GUIDEWELL

Florida Blue
In the pursuit of health®

Agent Compliance Reference Guide

For Florida Blue's Marketplace Individual Under 65 Products, Commercial Health and Ancillary products, Medicare Advantage (Part C), Medicare Prescription Drug Plan (Part D), and Medicare Supplement Policies:

- *Marketplace Metal Plans*
- *BlueSelect*
- *BlueCare*
- *BlueOptions*
- *MyBlue*
- *BlueMedicare HMO*
- *BlueMedicare PPO*
- *BlueMedicare Rx (PDP)*
- *BlueMedicare Supplement Plans*
- *Florida Blue Ancillary Products*

AGENT COMPLIANCE REFERENCE GUIDE BY SECTION	
SECTION I	General Compliance
SECTION II	Commercial Products
SECTION III	Medicare Supplement Products
SECTION IV	Medicare Advantage Plan (Part C) & Prescription Drug Plan (Part D) Products
SUPPLEMENTAL MATERIALS	Definitions
	References
	APPENDIX A - National Standards for Culturally Linguistically Appropriate Services (CLAS) In Health and Health Care
	APPENDIX B - Compliance Guide for HCR vs. Medicare Seminars & Events

This guide is for reference and information only and is distributed with the unequivocal understanding that both Florida Blue and Florida Blue Medicare (referred to herein as "Florida Blue") are not rendering legal or professional advice or opinions on specific facts, matters, rules, laws, regulations or the like. Accordingly, it is not to be relied upon as such, and Florida Blue assumes no liability in connection with its use. There is no attorney-client relationship. Recipients are strongly advised to consult with their own attorneys or other professionals, and to directly consult the applicable laws and regulations for specific guidance.

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AGENT COMPLIANCE REFERENCE GUIDE BY SECTION & TOPIC

SECTION I – GENERAL COMPLIANCE

Introduction
- Scope of Document
- Florida Blue's Compliance Plan

Agent Qualifications and Primary Duties
- Agent Licensing General Qualifications
- Summary of Agent Duties & Responsibilities
- Utilizing 2-20 Agents and 4-40 Customer Representatives
- Use of Non-Licensed Individuals

Standards of Professionalism
- Privacy/Confidentiality
    - Personally Identifiable Information (PII)
    - Information Security
    - Protected Health Information (PHI)
- Individually and Personally Identifiable Health Information (PHI) Elements Chart
- Privacy Safeguards
- Fraud, Waste & Abuse
- Discrimination
- Culturally and Linguistically Appropriate Services (CLAS)
- Unfair and Unethical Sales Practices
- Prohibited and Allowed Sales Practices Chart
- Consumer Needs
- Behaviors

Agent Training, Testing, and Certification
- Product Training
- Targeted Retraining
- On-Going Communications

Sales
- Contacting Clients
- Telecommunications
- Relationship Building- Gifts and Business Entertainment
- Authorized Representatives
- Provider/Pharmacy Information

Sales Materials
- Agency/Agent Marketing Materials
- Outdated Marketing Materials

SECTION I – GENERAL COMPLIANCE

Complaints, Allegations, Marketing Misrepresentations, and the Agent Oversight and Monitoring Process
- Complaints
- OIR Complaints
- Florida Blue Agent Corrective Action Process

Documentation and Records Retention Requirements
- Florida Blue Records Retention Requirements
- Sales/Marketing Appointment Documentation

SECTION II – COMMERCIAL PRODUCTS

Agent Training, Testing, and Certification
- Marketplace Agent and Broker FFM Registration Processes
  - Initial Registration
  - Renewal Registration
- Florida Blue's Validation of Agent Marketplace Registration
- Marketplace Agreements

Sales
- Marketplace Enrollment Applications
- Consumer Consent
- Consumer Healthcare.gov Accounts
- Medicare Anti-Duplication
- Data Matching Inconsistencies (DMIs)
- Interaction with Marketplace Navigators

Sales Materials
- Agency/Agent Marketing Materials
- Materials Auditing

Enrollment
- Guaranteed Issue/Guaranteed Availability
  - Marketplace Plans Guaranteed Issue
- Guaranteed Availability
  - Individual Market
  - Group Market
- Guaranteed Renewability
- Marketplace Enrollments
- Marketplace Direct Enrollment
  - SalesConnect Tool Online Marketplace Direct Enrollment
  - SalesConnect Telephone Marketplace Direct Enrollment
  - Consumer Web Sales (CSW) Marketplace Direct Enrollment

Return to Agent Compliance Reference Guide By Section

SECTION II – COMMERCIAL PRODUCTS	• Agent-Assisted Marketplace Enrollment
	  ○ Side by Side
	  ○ 3-Way Call
	• Off Marketplace Enrollments
	• Marketplace Special Enrollment Periods
	• Cancellations
	• Terminations/Reinstatements
	• Involuntary Terminations
	  ○ Terminations for Fraud
	  ○ Terminations for Non-Payment of Premiums
	• Voluntary Terminations
	• Retroactive Enrollments
	• Grievance & Appeals
	  ○ Marketplace Grievance and Appeals Requirements
	• Mental Health Parity and Addiction Equity Act (MHPAE)
	• Cancer Treatment Fairness Act (Cancer Parity)
	• Paper Applications
	
	Complaints, Allegations, Marketing Misrepresentations, and the Agent Oversight and Monitoring Process
	• Marketplace Complaints

SECTION III – MEDICARE SUPPLEMENT PRODUCTS	**Agent Training, Testing, and Certification**
	• CMS Certification/Re-certification Program
	
	Eligibility and Enrollment
	• Eligibility for Medicare Supplement
	• Enrollment Time Periods
	• Enrollment
	• Medicare Supplement Guaranteed Issue
	• Guarantee Renewability
	• BlueMedicare Supplement Enrollments
	• Enrollment Channels
	  ○ Telephone Enrollments
	  ○ SalesConnect Online Enrollments
	  ○ Paper Applications
	  ○ Florida Blue Website

Return to Agent Compliance Reference Guide By Section

SECTION IV – MEDICARE ADVANTAGE PLANS (PART C) AND PRESCRIPTION DRUG PLAN (PART D) PRODUCTS	**Agent Training, Testing and Certification** • CMS Certification/Re-certification Program **Sales** • Contacting Beneficiaries • Sales Leads • Agent Referral • Sales Appointment • Scope of Appointment (SOA) • Cross-Selling Prohibition • Enrollment Guide and Sales Appointment Channels • Authorized Representatives • Enrollment and Verification (EV) Checklist • CMS Medicare Communications and Marketing Guidelines • Medicare Advantage and Prescription Drug Communication Requirements for Third Party Marketing Organizations (TPMOs) • Agent, Broker, and Other Third-Party Requirements **Sales Materials** • CMS and Florida Blue's Material Approval Requirements • Agency/Agent Marketing Materials • Agency/Agent Ad Hoc Materials • Agency/Agent Websites • Open Enrollment Period Marketing • Nominal Gifts • Marketing of Rewards and Incentive Programs • Marketing Material Obsolescence • Materials Auditing **Sales/Marketing & Educational Events** • Sales/Marketing Events • Educational Events **Eligibility and Enrollment** • Eligibility for Medicare • Enrollment Time Periods • Initial Enrollment Period • Annual Enrollment Period • General Enrollment Period • Medicare Advantage Enrollment Period • Special Enrollment Period • Enrollment Channels ○ Telephone Enrollments

Return to Agent Compliance Reference Guide By Section

	○ SalesConnect Online Enrollments ○ Paper Applications ○ Florida Blue Website ○ CMS Online Enrollment Center ○ Third Party Marketing Organization (TPMO)

SUPPLEMENTAL MATERIALS	Definitions*
	References*
	APPENDIX A – National Standards For Culturally & Linguistically Appropriate Services (CLAS) In Health & Health Care*
	APPENDIX B – Compliant Guide For HCR vs. Medicare Seminars & Events*
	***See Supplemental Materials in Toolkit**

Return to Agent Compliance Reference Guide By Section

SECTION I – GENERAL COMPLIANCE

INTRODUCTION

Florida Blue and Florida Blue HMO contract with the Center for Consumer Information & Insurance Oversight (CCIIO), a division within CMS, as a health insurance issuer and HMO, respectively, to offer Qualified Health Plans (QHPs) through the Marketplace. This allows Florida Blue and Florida Blue HMO to offer both Commercial and Marketplace (Off and On Marketplace) products to consumers in Florida and includes Florida Blue's Marketplace QHP Metal plans, Blue Options, Blue Choice, and Blue Select; Florida Blue HMO's MyBlue, Simply Blue and BlueCare plans; BeHealthy Florida's Truli for Health group plans; and Ancillary product offerings such as Florida Blue-branded Dental, Vision, Accident, and Hospital Indemnity products.

Florida Blue and Florida Blue Medicare contract with the Centers for Medicare & Medicaid Services (CMS) to offer Medicare Advantage (MA) PPO Local and Regional plans, HMO plans and Medicare Prescription Drug Plans (PDPs) also referred to as Part D plans. Florida Blue also offers BlueMedicare Supplement insurance plans. These plans represent the company's Medicare product offerings to eligible beneficiaries in Florida.

Florida Blue is an authorized health insurance carrier; Florida Blue HMO, Florida Blue Medicare, and BeHealthy Florida are authorized health maintenance organization ("HMO") carriers in the State of Florida. Collectively, they are herein referred to as "Florida Blue".

Florida Blue understands the complexity of compliance requirements associated with selling and marketing its health care plans. Periodic updates may be made based on regulatory changes as well as Florida Blue updates to guidance, policies, procedures, and processes.

The goal of this guide is to bring awareness of and improve overall agent compliance with state, federal, and Florida Blue requirements.

Scope of Document

This Agent Compliance Reference Guide pertains to sales and marketing activities associated with Florida Blue's products and applies to all Florida Blue appointed agents, and all related staff that may engage in sales and marketing activities on behalf of Florida Blue. In addition to complying with all applicable laws and regulations, internal (employed) agents will consult with their management within Florida Blue while external agents must consult their own attorneys or other professionals. Specific product guidance for Florida Blue, Florida Blue HMO, and Florida Blue Medicare are provided in separate sections.

Florida Blue's Compliance Plan

Florida Blue strives to operate our health insurance plans, including our Medicare Advantage plans and those offered on the Federally-Facilitated Marketplace (Marketplace), in accordance with appropriate regulatory requirements. Our Compliance Program Description illustrates our company's compliance and ethics program, including its objectives and functions, and outlines the following:

- Compliance Officer, Compliance Committee and high-level oversight;
- Written policies, procedures and standards of conduct;
- Effective training and education;
- Effective lines of communication;
- Compliance monitoring, auditing and risk assessment; and
- Prompt response to compliance issues.

