual requirements.

COMPENSATION OVERVIEW

CareFirst's Medicare commission schedule is consistent and in accordance with CMS requirements. Producers are paid a commission for each member they enroll for a CareFirst BlueCross BlueShield Medicare Advantage product in accordance with CMS requirements and the terms of their contract. We pay commissions directly to the FMO. Please contact your direct upline for any questions regarding payment of commissions and current year MAPD commission amounts.

In order to receive commission payments, writing agents must have all of the following items completed and current with CareFirst:

1. Pass initial background check performed by CareFirst
2. Carry Errors and Omissions (E&O) Insurance—We require all agents to carry an Errors and Omissions (E&O) policy of at least $1,000,000 per claim and $1,000,000 aggregate at all times to maintain appointment with us
3. Hold active Maryland State License and appointment—for CareFirst BlueCross BlueShield Medicare Advantage
4. Signed agent contract with FMO upline
5. Affiliate and align with General Agent, if applicable
6. Pass Medicare Certification (annual certification)
7. Pass CareFirst Product Training certification (annual certification)

Please refer to your contract with your direct Uplines. To the extent there is any conflict between the description below and the terms of your contract with Uplines, the terms of the contract apply.

Definition of compensation

CareFirst will require that compensation paid to independent Agents, Brokers, and FMOs will only include monetary and non-monetary remuneration relating to the enrollment of a Medicare beneficiary:

a. Commissions;
b. Bonuses;
c. Gifts, prizes, awards; and
d. Referral/finder's fees

Compensation DOES NOT include:

1. Payment of fees to comply with state appointment laws
2. Training
3. Certification
4. Testing costs
5. Reimbursement for mileage to and from appointments with beneficiaries
6. Reimbursement for actual costs associated with beneficiary sales appointments, such as venue rental, snacks and materials
7. Costs associated with virtual appointments with beneficiaries

CareFirst payment guidelines for CareFirst BlueCross BlueShield Medicare Advantage enrollment:

1. The compensation year is January 1 through December 31. Payments must be calculated and made during the January 1 through December 31 enrollment year (including AEP enrollments)
2. Payments for enrollments effective at any point during a calendar year must be paid in full by December 31 of the calendar year of enrollment
3. Compensation payments will be based on the number of months an enrollee is enrolled during a calendar year

Initial sales

"Initial sale" means beneficiaries enrolling in an Individual Medicare product, who are "new" to Medicare and were not enrolled in a Like Plan in the month immediately preceding their Medicare product's effective date.

A "Like Plan" means a "like plan type" as described by CMS in the applicable Medicare Communication and Marketing Guidelines. A "like plan type" enrollment includes an MA plan or MAPD plan to another MA plan or MAPD plan.

An "Unlike Plan" means an "unlike plan type" as described by CMS in the applicable Medicare Communication and Marketing Guidelines. An "unlike plan type" enrollment includes a PDP plan, MA Plan moving to a MAPD plan.

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

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

CareFirst, in accordance with all applicable laws, will pay a full lump sum annual compensation payment initial maximum CMS fair market value (FMV) amount for initial sales regardless of effective date.

Compensation for "initial" enrollment type will be paid in two payments. The first commission payment will equal 50% of the maximum CMS fair market value (FMV) commission for initial enrollment upon CMS approval of the enrollment. The second payment will be made upon receipt of the MARx, Agent Compensation Report to verify "initial" enrollee type which will "true-up" to the CMS fair market value of 100% FMV for initial enrollment.

For an initial sale arising from an Unlike Plan change occurring after January 1, CareFirst will pay a prorated amount of the commission for the months that the Medicare enrollee is enrolled in the Medicare product during that calendar year. Compensation for this initial enrollment type will be paid in two payments.

For an initial sale arising from a Like Plan change occurring in an enrollee's first year of coverage, after January 1, CareFirst will pay a prorated amount of the commission for the months that the Medicare enrollee is enrolled in the Medicare product during that calendar year. Compensation for this initial enrollment type will be paid in two payments.

Renewal sales

"Renewal" means a Sale to a Medicare enrollee, when the Medicare enrollee is enrolled in their second year of coverage and was enrolled in a "Like Plan" from another plan or with CareFirst in the month immediately preceding the Medicare Product's effective date. CareFirst will pay the full FMV renewal commission amount allowed by CMS.

For a renewal sale arising from a Like Plan change occurring in an enrollee's second year of coverage from another plan, CareFirst will pay up the full renewal amount on a prorated basis for the months that the Medicare enrollee is enrolled in the Medicare product during that calendar year.

A renewal sale arising from a current CareFirst Medicare enrollee in the second year of enrollment, CareFirst will pay the full FMV renewal commission amount on a per month per member schedule.

Type of enrollment and commissions paid

Type of Enrollment*	Commission Paid	Full or Prorated
Initial Sale (no prior plan history)	Initial Commission	Full Two payments with "true-up"
Unlike or Like Plan Type Change, Payment Year 1 (First year of coverage)	Initial Commission	Prorated^ Two payments with "true-up"
Like Plan Change in Compensation Payment Year 2+ (Replacement) (Subsequent years of coverage)	Renewal Rate Commission	Prorated^—lump sum renewal rate
Subsequent Years—all enrollment types	Renewal Rate Commission	Paid - per member per month (begins January 1 following enrollment)

*Type of Enrollment and product history as defined and reported by CMS in the MARx monthly report to CareFirst. The Agent Broker Compensation Report Data File is sent to plans each calendar month. The report contains 1.) all new enrollments, whether retroactive, current, or prospective with broker compensation cycles and 2.) all changes to existing and prior enrollments as a result of retroactive enrollments and disenrollment. ^Prorated for the months that the Medicare product is in force during the enrollment year.