Florida Blue also follows applicable laws, regulations, and guidance regarding agent qualifications, training, compensation, sales and marketing practices, and primary duties.

Return to Agent Compliance Reference Guide By Section

AGENT QUALIFICATIONS AND PRIMARY DUTIES

Florida Blue utilizes only State-licensed representatives to perform sales and marketing activities and complies with state appointment laws and federal contracting requirements for a health insurance issuer, a Medicare Advantage Organization (MAO), and a Prescription Drug Plan (PDP) Sponsor.

Florida Blue is committed to ensuring that only qualified agents sell its products. The general qualifications for an agent are:

Agent Licensing General Qualifications

- Must be appropriately and currently licensed in the State of Florida to sell Florida health insurance and HMO policies.
- Must be appointed with Blue Cross Blue Shield of Florida, Inc. d/b/a Florida Blue; Health Options, Inc. d/b/a Florida Blue HMO; Florida Blue Medicare, Inc.; BeHealthy Florida, Inc. d/b/a/ Truli for Health; and/or Florida Combined Life pursuant to State of Florida appointment laws.

  NOTE: Information provided on the Appointment Application must match the information provided to the Florida Department of Financial Services' Bureau of Licensing found on www.myfloridacfo.com (e.g., name, address, phone number).

- Must have a valid and current e-mail address.
- Must have either a Social Security number or a Federal Tax ID number, if applicable.
- Must have a National Producer Number (NPN).
- Must not have been convicted of any criminal felony involving dishonesty or breach of trust or convicted of an offense under Section 1033 of the Violent Crime and Law Enforcement Act of 1994.

Summary of Agent Duties and Responsibilities

- Review, acknowledge and agree to abide by the company's Corporate Policies & Procedures, Standards of Conduct, including the Code of Ethical Business Conduct (Compass Program); Privacy/Health Insurance Portability and Accountability Act (HIPAA) Policy; Fraud, Waste & Abuse (FWA) Policy; and requirements set forth in the Florida Blue Agent Appointment Form.
- Abide by all applicable federal and state laws, rules, regulations, and guidance, including the prevention of fraud, waste, and abuse that pertain to the solicitation, sale, and administration of any Commercial, Marketplace, Ancillary, BlueMedicare Supplement, Medicare Advantage, and/or Medicare Prescription Drug Plan(s).

Return to Agent Compliance Reference Guide By Section

- **Represent Florida Blue and its plan offerings** with the highest level of honesty and integrity, always putting the needs of each consumer ahead of any personal consideration by offering the appropriate products to each eligible consumer or Medicare beneficiary with whom the agent meets (non-discrimination).

- When selling Florida Blue Medicare and BlueMedicare Supplement plans, **exclusively offer all** available Medicare products to each eligible Medicare beneficiary with whom the agent meets (non-discrimination). Help beneficiaries determine the most appropriate product based on their personal needs and situations.

- **Solicit and sell Florida Blue plans** using only Florida Blue's CMS- or OIR-approved marketing, advertising, sales/seminar presentations, and enrollment materials, where applicable.

- Validate the accuracy and completeness of all applications prior to submitting to Florida Blue and comply with timely enrollment application submission guidelines.

- Provide Florida Blue with all required and/or requested information and reports within timeframes determined by Florida Blue, OIR, and/or DHHS/CMS/CCIIO.

- Actively participate with Florida Blue and/or any government agency regarding all inquiries, investigations, and audits resulting from member, provider, OIR, DHHS/CMS/CCIIO, and/or any other regulatory agency concerns or allegations regarding any type of misconduct, fraud, or associated complaints, and/or marketing misrepresentation issues.

- Agents selling Florida Blue plans must be appropriately certified and/or registered before selling specific products. Initial and annual certification and/or registration is required.

  For Commercial products, please refer to Section II – Commercial Products (Agent Training, Testing and Certification).

  For Medicare Supplement products, please refer to Section III – Medicare Supplement Products (Agent Training, Testing and Certification).

  For Medicare Advantage (Part C) and Prescription Drug Plan (Part D), please refer to Section IV – Medicare Advantage (Part C) and Prescription Drug Plan (Part D) Products.

- Florida Blue records retention requirements of active contract year + eleven (11) years must be followed for Florida Blue Company-owned records. *See Section I – General Compliance Documentation and Records Retention Requirements.*

Utilizing 2-20 Agents and 4-40 Customer Representatives

Pursuant to §§626.112(4); 626.015(3),(6),(7); 626.2815 et seq.; 626.431(3); 626.7351 et seq., 626.7352 et seq., 626.7354 et seq., Florida Statutes, and Florida Administrative Code (F.A.C.) 69B-213:

A licensed 4-40 customer representative must:

- Possess a Florida 4-40 Resident Customer Representative license.

- Be appointed by a general lines (including health) agent or agency to assist in transacting the business of insurance within 48 months of licensure.

- Be employed by only one general lines agent or agency at any given time and must only be housed in the office of the agent or agency.

- Only engage in transacting insurance in the office of his/her agent or agency. Customer representatives may not solicit or conduct sales work outside of the agent's office.

  NOTE: Performing clerical or administrative tasks not requiring licensure, such as taking photos of a car for the agent or going to the post office, are allowed.

- Only perform customer representative duties as to the specific general lines of insurance products which their supervising agent is appointed by the insurer to handle.

- Always identify himself/herself as a customer representative working for the named agent and never make or allow the impression that the customer representative is an agent.

- Never transact life insurance or annuities. Customer representatives may only handle any duties related to life insurance and annuities if the duties could be performed by unlicensed persons; or if the customer representative holds a life agent license and appointment.

- Be a salaried/hourly employee of the agent or agency. They can receive commission. However, compensation cannot be primarily based on commissions. Commissions and other insurance-related payments should be no more than half their total pay during any given year.

- Ensure their appointment and supervision is compliant with the rules of the Department of Financial Services ("DFS" or "Department") and the Florida Insurance Code.

- Complete 10 hours of continuing education biennially by the end of the licensee's birth month.

Return to Agent Compliance Reference Guide By Section

The allowed functions (subject to specific limits) of the customer representative include:

- Taking insurance applications.

  NOTE: All applications and/or binders initiated by the customer representative must be co-signed by the designated supervising agent, unless otherwise delineated in the written instructions conveyed to the customer representative by the designated supervising agent.

- Giving quotes
- Interpreting policies
- Explaining procedures
- Giving insurance advice
- Soliciting new customers at the agent's office or by telephone from that office
- Binding new or additional coverages
- Performing preliminary work to assist in processing a claim, as by taking claims statements, getting estimates, assembling or ordering claims files.

  NOTE: the customer representative cannot make or sign the actual substantive determination of the amount of a claim, loss, or damage payable, nor conduct settlement negotiations, make settlement of a claim or issue, or sign claims checks or drafts.

<u>A Licensed 2-20 Agent or Agency must</u>:

- Possess a Florida resident general lines agent license with the type and class of licensure referred to as a 2-20 and with authorization to transact the same line of insurance as the appointed 4-40 customer representative will be transacting (2-20 health license; 4-40 health license).

- Supervise the work of the appointed 4-40 customer representative and be responsible and accountable for all acts of the 4-40 customer representative within the scope of the agent's or agency's 2-20 license. This includes daily interaction with customer representatives they are accountable for.

  - Supervising agent includes:

    - The appointing agent in instances where a customer representative is appointed by an agent; or

    - An agent designated by an agency to supervise a customer representative in instances where an agency appoints a customer representative.

  - Designated supervising agent includes:

    - A general lines agent designated by an agency to supervise the customer representatives the agency has appointed. He or she need not be the agency's named agent in charge.

Return to Agent Compliance Reference Guide By Section

- The term “supervise” is defined in F.A.C. 69B 213-020(3) as:

  - Having charge and direction of,
  - To direct course and oversee details,
  - To regulate with authority,
  - To manage,
  - To have or to exercise the charge and oversight of,
  - To oversee with power of direction,
  - To take care of with authority; and,
  - Includes the duty to review and correct errors of persons whom supervision is to be exercised.

- The supervising agent should periodically review samples of all areas of the customer representative’s work, in such amounts and with such frequency as to provide reasonable assurance that repetitive errors in their work will be noted and corrected at an early stage.

- Where the customer representative provides sales presentation, advice, or interpretation to clients or prospective clients by phone or in person, the supervising agent should periodically sit or listen in on such conversations with the customer representative’s knowledge, to assure that competent and sound advice and information is being provided by the customer representative.

- When the appointing agent and designated supervising agent are the same person, the appointing agent must supervise the customer representative.

- The supervisory role may not be delegated to anyone unless delegation is to a licensed and appointed agent who has been designated as the supervising agent.

- Unless the appointing agent delegates management of the customer representative to a designated supervising agent, the customer representative must continue to be managed by the appointing agent even when the customer representative is performing customer representative services for other agents or staff within the agency.

- The supervising agent or designated supervising agent must take reasonable steps to assure that the customer representative does not exceed the allowable scope of their licensure, duties, and authority.

  NOTE: Agents who use the services of customer representatives but do not supervise them must also follow the rules provided in F.A.C. 69B-213.010(2).

- When an agency first appoints a customer representative, it must complete Form DFS-H2-501 and send it to the Department in writing. The form designates the general lines agent who is in good standing and will supervise the customer representative. This agent must sign the appointment paperwork submitted to the Department, thereby accepting and acknowledging the responsibility for the supervision of the customer representative.

Return to Agent Compliance Reference Guide By Section

- The appointing agency must assure that there is always a licensed and appointed general lines agent within the agency who has agreed to supervise the customer representative, and who is in fact supervising the customer representative in accordance with the supervisory requirements outlined in F.A.C. 69B-213.

- The appointing agency shall immediately specify in agency records any change in the identity of the agent performing the customer representative supervisory duties for any customer representative appointed by the agency.

    - The appointing agency may change the designated supervising agent at any time provided notice of such is maintained in the agency's records.

    - The appointing agency must designate a new designated supervising agent whenever the prior designated supervising agent ceases in fact to properly perform the supervisory duties; or the appointing agency shall terminate the appointment.

    - A new designated supervising agent is established by using the provisions set forth in subsection 69B-213.060(4), F.A.C.

- Whenever the designated supervising agent of record is no longer in fact supervising the customer representative, the agency must immediately require the customer representative to stop performing all customer representative duties, until a new designated supervising agent is properly designated.

  NOTE: The appointing agent continues to be accountable and liable for the acts of that customer representative during such period until a new designated supervising agent is established.

- It is the responsibility of the agency's agent in charge to see that the agency complies with all requirements of the Florida Administrative Code and Florida Statutes imposed upon the agency by Chapter 69B, F.A.C.

- The appointing agency is the employer of the customer representative in terms of payroll. When the designated supervising agent quits or is terminated, the agency needs to have processes in place to identify and designate in the agency records another general lines agent who assumes the responsibility to undertake the supervision of the customer representative, without the parties involved having to make an entirely new appointment of the customer representative.

- When an appointing agency appoints a customer representative, they are not allowed to expand the scope of the customer representative's role or grant greater independence or autonomy, as compared to customer representatives appointed directly by an agent.

    - The customer representative serves as an assistant to the designated supervising agent. An agency cannot transact insurance in the sense of binding coverages, advising clients or applicants, or similar activity; only a licensed agent can perform those tasks, or licensed customer

Return to Agent Compliance Reference Guide By Section

representatives working under the supervision of the licensed and appointed agent.

- When terminating the status of an agent as the designated supervising agent of a customer representative, notification must be made to the state by using either Form DFS-H2-39, Termination of Appointment Form or by written notice to the Department.

    - The supervisory status shall be terminated by either the supervising agent or the agency and may be unilateral. If the status is terminated by the supervising agent, the supervising agent shall supply the agency with a copy of the filing; and if filed by the agency, the agency shall supply a copy to the agent. Regardless of which method is used or who files, the party filing same shall supply a copy of the termination notice to the customer representative.

    - The appointing agent or agency and the designated supervising agent remain accountable and responsible for the acts of the customer representative until the Department receives proper notice of termination or either the appointment or notice of termination of supervision, notwithstanding the customer representative was expressly told by the supervision agent or agency to cease all customer representative duties.

    - When the supervising status is terminated by written notice rather than Form DFS-H2-39, the notice must comply with the following:

        - If filed by the designated supervising agent, the notice shall be signed and dated by the designated supervising agent; if filed by the agency, it shall be signed and dated by the agency's primary agent.

        - The notice shall state the effective date of termination of supervision.

        - The notice shall give the full name, address, and phone number of the agency.

        - The notice shall identify and state the full name of the designated supervising agent being relieved of that status and shall supply his or her license identification number.

        - The notice shall contain a statement, to the clear effect that as of the effective date of the notice, [agent's name] is no longer the designated supervising agent for the customer representative identified in the notice.

        - The notice shall identify and state the full name and license identification number of the customer representative.

        - The notice shall be maintained in the appointing agent or agency's records and must be produced upon the Department's request.

Return to Agent Compliance Reference Guide By Section

    - No fee is required to terminate an appointment, or to terminate status as a designated supervising agent.

  - When terminating the appointment of a customer representative, notification must be made electronically to the state or by written notice to the Department. Regardless of which method is used, a copy of the termination document must be supplied within 20 calendar days of the termination to both the customer representative and the Department.

  - When the appointment is terminated by the customer representative, the customer representative must provide written notice to the Department. The notice shall:

    - Be signed and dated by the supervising agent, the appointing agent where the appointment was by an agent, or by the customer representative;
    - State the effective date of termination of appointment;
    - Give the full name, address, phone number, and license or registration identification number of the appointing agent or agency;
    - Contain a statement to the clear effect that as of the effective date of the notice, the appointment of the customer representative identified is terminated;
    - State the full name and license identification number of the customer representative;
    - State the reason for the termination of appointment;
    - Be sent to the Department of Financial Services, Bureau of Agent & Agency Licensing, 200 East Gaines St., Tallahassee, FL 32399-0319.

Use of Non-Licensed Individuals

Pursuant to §626.112 et seq., and 626.8305 et seq., Florida Statutes, unless licensed as a health agent, no individual can:

- Solicit insurance or procure applications. The solicitation of insurance is the attempt to persuade any person to purchase an insurance product by:

  - Describing the benefits or terms of insurance coverage, including premiums or rates of return;

  - Distributing an invitation to contract to prospective purchasers;

  - Making general or specific recommendations as to insurance products;

  - Completing orders or applications for insurance products;

  - Comparing insurance products, advising as to insurance matters, or interpreting policies or coverage.

- Analyze or abstract insurance policies.

Return to Agent Compliance Reference Guide By Section

- Counsel, advise or give opinions to persons relative to insurance contracts other than as a consulting actuary advising insurers or counseling and advising labor unions, associations, trustees, employers or other business entities, their subsidiaries and affiliates relative to their interests and those of their members or employees under insurance benefit plans.

An individual employed by an agent or agency on salary who devotes full time to clerical work, with incidental taking of insurance applications or quoting or receiving premiums on incoming inquiries in the office of the agent or agency, is not deemed to be an agent or customer representative if that individual's compensation does not include in whole or in part any commissions on that business and is not related to the production of applications, insurance, or premiums.

- An employee of an agent or agency may not bind insurance coverage unless licensed and appointed as an agent or customer representative.

- An employee of an agent or agency may not initiate contact with any person for the purpose of soliciting insurance unless licensed and appointed as an agent or customer representative. **Please review the applicable laws for specific guidance.**

Return to Agent Compliance Reference Guide By Section

STANDARDS OF PROFESSIONALISM

Florida Blue expects that agents selling its products will always conduct themselves in a professional manner when interacting with consumers. Agents must comply with the most current federal and state laws, rules, regulations and guidance while representing, soliciting and selling Florida Blue products.

Privacy/Confidentiality

All customers, beneficiaries, and members have a right to the privacy and confidentiality of their personally identifiable information and protected health information ("PII" and "PHI," respectively) and to expect that this information will be used in a manner that protects this right. Maintaining the privacy and confidentiality of others' PII and PHI is required in accordance with applicable laws and regulations, and therefore is mandatory for all agents who have access to it.

Personally Identifiable Information (PII) - is any information that can be used to distinguish or trace an individual's identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual. The definition of PII is not anchored to any single category of information or technology. Rather, it requires a case-by-case assessment of the specific risk that an individual can be identified.

Examples of PII include name, social security number, biometric records, etc., alone or when combined with other PII such as date and place of birth, mother's maiden name, etc., that make the information linked or linkable to a specific individual. An individual's PII generally becomes protected health information when that person applies for health insurance.

Information Security - Florida Blue employs a comprehensive information security program designed to protect customer information and ensure physical safeguards of all its hardware, software and systems. This includes security and confidentiality of customer information, protecting against any anticipated threats or hazards to the security or integrity of the information, and protecting against unauthorized access to or use of the information that could result in substantial harm or inconvenience to any customer.

Agents licensed in the state of Florida must follow suit by ensuring they are taking the necessary precautions to provide physical, technical and administrative safeguards of any electronic devices used to conduct business and any physical copies of PII or PHI in order to protect confidential information they handle

Protected Health Information (PHI) - is any information that provides individually identifiable health and/or financial information that relates to the past, present or future physical or mental condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of health care to an individual. Agents must abide by all state and federal privacy laws such as the Health Insurance

Return to Agent Compliance Reference Guide By Section

Portability and Accountability Act – Administrative Simplification [HIPAA-AS], and any other applicable state or federal laws pertaining to the privacy of such information. Information collected by an agent during the course of enrollment in a health plan is PHI.

Individually and Personally Identifiable Health Information (PHI) Elements Chart

The following 18 elements are examples of PHI:

Individually and Personally Identifiable Health Information (PHI) Elements	
1. Names	10. Account numbers
2. All geographic subdivisions smaller than a state, such as a ZIP code	11. Certificate/ license numbers
3. All elements of dates (except year) for dates related to an individual, such as a date of birth	12. Vehicle identifiers and serial numbers, such as license plate numbers
4. Telephone numbers	13. Device identifiers and serial numbers
5. Fax numbers	14. Web Universal Resource Locator (URL)
6. Electronic Mail (e-mail) addresses	15. Internet Protocol (IP) address numbers
7. Social Security numbers	16. Biometric identifiers
8. Medical record numbers	17. Full face photographic images and any comparable images
9. Health plan beneficiary numbers	18. Any other unique identifying number, characteristic, or code set

Privacy Safeguards

Here are some of the requirements for protecting PII and PHI:

- Limit access to information to that which is reasonably necessary to achieve the purpose of the use or disclosure and allow only those persons who require information to have access consistent with their job responsibilities. This includes PII, PHI and SSN information.

  Do not leave documents or papers with PII and PHI unattended. PII and PHI information must be kept securely. Only collect and use the minimum amount of PII and/or PHI necessary to accomplish the intended purpose.

Return to Agent Compliance Reference Guide By Section

- Do not use Social Security numbers (SSNs), both internally and externally, unless there is a compelling business reason for that use or disclosure. CMS prohibits the use of SSNs and does not allow collection of SSN information for enrollment in a Medicare product.

  Agents must not ask a Medicare beneficiary for their SSN.

- Maintain administrative, technical, and physical safeguards that comply with regulatory requirements to safeguard PII and PHI.

  This includes initiating policies and procedures related to safeguarding PII and PHI, implementing information system security safeguards to prevent PII and PHI from being seen by people whose job responsibilities are not aligned with viewing this type information and keeping documents that contain PII and PHI under lock and key.

- Prohibit releasing a roster of membership or databases of PII and/or PHI to any individual for personal gain or for any use.

  Whether an agent is holding a seminar at their office, a public facility, or at a Florida Blue Retail Center, under no circumstances should a list of names of those attending be visible to the public. Agents are also not allowed to ask a participant's name when arriving at a seminar and/or as a condition to attend.

  Agents are also prohibited from copying a roster of membership or databases of PII and/or PHI for any unauthorized use, such as for the purpose of contacting the members on the agent's own behalf or on behalf of another insurance carrier.

- **Immediately report to your manager any known or potential breach of privacy or non-permitted disclosure of PII or PHI for escalation. Any known or potential breach of privacy or non-permitted disclosure of PII or PHI must be reported to Florida Blue's Business Ethics, Integrity and Compliance Department (BEIC). Contact BEIC at 1-888-574-2583.**

  An example would be mailing a letter to a client that contains PII or PHI information to the wrong address which may cause the recipient to open the letter in error and see the PII or PHI information. Florida Blue must report any known or potential privacy breach to the proper authority(ies) and in accordance with contractual obligations.

Fraud, Waste & Abuse

Florida Blue has had a long-standing and deep commitment to conducting business ethically, with integrity and in compliance with applicable laws, regulations and requirements of the Blue Cross and Blue Shield Association (BCBSA).

Florida Blue is dedicated to providing its members, employees and contracted entities, including agents, with mechanisms to report fraud, waste and abuse. The Special Investigation Unit (SIU) reviews, investigates and documents fraudulent, wasteful or abusive acts with respect to an employee, a member, an agent(s) or any companies/ vendors contracted with Florida Blue, and refers cases to the proper legal or regulatory

Return to Agent Compliance Reference Guide By Section

authorities for investigation or possible civil and/or criminal sanctions; and, initiates recovery of monies identified as fraudulently or improperly paid. SIU is also responsible for referring documented cases to Florida Blue's Legal Affairs Department of any case involving an employee.