Compensation must be recovered when:

An enrollee disenrolls from a plan within the first three (3) months of enrollment (rapid disenrollment) or any other time an enrollee is not enrolled in a plan, but when CareFirst paid compensation for that time period.

CareFirst must recover a prorated amount of compensation (initial and renewal) from an agent when an enrollee disenrolls from a plan, equal to the number of months not enrolled.

If a full initial compensation is paid, regardless of effective date, and the enrollee disenrolls mid-year, the total number of months not enrolled must be deducted from future compensation and recovered from the agent/broker .

Example—Age-in effective April 1 and disenrolls September 30 of the same year. Full initial was paid. Recovery is equal to 6/12ths of the initial compensation (January through March and October through December).

AGENT OF RECORD

A properly credentialed agent (i.e. contracted, certified, licensed and appointed) will record new business by providing their National Producer Number (NPN) on CareFirst BlueCross BlueShield Medicare Advantage applications. The agent must complete all required agent fields on each application (electronic or paper) upon submission to be considered agent of record. Agents will educate their clients to submit the application through their customized links provided by their contracted FMO's proprietary quoting and enrollment portals. This will ensure the sale reflects the intended selling agent and commissions will be paid accurately.

Applications received without the agent identifying information will be deemed direct business and no commissions will be paid by CareFirst. To receive continuous renewal payments, the agent must remain the Agent of Record on the policy and must meet the CareFirst annual Ready-to-Sell requirements:

- Must be actively contracted
- Must be actively licensed and appointed in the state of the sale at the renewal processing date
- Meet annual requirements to remain in active 'Ready to Sell' status

Any agent not properly licensed, appointed and certified with 'Ready to Sell' status at the time of the sale will not be considered agent of record. This will be considered an 'unqualified sale' and no commissions will be paid. (Also see Compensation Overview about any potential chargebacks or recovery of commissions related to 'unqualified' sales)

The last application received for an enrollee will be the processed application and determine agent of record during a valid Medicare election period. However, agents may not submit applications during any future Medicare election periods with a different effective date for the same enrollee and plan with the intention of changing the agent of record only.

If a new application is received with no agent information, but the previous application had agent information, the agent information will not be overwritten and will remain agent of record.

Individual member or agent-initiated 'Agent of Record' change requests will not be accepted.

Agent of record retention

Plan Change: Member must have a valid Election Period

- If a member initiates a plan change or reinstatement without assistance from another agent - the existing agent will not be overwritten and will remain agent of record
- If a member initiates a plan change or reinstatement with the assistance from another agent, including any Tele-Sales agent, CareFirst Field Sales Agent (internal sales rep), or another FMO agent – the existing agent will be overwritten and the new agent will become agent of record

AGENT RESOURCES

Medicare Communications and Marketing Guidelines (MCMG)

https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Draft_2020_MCMG.pdf

Field Marketing Organizations

Primary Contact for Sales and Service Support for General Agencies and agents directly contracted with FMO. The FMO will contact each agent who has selected the General Agency or FMO to contract with them. All onboarding and contracting will be performed with the FMO directly.

GS National

Brian Breisinger
bbreisinger@gsnational.com
855-330-5566
www.gsnational.com
300 Bilmar Drive. Suite 200
Pittsburgh, PA 15205

Ritter Insurance Marketing

Jake McGeoy
jake.mcgeoy@ritterim.com
Local 717-540-3720
National 800-769-1847
www.RitterIM.com

Hierarchy changes

You may change sales hierarchies no more than once per year. When you move hierarchies, the commissions for the existing business continues within the original hierarchy. Any new business will be compensated within the new hierarchy relationship.

You may change sales hierarchies and may move existing business to the new sales hierarchy at any time upon written mutual agreement with your direct upline. With written consent, your existing business and new business will be compensated within the new hierarchy relationship.

You are not permitted to switch sales hierarchies from September 1 through December 31 each year.

AGENT SUPPORT

Agents are encouraged to work with their direct upline (General Agency or FMO) for sales and service support. The upline will contact the CareFirst team to provide responses back to the agent on the following types of requests:

- Credentialing and certification
- Commission inquiries
- Eligibility questions/Plan changes
- Providers and pharmacy / formulary lookup
- Escalations and grievances
- Agent of Record Requests
- Intake for review of marketing materials
- Request for CareFirst Broker Badge

CareFirst Agent Sales Support will support agents directly with the following requests:

- Intake and fulfillment of sales booklets and materials
- Intake for scheduled marketing events
- Provide enrollment status update

CareFirst Medicare agent sales

Medicare Agent Sales Hotline: 833-601-0461

Agent Support Email:
MedicareAgentSalesSupport@carefirst.com

CareFirst over 65 sales

The CareFirst Broker Representatives will be supporting the FMOs and General Agencies with agent onboarding, sales training, sales events, sales strategies and other sales related activities. Agents should contact their upline directly for initial assistance. FMOs and General Agencies will coordinate additional communication and training with the agent. Please work through your FMO or General Agency to coordinate communications with the partnered CareFirst Broker Representative.

CareFirst Broker Portal

www.carefirst.com/broker

Login access to the CareFirst Broker portal will be given to each agent through the onboarding process.

Access to agent product training will be available after logging in.

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