It is the agent's responsibility to immediately report any suspected or confirmed fraud, waste or abuse activities to Florida Blue's SIU. Contact SIU at 1-800-678-8355 or by e-mailing them at specinvestunit@bcbsfl.com.

Any employee who suspects fraud, waste or abuse by a member or contracted company or vendor shall immediately report the suspicion to the SIU. Contact SIU at **1-800-678-8355** or by e-mailing them at **specinvestunit@bcbsfl.com**. An employee who has knowledge of a suspected fraud, waste or abuse situation involving a Florida Blue employee shall notify the SIU, Legal Affairs, Human Resources or the Business Ethics, Integrity and Compliance (BEIC) Department.

Discrimination

In accordance with Federal civil rights laws, Title VI of the Civil Rights Act of 1964 (Title VI), Title IX of the Education Amendments of 1972 (Title IX), Section 504 of the Rehabilitation Act of 1973 (Section 504), and the Age Discrimination Act of 1975 (Age Act), Florida Blue offers its products to all eligible consumers, including those who are under age 65 disabled or physically impaired. Florida Blue also complies with Section 1557 requirements which prohibit discrimination on the basis of sex in all health programs and activities receiving Federal financial assistance. In addition, Florida Blue has an established non-discrimination complaint review process for member complaints where they feel they have been discriminated against.

Agents must not target consumers from higher income areas. Agents selling Florida Blue's Medicare products must not state or otherwise imply that those type plans are available only to seniors rather than to all Medicare beneficiaries, including those who are disabled and under age 65.

CMS guidelines strictly prohibit health screenings at Medicare marketing and sales events as it may give the appearance of "cherry picking". Cherry picking implies there is discrimination against a beneficiary based on their health status; **see chart below.**

Agents must not discriminate against an individual on the basis of any of the below attributes as this is prohibited by law.

<table>
<tr><td>• Creed</td><td rowspan="10">• Health Status
- Medical conditions (Mental or Physical)
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability
- Disability</td></tr>
<tr><td>• Gender</td></tr>
<tr><td>• Age</td></tr>
<tr><td>• Race</td></tr>
<tr><td>• Ethnicity</td></tr>
<tr><td>• Religion</td></tr>
<tr><td>• National Origin</td></tr>
<tr><td>• Geographical Location</td></tr>
<tr><td>• Level of Income</td></tr>
<tr><td>• Sexual Orientation</td></tr>
</table>

Culturally and Linguistically Appropriate Services (CLAS)

In an effort to eliminate health inequities and bring about positive health outcomes for diverse populations, fifteen (15) national standards were created which serve as the framework for all health care organizations in addressing cultural competency. These standards are the cornerstone for advancing health equity through culturally and linguistically appropriate services. Some of the standards include:

- Providing bi-lingual and/or non-English materials
- Providing language assistance services as needed and in the preferred language at no cost to consumers
- Creating grievance resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve complaints

Florida Blue strives to meet these standards in all sales and marketing activities. Agents should always treat others with respect and be mindful of cultural differences when meeting with consumers.

See Appendix A - National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

Return to Agent Compliance Reference Guide By Section

Unfair and Unethical Sales Practices

Florida Blue invests considerable resources to identify, educate, enroll, and retain consumers who have selected our products. The company relies on agents to help increase membership growth and retention by evaluating consumers' needs and making sound recommendations about their health and prescription drug coverage. Agents are subject to statutory and regulatory requirements including §626.951 et seq., the Florida Unfair Insurance Trade Practices Act. All such applicable requirements must always be understood and adhered to. Accordingly, Florida Blue has a justifiable expectation that no agent will engage in unethical sales activities such as "twisting," "churning," or "sliding."

The following are examples of prohibited and allowed actions of agents. Prohibited sales practices are subject to corrective actions, up to and including termination, depending upon the severity of the incident.

Prohibited and Allowed Sales Practices Chart

Prohibited Sales Practices	**Allowed Sales Practices**
Misrepresentation • Agent misrepresents her/himself or qualifications. • Agent misrepresents herself/himself by stating she/he has special financial knowledge, has obtained specialized financial training or is certified or qualified to provide specialized financial advice. • Misrepresent the benefits, advantages, condition or terms of any insurance policy. • Knowingly make a false or fraudulent written or oral Statement or material omission in the comparison of a life, health or Medicare Supplement insurance replacement policy with the policy it replaces for the purpose of obtaining a fee, commission, money or other benefit from any insurer, agent, broker or individual. This also includes failure to advise of the existence and operation of a pre-existing condition clause in a replacement policy.	• Agents should always be truthful about their qualifications. This builds credibility and trust with the consumer. • Agents must accurately represent the services, benefits and premiums associated with Florida Blue insurance products. • Agents shall clearly indicate to prospective insureds that they are acting as insurance agents with regard to insurance products and identified insurers

Return to Agent Compliance Reference Guide By Section

Prohibited Sales Practices	**Allowed Sales Practices**
• Making disparaging comments about competitors, their policies, contracts, services or business models; or unfairly minimizing competing methods of marketing insurance. • Misrepresent any insurance policy as being shares of stock or ownership interest in the company. • Misrepresent the true nature of the name or title of any insurance policy. • Provide untrue, deceptive, false or misleading information before the public for insurance-related purposes.	
Unlawful Rebates • As inducement for an insurance contract, paying, allowing or giving, or offering to pay, allow or give, directly or indirectly, any unlawful rebate of premiums payable on the contract. • As an inducement for an insurance contract, giving, selling or purchasing anything of value whatsoever not specified in the insurance contract. • Unlawfully rebating, attempting to unlawfully rebate, or unlawfully dividing or offering to divide his or her commission with another.	• The State of Florida requires a $100 annual limit when giving gifts to consumers, members, prospective members, etc. Gifts given to consumers must be tracked to determine when their $100 annual limit has been met. As a rule, agents should not engage in this type of activity unless through company-sponsored activities and must follow established business processes when promoting Florida Blue products. • The rules are different for Medicare. Refer to Section IV – Medicare Advantage Plan (Part C) and Prescription Drug Plan (Part D) within Sales Materials for information on nominal gifts.

Return to Agent Compliance Reference Guide By Section

<table>
<tr><th>Prohibited Sales Practices</th><th>Allowed Sales Practices</th></tr>
<tr><td>Twisting

• Knowingly making any misleading representations or incomplete or fraudulent comparisons or fraudulent material omissions of or with respect to any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge assign, borrow on, or convert any insurance policy or to take out a policy of insurance in another insurer.</td><td>• Agents must always act in the best interest of the consumer. Be sure to understand the consumer's needs and be truthful about recommendations, even if it would result in no sale to you.</td></tr>
<tr><td>Sliding

• Representing to an applicant that a specific Ancillary product or coverage is required by law in conjunction with the purchase of insurance when it is not.

• Representing that a specific Ancillary product or coverage is included in a policy without an additional charge when a charge is required.

• Charging an applicant for a specific ancillary product or coverage, in addition to the cost of the insurance coverage applied for, without his/her consent.</td><td>• Agents must always act in the best interest of the consumer. Be sure to understand the consumer's needs and be truthful about recommendations, even if it would result in no sale to you.</td></tr>
<tr><td>False Advertisement
• Using any advertisement that misleads a consumer to believe that the state or Federal Government:

– Approves, endorses or recommends Florida Blue, its policies, advertising or its financial condition.

– Is responsible for insurance sales activities.</td><td>• Make sure consumers understand that Florida Blue contracts with the state and Federal Government to offer its insurance products and that neither are financially responsible, nor do they endorse the insurance policies sold by Florida Blue.</td></tr>
</table>

Return to Agent Compliance Reference Guide By Section

<u>Prohibited</u> Sales Practices	<u>Allowed</u> Sales Practices
– Guarantees returns on insurance products. – Stands behind any person's credit. – Is a source of payment of any insurance obligation of or sold by anyone.	
<u>Churning</u> • Using the values of an existing life insurance policy or annuity contract in a fraudulent, deceptive or misleading way to purchase another insurance policy with the same insurer for the purpose of earning additional premiums, fees, commissions or other compensation which does not result in a way that benefits the policyholder.	• Agents must always act in the best interest of the consumer. Be sure to understand the consumer's needs and be truthful about recommendations, even if it would result in no sale to you.
<u>Defamation</u> • Knowingly making, publishing, disseminating or circulating directly or indirectly or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written Statement of any kind which is false or maliciously critical of or derogatory to any person which will injure or damage that person. • Disparaging the goods, services or business of another person by way of false or misleading representation.	• Agents must always speak about others in a positive way or refrain from commenting.

Return to Agent Compliance Reference Guide By Section

Prohibited Sales Practices	Allowed Sales Practices
Fraudulent Signatures • Agents cannot accept or agree to an electronic consent portion of an enrollment application or contract via the computer on behalf of a consumer. • Signatures must only be completed by the consumer or their authorized representative, and always in their own name. • A facsimile signature of any individual executing an insurance policy is legally valid and binding and may be used in lieu of an original signature.	• If an agent is completing an electronic application in SalesConnect during a face-to-face appointment, the agent **MUST** allow the consumer to complete the electronic Consent to Contract portion. • The agent will move the computer to allow the consumer to complete the Consent to Contract portion of the application. • Agents must follow Florida Blue established business processes when submitting applications.
High Pressure Sales Tactics • Certain segments of consumers are very vulnerable and can easily be taken advantage of. Never use "Hard Sell" tactics or make the consumer feel pressured. Use of words or phrases that refer to a sense of urgency or imply there is a deadline where there is none are prohibited.	• The agent's goal must be to assist the consumer with enrolling in a benefit plan that will meet their needs and provide a positive customer experience during the benefit year.

NOTE: Florida Blue monitors and tracks potential allegations of agent misrepresentation.

Consumer Needs

*TIP: Agents should check **in advance** of an appointment to determine if there are any special needs in order to have a successful sales meeting.*

Florida Blue has a long-standing and deep commitment to meeting the needs of consumers and customers. This commitment includes reasonably accommodating the needs of individuals with disabilities and/or with limited English proficiency. When conducting marketing and sales activities to consumers, including those with special needs, (e.g. vision,

Return to Agent Compliance Reference Guide By Section

hearing impaired, other disabilities and consumers with Limited English Proficiency), agents must ensure that the consumer's needs are considered. Examples include:

- Providing marketing materials in the preferred language, in an alternate format and/or in a digitally accessible format upon request.

- If requested by a consumer or their legal representative, arranging for a translator to be present, either in person or by telephone. If an agent is not proficient in the language spoken by the consumer, he/she must have/use a translator who is proficient in the language of the consumer.

- Ensuring sales meeting locations will include accommodations for people with special needs in accordance with applicable law. As appropriate, inviting caretakers, family members, and/or authorized representatives to attend the marketing session.

Behaviors

Florida Blue expects its agents to exhibit the appropriate behaviors when interacting with consumers.

- Show warmth, respect, empathy and patience.

- Enunciate words clearly and slowly.

- Go at the consumer's pace in order to promote better understanding.

- Don't go too fast or change topics too quickly.

- Use simple, clear and consistent language.

- Repeat and/or rephrase important points.

- Ask and encourage questions throughout the process.

Return to Agent Compliance Reference Guide By Section

AGENT TRAINING, TESTING AND CERTIFICATION

Florida Blue believes that each consumer should be able to understand the benefits of the plans they are reviewing and select the right health care and/or prescription drug coverage to meet their personal needs. The company recognizes that agents play a significant role in helping consumers with their coverage choices.

Florida Blue provides an effective training program to all agents with information about its product offerings and expects each agent selling its products to be highly qualified and properly trained according to the company's mission, vision, values, policies, procedures and processes.

In addition, when selling government-contracted health insurance products, agents must complete the appropriate certification or registration in order to sell these type products. Agents selling Marketplace products must complete the Federally-Facilitated Marketplace (FFM) registration process, while agents selling Florida Blue Medicare products and/or BlueMedicare Supplement products must have successfully completed the Florida Blue Medicare General Compliance and FWA Training.

Agents electing to sell both product types must complete both program requirements.

In accordance with DHHS/CMS/CCIIO guidance and Florida Blue policy:

- **Appointed agents will not be authorized to sell government-contracted health insurance products (i.e., Marketplace plans, Medicare Advantage plans, Part D plans) until proof of completion of the agent's CMS Certification and/or FFM Registration process is received and documented following the appropriate Florida Blue process**.

- Appointed agents will not be authorized to sell BlueMedicare Supplement plans until successful completion of the Florida Blue Medicare General Compliance and FWA Training.

- Initial and renewal sales commissions will not be paid for enrollments made by an agent who is not certified or registered as required.

- Agents must remain in good standing and complete annual registration and/or re-certification to continue to be paid product renewal commissions.

- Florida Blue may require re-training of any appointed agent at any time, if complaints and/or marketing misrepresentations are identified.

For Commercial products, please refer to Section II – Commercial Products (Agent Training, Testing and Certification).

For Medicare Supplement products, please refer to Section III – Medicare Supplement Products (Agent Training, Testing and Certification).

Return to Agent Compliance Reference Guide By Section

For Medicare Advantage (Part C) and Prescription Drug Plan (Part D), please refer to Section IV – Medicare Advantage (Part C) and Prescription Drug Plan (Part D) Products.

Product Training

Agents are provided comprehensive product information and training for all lines of business via classes, seminars, webinars, and CBTs. For quick reference, product information is available on the Agent Resource Center and the Sales Resource Center (SRC) – for internal agents only.

Targeted Retraining

Florida Blue may require re-training and/or recertification (i.e., Florida Blue's Medicare General Compliance and FWA Training) of any appointed agent at any time, for complaints and/or potential marketing misrepresentations. Florida Blue reserves the right to determine which contract year recertification will be required to be re-taken.

On-Going Communication

Sales Bulletins and Agent Bulletins are utilized to inform and educate agents on new or relevant topics. Regular calls and/or meetings are held with agents to answer questions about benefits, network, and to obtain insight regarding the public's reaction to the products being offered.

SALES

It is important when agents engage in the selling process that they understand and follow the many requirements put in place for consumer protections. Some of the consumer protections addressed in this section include:

- Restrictions for contacting clients and when authorizations are needed before contacting them for marketing purposes
- Telephone Consumer Protection Act, Florida Telemarketing Act, CAN-SPAM Act and other state and federal laws/regulations regarding marketing activities
- Gift and business entertainment requirements
- Information about Authorized Representatives

Contacting Clients

Federal requirements place some restrictions related to using member PHI. These restrictions are outlined in various regulatory sources such as in the Marketplace Agreements and the CMS Medicare Manuals to protect consumers from misuse of personal information. Agents must be mindful of HIPAA and other health information privacy laws (including other provisions in the ACA) that govern the use of consumer and member information when contacting clients.

NOTE: The HIPAA marketing rules applicable to past or present Florida Blue members also apply to past or present members of dental and long-term care insurance products. With respect to current members of any other insurance product, those members' authorization to contact must always be obtained in order to use and disclose their protected health information for marketing activities.

For specific information pertaining to Medicare Advantage (Part C) and Prescription Drug Plan (Part D), please refer to Section IV – Medicare Advantage (Part C) and Prescription Drug (Part D) Products (Contacting Beneficiaries).

Telecommunications

Agents may not send, initiate or cause the sending of any text message or implement any telecommunications activities to promote or sell Florida Blue products, **unless prior written approval from Florida Blue is received**. If an Agent receives such approval and implements telecommunications activities in connection with the promotion or sale of any Florida Blue product, then the Agent must conduct all telecommunications activities (including text messages, facsimile transmissions, telephone calls or other related contact) in full compliance with all Telecommunications Laws.

NOTE: "Telecommunications Laws" refers to applicable federal and state laws, rules and regulations that apply to sending electronic and telephone messages and using telecommunications activities, including but not limited to the Controlling the Assault of Non-Solicited Pornography and Marketing Act (CAN-SPAM Act) (15 U.S.C. § 6101-08) and the rules, regulations, and guidance promulgated thereunder by the Federal Trade Commission (16 CFR Part 316); the Telephone Consumer Protection Act (47 U.S.C. § 227) and the rules, regulations, and guidance promulgated thereunder by the Federal Communications Commission (47 CFR Parts 64 and 68); the Telemarketing and Consumer Fraud and Abuse Prevention Act (15 U.S.C. § 6101-08) as implemented by the Telemarketing Sales Rule and the rules, regulations, and guidance promulgated thereunder by the Federal Trade Commission (16 CFR Part 310); and all other applicable federal and state laws, rules, and regulations and industry standards, e.g., the CTIA, applicable to inbound and outbound electronic and telephone communications, including, but not limited, to voice and video replay and recordings, text (SMS/MMS) messages, and calls to landline and wireless numbers.

Agents must:

- comply with all applicable laws, rules and regulations, including but not limited to Telecommunications Laws and rules, regulations, legislation or conventions related to privacy rights of individuals;

- obtain, document, and maintain all required consents necessary under Telecommunications Laws to perform the services regardless of platform and technology;

- obtain and retain all permits, licenses and/or governmental or third-party consents, approvals or assignments that are required in connection with the performance of their services;

- perform all services/electronic messaging and telecommunications activities in a timely manner with a high level of care, skill and diligence consistent with industry best practices;

- not violate, misappropriate or infringe any third-party rights, including but not limited to individuals' rights of privacy and publicity; and

- acknowledge that any violation of Telecommunications Laws by the Agent will be deemed beyond the scope of the independent contractor relationship between Companies and the Agent.

Agents are reminded that they are held responsible to Florida Blue and its Affiliates relative to all claims arising out of the performance of their duties, or the breach of contract including any representation or warranty concerning the Agent's activities.

Relationship Building – Gifts and Business Entertainment

Offering or accepting business gifts, entertainment or travel is generally discouraged because it may create a perception of creating an inappropriate relationship or conflict of interest, even if the intent is innocent and there is no influence on your business judgment.

Return to Agent Compliance Reference Guide By Section

In addition to perception, there are various circumstances where the offer or acceptance of a gift, including anything of value such as cash, entertainment, gift cards, tickets to events, travel, or other favorable treatment, is illegal or, at a minimum, creates a conflict of interest.

The Compass Code of Ethical Business Conduct recommends that agents, employees and others associated or affiliated with the company avoid offering or accepting any gift or type of business courtesy under any circumstances from firms or individuals conducting business with the company. This includes competitors and those who would like to conduct business with us. Acceptance of non-monetary gifts that could be reasonably construed to be connected with the company's business relationship with that firm or individual is not allowed.

- Bribes, kickbacks or other valuable consideration may not be offered to anyone, including customers or members of their family, in connection with the sale of any of our products or services, or to obtain preferential treatment, secure or retain business or solicit an improper benefit personally or for the company.

- Under no circumstances can gifts, meals or entertainment be offered to any government official. A violation by you of the laws and regulations regarding gifts to government employees can result in serious criminal and/or civil legal consequences.

- Avoid situations where the offering of gifts or entertainment may give the appearance of trying to influence potential customers, group administrators, or any person who has authority over an ERISA (Employee Retirement Income Security Act of 1974) health plan choice.

For specific information pertaining to Medicare Advantage (Part C) and Prescription Drug Plan (Part D), please refer to Section IV – Medicare Advantage (Part C) and Prescription Drug (Part D) Products (Sales/Marketing & Educational Events).

Authorized Representative

Consumers who are unable to sign an enrollment form or disenrollment request or complete an enrollment request mechanism due to reasons such as physical limitations or illiteracy may have a legally authorized representative who can make health care decisions on their behalf. Generally, a court-appointed legal guardian, persons having Durable Power of Attorney for health care decisions or individuals authorized to make health care decisions under Florida surrogate consent laws (i.e., health care surrogate) are authorized to act on the consumer's behalf in this capacity. *See Florida Laws: FL Statutes - Title XLIV Chapter 765 Health Care Advance Directives, Part II - Health Care Surrogate (ss. 765.201-765.205).*

Provider/Pharmacy Information

The company offers consumers and members' access to its provider network listing via the Online Provider Directory (OPD) located on the Florida Blue website. Updates to this site

are made on a regular basis and provide the most up-to-date information about our provider networks by product line.

A common provider search error occurs when a provider's name is shown as a participating provider but the network of the health insurance product(s) they participate in are not checked or are misread. As a result, many consumers file complaints that they were misled by an agent (marketing misrepresentation) because this step was not done. As a best practice, agents should always verify whether a consumer's provider(s) is/are participating and ensure that they are in the network of the product they are selecting to purchase.

Return to Agent Compliance Reference Guide By Section

SALES MATERIALS

Agency/Agent Marketing Materials

Health insurance advertisements in Florida must provide prospective members with clear and unambiguous statements and represent truthful, clear and adequate disclosure of benefits, limitations and exclusions of policies sold. Florida Blue works closely with the OIR and CMS to ensure its advertisements and other materials meet state and federal compliance standards.

Under the Florida Administrative Code (FAC), insurance agents/agencies must follow the same advertising standards as insurers. Likewise, insurers are accountable for the advertising of their agents when advertising the insurer's products. Even though a particular insurer's name is not listed, the insurer whose products are represented by the agency may be liable for insurance ads. Florida Blue agencies must follow the FAC rules when developing advertisements. For more information and details about the FAC's standards, visit **flrules.org**.

Florida Blue provides its Contracted General Agencies (CGAs) with a Marketing Guide to help make marketing efforts successful, easy to execute and compliant. The guide includes advertising rules required by Florida law, requirements for using the Florida Blue brand, guidelines to follow when developing advertisements, and guidelines by medium such as internet requirements *(agency websites, internet advertising, social media)*, broad media requirements (billboards, radio/television, telemarketing scripts, phonebook) and stationery requirements *(letterhead/envelopes, business cards)*.

In addition, Florida Blue provides agencies with approved agent collateral, videos, advertising guidelines along with dynamic templates available for customization and download via its Marketing Connect *(Commercial Products)* and CustomDocs *(Medicare Products)* tools.

NOTE: Agencies/agents or other third parties are not permitted to submit materials directly to OIR or CMS for Florida Blue advertising/marketing materials. Florida Blue files its own materials to the OIR and CMS for approval. Electronic Marketing Organizations (EMOs) and Field Marketing Organizations (FMOs) are an exception when marketing materials are submitted using the multi-plan marketing material submission process in the Health Plan Management System (HPMS) Marketing module.

For specific information pertaining to Commercial Products, please refer to Section II – Commercial Products SALES MATERIALS - COMMERCIAL

For specific information pertaining to Medicare Advantage (Part C) and Prescription Drug Plan (Part D), please refer to Section IV – Medicare Advantage (Part C) and Prescription Drug Plan (Part D) Products (Sales Materials).

Return to Agent Compliance Reference Guide By Section

Outdated Marketing Materials

All outdated/revised Florida Blue marketing materials must be destroyed. Written verification of material destruction may be requested.

Return to Agent Compliance Reference Guide By Section

COMPLAINTS, ALLEGATIONS, MARKETING MISREPRESENTATIONS AND THE AGENT OVERSIGHT AND MONITORING PROCESS

Florida Blue is committed to ensuring that all agents certified to sell its plans follow applicable laws and regulations, the appropriate guidance, as well as Florida Blue's policies and procedures. As such, agents must always be truthful and sincere, and not intentionally mislead or confuse consumers, nor misrepresent the company.

When Florida Blue identifies or is informed of a possible allegation of inaccurate or improper sales activity or inappropriate conduct by an agent, the issue is investigated thoroughly following Florida Blue's Agent Corrective Action process. Agents who are found to be in violation of marketing guidance or Florida Blue's policies and procedures will be subject to corrective actions, which can include without limitation: coaching/counseling, additional training/re-training, verbal warning, written warning, suspension, termination, reporting to local, State, or Federal authorities for further investigation, or a combination of the above.

Complaints

Florida Blue receives allegations, complaints and marketing misrepresentations via many different sources, including:

- CIIOO Marketplace Account Manager
- CCIIO Health Insurance Case Management System (HICS)
- Florida Department of Financial Services (DFS) / Office of Insurance Regulation
- Social Media
  - Facebook
  - Twitter
  - Instagram
- Florida Blue.com
Florida Blue.com/Medicare
Florida Blue.com/Dental
- Florida Blue Mobile App
- Florida Blue Area Managers
- Agents (Contracted & Employed)
- Agent Service Center
- CMS Medicare Advantage/Part D Account Manager
- CMS Health Plan Management System (HPMS)
  - Complaint Tracking Module (CTM)
- Florida Department of Elder Affairs – SHINE (Serving Health Insurance Needs of Elders) Program
- Florida Blue Internal Departments
  - Customer Service
    - Call Center
    - Member Correspondence
  - Enrollment, Maintenance & Billing
  - Business Ethics, Integrity & Compliance
    - Compass Hotline
    - EthicsPoint Website
  - TeleSales
  - Retail Centers
- Contracted Vendor's Call Center

Return to Agent Compliance Reference Guide By Section

OIR Complaints

The OIR investigates any complaints received from consumers and notifies health insurance carriers via the Market Conduct Report. Florida Blue's Legal Affairs Department coordinates with Compliance and other appropriate parties to resolve complaints received by the state.

Florida Blue Agent Corrective Action Process

Florida Blue strives to protect its members/potential members from unethical, illegal, and non-compliant activities and takes appropriate action to detect and prevent aggressive marketing techniques targeted at all consumers. The Agent Corrective Action Process addresses agent complaints in accordance with compliance requirements. When requirements have not been met, corrective actions are implemented utilizing this process. Issues are investigated thoroughly, and corrective actions taken as necessary, up to and including termination/revocation of appointment. All corrective actions are tracked to completion.

Monitoring and oversight activities are conducted so as to help agents effectively apply compliance guidance to real life, everyday sales situations. This is designed to help improve overall agent performance. By providing feedback, agents can learn the activities and topics where compliance gaps and opportunities exist. The goal is to identify and correct compliance deficiencies to reduce and/or eliminate customer complaints, marketing misrepresentations, and compliance deficiencies.

Listed below are some examples of situations/occurrences which could result in appropriate corrective actions based on each offense. This only serves as a guide and does not represent all situations that may occur.

Situation/Occurrence Examples
1. Providing incorrect and/or incomplete information to client. Application written by agent is incomplete or incorrect. Examples include but are not limited to: a. Enrollment/disenrollment procedures i. Agent fails to instruct client that he/she must complete certain changes via the Marketplace which results in a HICS case. ii. Incorrectly advising client that enrolling in a Medicare Supplement plan will automatically disenroll them from a Medicare Advantage plan. b. Erroneous or incomplete information about Florida Blue Marketplace plans which results in a complaint. c. Benefits, Exclusions, Limitations: i. Agent fails to or, incorrectly advises on Marketplace plan benefits, prescription drugs covered and/or participating providers available in the

Return to Agent Compliance Reference Guide By Section

Situation/Occurrence Examples
network. ii. Agent fails to or, incorrectly advises on plan limitations, exclusions, disclaimers. d. Failure to complete application correctly or completely i. Agent fails to indicate appropriate election period ii. Agent uses incorrect election period on application.
2. Failure to follow mandated procedures including, but not limited to: a. Enrollment forms/disenrollment forms held or lost by agent. b. Use of non-OIR or non-CMS approved marketing material.
3. Behavioral/Inappropriate Sales tactics. Examples include, but are not limited to: a. Steering consumer for sole benefit of agent. b. Aggressive and/or deceptive practices. c. Rude/inappropriate behavior towards consumers/members or Florida Blue staff.
4. Unethical/Fraudulent behavior: a. Falsification of records: (e.g. enrolling member without consent or authorized representative). b. Inappropriate use of SalesConnect Tool for enrollments (e.g. enrolling member without their or authorized representative's completion of consent to contract). c. Fraud, Waste and/or Abuse. d. Selling to and/or enrolling consumers and/or beneficiaries without successful completion of the MARKETPLACE Certification and/or current Florida Blue Medicare General Compliance and FWA Training, if applicable. Assumes licensing requirements are current and in good standing.

Return to Agent Compliance Reference Guide By Section

DOCUMENTATION AND RECORDS RETENTION REQUIREMENTS

Florida Blue Records Retention Requirements

Records and information created or received while conducting Florida Blue business are Company-owned records. Florida Blue's record retention schedule is the sole governing authority for retention periods of Company-owned records.

As such, Florida Blue requires its agents to document all sales appointments and maintain thorough and auditable records for a period including the active contract year + eleven (11) years. Scheduled or random audits of agent documentation may occur. Agents must have the requested documentation immediately available to provide to Florida Blue upon request.

Sales/Marketing Appointment Documentation

The State of Florida requires every agent transacting any insurance policy to maintain or have readily accessible by electronic or photographic means, records of policies transacted by him or her to enable clients/members and/or the Department of Financial Services to obtain all necessary information, including daily reports, applications, change endorsements, or documents signed or initialed by the insured concerning these policies.

When a complaint or potential marketing misrepresentation is received / identified, the Agent Corrective Action Process is implemented. In all cases, the agent is asked to provide a description of what occurred during the sales appointment. Therefore, documentation of the sales appointment plays an integral role in determining whether agent corrective actions are necessary and to what extent is appropriate.

Examples of documentation include:

- Individual's name and relationship to enrollee
- Description/summary of sales appointment discussion

  Note: It is in the agent's best interest to provide a more detailed description as this may help a complaint/ marketing misrepresentation turn in the agent's favor.

- If an individual has an authorized representative that the agent must contact, document steps taken such as meeting rescheduled, etc.
- Copies of documentation collected for enrollment
- Any other information the agent feels appropriate

Return to Agent Compliance Reference Guide By Section

SECTION II – COMMERCIAL PRODUCTS

AGENT TRAINING, TESTING AND CERTIFICATION - COMMERCIAL

For general agent training information, refer to Section I – General Compliance (Agent Training, Testing and Certification). This section is specific to Commercial Marketplace products.

Marketplace Agent and Broker FFM Registration Processes

Agents selling Florida Blue Marketplace Qualified Health Plans (QHPs) must be appropriately FFM Registered before accessing Florida Blue sales tools and receiving compensation.

Initial Registration

New user registration must be completed on the CMS Enterprise Portal. This includes a step to complete identity proofing. Once complete, agents access the Marketplace Learning Management System (MLMS) through the CMS Enterprise Portal and complete the required FFM training. A minimum passing score of 70% is required. The required Marketplace Agreements are executed to complete the registration process.

NOTE: CMS advises agents to download a copy of their Marketplace registration certificate of completion for their records. Florida Blue does not require agents to submit their certificate of completion; please retain for your records only.

Renewal Registration

Agents must renew their registration annually. Agents must use their existing portal credentials to log in to the CMS Enterprise Portal. Once logged in, agents complete the required training and execute the Marketplace Agreements. For those who have previously registered, identity proofing is not repeated. CMS offers a condensed version of FFM Registration training for returning agents.

Time Period		Applicable Enrollment Period	Year of FFM Registration Needed	Comments
Start	End			
1/1	10/31	SEP	Current Year	• Current Year FFM Registrations end the day before the first day of the OEP – October 31 • Agents cannot sell backdated SEPs

Time Period		Applicable Enrollment Period	Year of FFM Registration Needed	Comments
Start	End			
Date of Completion for Next Year's FFM Registration (i.e., 8/30)	12/31	OEP, SEP	Next Year	• Marketplace OEP is November 1 - December 31 • CMS provides daily updates to its FFM Registration Completion and Termination Report • Florida Blue receives and validates FFM registration completions and terminations daily

NOTE: ALL FFM Marketplace Agreements with agents and brokers expire October 31st annually. Agents who have not renewed their FFM Registration for the upcoming year by October 31st will be removed from the Florida Blue system. Once notification of renewal registration is validated, access to Florida Blue sales tools will be reinstated.

Florida Blue's Validation of Agent Marketplace Registration

Florida Blue utilizes and collects FFM agent registration and termination information. Agents provide Florida Blue with their FFE Marketplace User ID. Florida Blue maintains the agent's Marketplace User ID and associates it with the agent's National Producer Number (NPN) and the Florida Blue Agent of Record (AOR) ID number. Florida Blue will validate the agent's FFM registration via the Agent and Broker Registration and Termination list on data.healthcare.gov.

Marketplace Agreements

As part of the Marketplace registration requirements, agents must agree to abide by the provisions outlined in the Individual Marketplace Agreements. This includes the Privacy and Security Agreement that contains extensive privacy and security requirements agents must abide by. See Section 1312(e) of the ACA and all related provisions.

Agents utilizing the Marketplace are bound by the privacy and security standards and authorized functions of PII outlined in the Marketplace Agreements. Refer to the *Agent Broker General Agreement for the FFM Individual Market* and *Agreement Between Agent or Broker and CMS for the FFM Individual Market* for specific requirements and information.

NOTE: Complete FFM registration and training information can be found on the Center for Consumer Information & Insurance Oversight (CCIIO) website on the Agent and Broker Resources page.

Return to Agent Compliance Reference Guide By Section

SALES - COMMERCIAL

For general sales information, refer to Section I – General Compliance (Sales). This section is specific to Commercial products.

Marketplace Enrollment Applications

Florida ACA health insurance policies are for Florida residents only. Agents must ensure the consumer provides a Florida address for the physical residence. The consumer should be willing to produce a Florida Driver's License or other form or identification that verifies their residency in Florida.

Review the consumer's information to ensure accuracy and completeness, including spelling, date of birth and Social Security number. Contact information must be that of the enrollee, not the agent.

NOTE: Agents must never change the NPN on the consumer's application or access their account without the consumer's permission.

Consumer Consent

One of the FFM standards of conduct specifies that agents and brokers must obtain consent of an individual prior to helping them apply for financial help or enrolling in a qualified health plan through the Marketplace. Consent may be obtained verbally, in person, by phone, or electronically. The record of consent should include the individual's name, the date the consent was given, and the name of the agent to whom the consent was given. The consumer's consent should acknowledge that the agent has informed them of the functions and responsibilities associated with an agent's or broker's role in the Marketplace. Consent records, including call recordings must be properly secured, readily available and retained per Florida Blue Records Retention Requirements.

Consumer Healthcare.gov Accounts

Consumers must create and log into their own healthcare.gov account. Agents should inform the consumer to never share their login ID and password with anyone, including the agent. If no account exists when an enrollment is submitted, instruct the consumer to create a healthcare.gov account. Provide them with their FFM application ID that was generated from the enrollment submission. Consumers should include their FFM application ID at account creation for healthcare.gov to associate the consumer with the application created by the agent.

Agents should inform the consumer that changes should be updated as they occur, and within thirty (30) days of the change. Changes in circumstances may include updates to their income, demographics, and household information. Failure to do so may affect any

financial assistance received, particularly Advanced Premium Tax Credits and cause the consumer to potentially repay excess premium tax credits received.

Medicare Anti-Duplication

Federal requirements state that consumers cannot receive financial assistance from the government for different federally-funded programs. For new sales and active renewals, agents need to ensure consumers are aware of Medicare anti-duplication requirements. At the beginning of the sales process, agents should inquire if the consumer or any of their dependents are entitled to Medicare Part A and/or enrolled in Medicare Part B. If so, agents are not allowed to enroll consumers in a Marketplace qualified health plan (QHP). For passive renewals, if agents discover a member is already entitled to Medicare Part A and/or enrolled in Medicare Part B, outreach should be performed to discuss the member's coverage options and ensure they are not duplicating benefits with their QHP.

Data Matching Inconsistencies (DMI)

Data Matching Inconsistencies (DMI) occur when the consumer's information submitted on the application doesn't match information contained in federal databases. CMS assigns the enrollee's account with a temporary eligibility status then conducts outreach to resolve the DMI issues. DMI notices are sent prior to coverage adjustment of termination. Consumers who fail to resolve DMIs can experience a loss of Marketplace coverage and/or loss or adjustment to their Marketplace financial assistance. Consumers have 95 days to resolve citizenship or immigration DMIs and 90 days for all other DMIs.

Agents should proactively offer assistance to help resolve these issues. Encourage the consumer to check their Marketplace account, email, phone log and/or U.S. Mail often to quickly identify notifications of data matching issues.

Interaction with Marketplace Navigators

Navigators are individuals registered in the State of Florida and either authorized directly by an exchange or someone who is working on behalf of an entity authorized by an exchange, to facilitate the selection of a qualified health plan through the exchange and perform other duties such as:

- conducting public education activities to raise awareness of the availability of qualified health plans;
- distributing fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits and cost-sharing reductions;
- facilitating enrollments in qualified health plans;

Return to Agent Compliance Reference Guide By Section

- providing referrals to any office of health insurance consumer assistance, health insurance ombudsman or any other appropriate state agency for any enrollee with a grievance, complaint or questions regarding their health plan, coverage or a determination under such plan or coverage;

- providing information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange; and

- protecting the public from unauthorized activities or conduct.

In order to act in the best interest of consumers, Navigators are bound by strict conflict of interest rules and must provide fair, accurate and impartial information and services to the consumers they serve. As such, Navigators are prohibited from:

- soliciting, negotiating or selling health insurance;

- recommending the purchase of a particular health plan or representing that one health plan is preferable over any over;

- recommending or assisting with the cancellation of insurance coverage purchased outside the exchange;

- receiving compensation **or anything of value from an insurer, health plan, business or consumer in connection with performing activities as a navigator**, other than from the exchange or an entity/individual who has received a navigator grant under the Affordable Care Act.

Agents should avoid any direct interaction with or invitations to/from Navigators and avoid activities that could create any appearance of impropriety. This includes giving Florida Blue sales materials to Navigators, compensation, or anything of value exchanged directly or indirectly between the agent and navigator in connection with performing the activities of a navigator.

When in the presence of Navigators, agents must not have any discussions about:

- soliciting, negotiating or selling health insurance;

- recommending the purchase of a particular health plan or representing one health plan as preferable over another;

- recommending the purchase, assisting with enrollment or providing services related to health benefit plans or products not offered through the exchange other than providing information about Medicaid and the Children's Health Insurance Program (CHIP); and

- recommending or assisting with the cancellation of insurance coverage purchased outside the exchange.

Return to Agent Compliance Reference Guide By Section

SALES MATERIALS - COMMERCIAL

Agency/Agent Marketing Materials

MarketingConnect is an asset management tool that was created to give the sales channels access to Florida Blue marketing materials by providing an online catalog of ***pre-approved*** advertising/marketing materials that is accessible online at Guidewell.webdamDB.com or through Florida Blue's web-based sales tool, AgentPoint (formerly known as AgentPoint). This tool allows agents access to customize and download flyers, print ads, radio scripts, website copy and more. Access to MarketingConnect is limited to CGAs, NCAs and their delegates (DII and DIII level). Agencies/agents are encouraged to use these pre-approved templates for advertising purposes.

NOTE: As of September 1, 2020, MarketingConnect will only be utilized for commercial lines of business.

For questions or needed support related to the Florida Blue Marketing Guidelines requirements, agencies/agents must coordinate with their Area Manager.

Materials Auditing

Florida Blue may periodically request copies of an Agency's/Agent's marketing materials to help ensure only current, valid OIR-approved materials are being used; and, that the OIR-approved content was not modified by the Agency/Agent.

Additionally, a random audit of Agency/Agent websites may be conducted to ensure the most current Florida Blue and OIR-approved materials are being used in accordance with OIR guidance and Florida Blue's requirements

Return to Agent Compliance Reference Guide By Section

ENROLLMENT - COMMERCIAL

In order to meet consumers' needs, Florida Blue provides its agents with several different methods for completing On and Off Marketplace, electronic, telephonic and paper *(Off-Marketplace only)* applications. For consumers who prefer to enroll without agent assistance, the company provides an online enrollment tool, referred to as CWS (Consumer Web Sales) which is available on the www.FloridaBlue.com website.

NOTE: If the consumer needs help and calls the 800 number provided in the application portal on the website, a licensed agent is available to provide assistance.

For Marketplace enrollments, agents can use any of the methods described above, including Florida Blue's SalesConnect Tool to utilize the Marketplace enhanced direct enrollment (EDE) capability, when allowed. More detailed information is outlined below. CMS also provides consumers with an online enrollment tool to complete an application on the www.healthcare.gov website.

Guaranteed Issue/Guaranteed Availability

Florida Blue follows all federal and state guidance for guaranteed issue of its plans, as appropriate.

Marketplace Plans Guaranteed Issue

Beginning in 2014, everyone who applies for individual health insurance is guaranteed coverage. Florida Blue must continue to offer non-grandfathered health insurance coverage to and accept applications from every individual or employer who applies for coverage in the individual or group markets, respectively. Consumers can no longer be denied health coverage because of pre-existing conditions. Medical history cannot be used to determine the cost of health coverage the consumer chooses. Medical underwriting in its previous form has essentially gone away. Factors that now determine premium amounts are:

- Ages of everyone applying for coverage
- Number of people to be covered on the policy
- Location of residence of the subscriber
- Tobacco use

NOTE: Federal guidelines describe "guaranteed issue" as being synonymous with "guaranteed availability". Student health insurance coverage is exempt from the guaranteed availability and guaranteed renewability requirements.

Return to Agent Compliance Reference Guide By Section

Guaranteed Availability

Individual Market

Florida law requires that health insurance issuers offering individual health insurance coverage cannot deny enrollment or decline to offer coverage or impose any preexisting condition exclusion of coverage, if an eligible individual desires to enroll in an individual health plan.

Group Market

Regulations require that health insurance issuers offering group health insurance in the small or large group market cannot deny enrollment or decline to offer coverage if an eligible group desires to enroll in a group health plan.

Annually, in the small group market only, Federal law allows small groups that otherwise meet the requirements to waive the minimum participation/contribution requirements during an enrollment period that occurs between November 15th and December 15th for a January 1 effective date.

Guaranteed Renewability

Florida Blue provides guaranteed renewability of coverage for its individual and group members. The company will only cancel, non-renew or discontinue a contract if the member has failed to pay premiums, committed fraud or made a material misrepresentation, failed to comply with a material provision of the plan such as employer contributions or group participation, the plan will no longer offer coverage in a market, and/or no enrollees live or work in the service area.

If a plan will no longer be offered, Florida Blue will provide notice to members at least 90 days prior to the date of the non-renewal of coverage and will offer any other available health insurance coverage in that market and uniformly apply this to all contract holders regardless of their claims experience.

Marketplace Enrollment

The Affordable Care Act requires issuers contracted with CMS to offer qualified health plans (QHPs) on the Marketplace to also sell the same QHPs Off Marketplace. Consumers will not be able to receive tax credits or cost-sharing reductions when selecting a QHP Off Marketplace.

When agents meet with consumers to enroll them in the Marketplace, there are several things to remember:

- Only agents who are registered with the Marketplace can access the Marketplace and sell qualified health plans.

Return to Agent Compliance Reference Guide By Section

- Actual subsidy eligibility can only be determined by the Marketplace. Any other subsidy estimation tools should only be used as a guide.

- Agents must never give tax advice. Consumers should be referred to their tax professional or attorney.

- In order to eliminate consumer confusion, separate proposals are required for each health product category and cannot be co-mingled in the same proposal. Products included in this requirement are Florida Blue's QHP Off Marketplace health plans, existing underwritten health plans, Marketplace health plans, and ancillary plans.

- Pediatric dental is not required with Marketplace health plans.

Marketplace Direct Enrollment

During the Open Enrollment Period, Florida Blue offers its agents the ability to help consumers select a qualified health plan and complete a Marketplace application via SalesConnect using the "Direct Enrollment" capability allowed by CMS. Through this pathway, agents log on to an agent/broker landing page available through direct enrollment on the Marketplace website where they can complete an application for the consumer.

SalesConnect Tool Online Marketplace Direct Enrollment

SalesConnect is a Florida Blue developed web-based enrollment tool that is used by both internal and external agents. Generally, agents assisting customers using this pathway will follow these general steps:

- Work with the consumer to determine whether he or she would like to apply for qualified health plan coverage through the Marketplace.

- Advise the consumer to gather the appropriate documents he or she will need to complete the application. This information can be found via a link located on the www.healthcare.gov website.

- Log on to AgentPoint and supply the appropriate credentials to access Florida Blue's SalesConnect. Agents will be securely redirected to an agent/broker landing page on the Marketplace website. Agents must read the following disclaimer to the consumer and document their response:

  "A portion of your application will be completed on the Health Insurance Marketplace, where I will be entering your responses regarding your eligibility and attesting to the accuracy of those responses on your behalf. Do I have your permission to complete the Marketplace eligibility application and attest by applying an electronic signature on your behalf?"

  NOTE: If the consumer does not provide their permission, agents must refer him/her to enroll directly through the Marketplace website.

- Log in to the agent/broker landing page on the Marketplace website.

Return to Agent Compliance Reference Guide By Section

- With the consumer, complete the eligibility application on the Marketplace website for the consumer.

  NOTE: Agents must not set up the consumer's own "MyAccount" username and password. The consumer can return to the Marketplace website separately or call the Marketplace call center to set their MyAccount username and password.

- Once the agent has completed the application with the consumer and received the consumer's eligibility determination from the Marketplace, the agent will be securely redirected back to Florida Blue's SalesConnect website. Once back on SalesConnect, the agent can compare and select a plan with the consumer.

  NOTE: When using Florida Blue's Direct Enrollment via SalesConnect, agents will only be able to view Florida Blue's qualified health plans. If the consumer does not want a Florida Blue qualified health plan, the agent must refer him/her to the Marketplace website where all available plans, including Florida Blue's, will be shown. The consumer can then make their selection and enroll directly through the Marketplace website.

- If applicable, select the amount of the advance premium tax credit that the consumer would like to apply.

- Prior to submission of the enrollment application, all tax filers must acknowledge and e-sign the application. This is a federal requirement. Tax filers may or may not be on the application. <u>This is in addition to the required consumer acknowledgement.</u>

- Upon submission of the application and confirmation from the Marketplace, the final step is to make a payment on the Confirmation page. Collection of the Marketplace binder payment is OPTIONAL however; agents are strongly encouraged to collect the binder payment at the time of application submission if possible. Agents will be directed to Florida Blue's payment vendor to enter binder payment details and submit the payment. Binder payment methods include: Credit/Debit Cards, Money Market Savings, Checks, or Electronic Fund Transfers (EFT).

  NOTE: If the binder payment is not collected at the time of application submission, the consumer will automatically be paper billed. The binder payment can be in the form of check, credit card/debit card, or money order and must be received prior to the effective date or the contract will be cancelled. The applicant will not be enrolled for coverage on the MARKETPLACE if the binder is not received in time.

- At this point, the agent will submit the enrollment information to the Marketplace. The agent's identifying information will be included in the official Federally-facilitated Marketplace enrollment record sent to Florida Blue so that commissions can be made for the sale.

Return to Agent Compliance Reference Guide By Section

SalesConnect Telephone Marketplace Direct Enrollment

Agents can also enroll consumers electronically in SalesConnect while talking to them over the phone. For Marketplace enrollments, agents will follow the process outlined above.

- Once the agent has all steps up to the acknowledgements completed, at that point, an email is sent to the consumer with instructions and a link to the password-protected enrollment application.
- The consumer reviews the application and determines whether the information captured is correct. If not, the consumer will submit a corrections page back to the agent who makes the necessary changes and resends the application back to the consumer for his/her review and approval.
- Once the application is correct, the consumer completes the appropriate acknowledgements and e-signs the application.
- Then the consumer can make a binder payment. If the binder payment is not collected at the time of application submission, the consumer will be paper billed. The mailed payment must be received prior to the effective date; if not, the contract will be cancelled.

Consumer Web Sales (CWS) Marketplace Direct Enrollment

Consumers who log on to www.floridablue.com or www.bcbsfl.com to complete an application can self-initiate an enrollment in a Marketplace plan via Direct Enrollment. The consumer will set up a Florida Blue and Marketplace account, obtain their subsidy determination, select their plan, complete the appropriate attestations and acknowledgements and can make their binder payment.

Agent-Assisted Marketplace Enrollment

There are two ways agents can assist a consumer with completing their application directly on the Marketplace website: 1) sitting next to the consumer (aka Side by Side); and, 2) via a 3-way call with the Marketplace.

Side by Side

Generally, agents assisting customers using this pathway will follow these general steps:

- Advise the consumer to gather the appropriate documents he or she will need to complete the application. This information can be found via a link located on the www.healthcare.gov website.
- Guide the consumer in setting up his or her own Marketplace account. Agents can assist the consumer in creating his or her account if needed, but the consumer or a legally authorized representative must create his or her own Marketplace username

and password and should not share this information with third parties, including agents.

- Once completed, agents will help the consumer as he or she completes the eligibility application on the Marketplace website.

- In the application, the consumer will be prompted to enter the agent's Marketplace User ID and NPN on the application to indicate that an agent assisted him or her.

  NOTE: In order to receive compensation for this sale, agents must provide this information to the consumer and ensure that the consumer correctly fills in this information.

- The consumer will then receive an eligibility determination. Please have the consumer print this for his or her records.

- If determined eligible, have the consumer use the plan shopping feature on Healthcare.gov. You can assist the consumer in comparing qualified health plans on the Marketplace website and submitting his/her selection.

3-Way Call

If for some reason the Marketplace website is not available, agents can arrange a 3-way call between themselves, the consumer and the Marketplace Call Center (1-800-318-2596). The Marketplace Call Center representative will take the application over the phone and advise of the eligibility determination. Consumers can then select a plan and complete the application.

NOTE: In order to receive compensation for this sale, agents must be on the phone with the consumer and Call Center representative to complete an application and/or make a plan selection. The Call Center representative will record the agent's information and ensure it is part of the enrollment application at the consumer's request.

Off Marketplace Enrollments

Federal law requires Florida Blue to make available the exact same plans offered through the Marketplace for Off Marketplace enrollments. Off Marketplace plans do not go through the Marketplace and will not receive any tax credits or cost sharing reductions. Off Marketplace Enrollments can be completed via SalesConnect, CWS or paper applications.

Marketplace Special Enrollment Periods

Federal guidance provides consumers with a 60-day election period (in most cases) for the special and limited open enrollment rights in the individual market when they experience certain significant life changes. For the most up-to-date information, refer to the CMS website for The Center for Consumer Information & Insurance Oversight (CCIIO). The

Marketplace provides an explanation of special enrollment periods to consumers: https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period.

NOTE: SEPs for the Group Market will provide for a 30-day special enrollment period.

Cancellations

A Cancellation transaction is a withdrawal of a plan selection for health insurance coverage before the effective date of coverage. Cancellations can be initiated by the issuer when the applicant does not pay the binder payment by the binder payment deadline, or by the applicant if they select coverage from a different issuer or decide prior to the effective date to decline coverage.

Terminations/Reinstatements

Termination of coverage can either be voluntary or involuntary and occurs after the coverage effective date and the contract has been effectuated by a successful binder payment. Some of the reasons for involuntary termination include fraud, non-payment of premium after exhausting the grace period and loss of eligibility for coverage in a Marketplace QHP. Florida Blue or the Marketplace can initiate involuntary termination of an individual's enrollment in a Marketplace plan.

Involuntary Termination

Termination for Fraud

Florida Blue (and any QHP issuer) may terminate an enrollee if he/she knowingly performs an act, intentional misrepresentation, practice, or omission that constitutes fraud defined by state-specific rules. The Marketplace may also terminate an enrollee when it has determined that an enrollee has committed fraudulent activity while doing business with the Marketplace.

Termination for Non-Payment of Premiums

Florida Blue is permitted to terminate coverage for enrollees who fail to make full payment of their monthly premium. For enrollees who receive APTC and have paid at least one month of premium in full, Florida Blue must observe a three-month grace period before termination can occur. For enrollees who do not receive APTC and have paid at least one month of premium in full, Florida Blue must observe a one-month grace period before termination can occur.

Voluntary Termination

Members may voluntarily request termination through the Marketplace. The Marketplace must permit an enrollee to terminate his or her coverage in a QHP, including as a result of the enrollee obtaining other minimum essential coverage, with appropriate notice to the Marketplace or Florida Blue for off-Marketplace coverage.

Return to Agent Compliance Reference Guide By Section

Retroactive Enrollments

The purpose of a retroactive enrollment is to adjust a member's effective date of coverage. Retroactive enrollments can be for an enrollment or termination and can occur when an unforeseen life event takes place. Examples include, but are not limited to, a birth, death, Marketplace or Florida Blue error such as incorrect data being manually entered from a paper application, or from an administrative process, like an eligibility appeal decision.

Grievance & Appeals

Florida Blue has established processes for allowing its members to submit a grievance and/or appeal a decision made that will affect coverage of services they receive and provides this information via its member contract documents.

Marketplace Grievance and Appeals Requirements

The grievance and appeals processes for members enrolled in Individual Marketplace plans are the same as the requirements that apply to group health coverage. Accordingly, Florida Blue is subject to the Department of Labor (DOL) claims procedure regulation that is the same as those for group health plans. Florida Blue complies with the additional standards outlined above that are imposed on group health insurance coverage. Resource for Marketplace Appeals: https://www.healthcare.gov/marketplace-appeals/

Mental Health Parity and Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addition Equity Act of 2008 requires that health plans provide mental health and/or substance use benefits be equal to medical and surgical benefits. Florida Blue will provide this coverage in accordance with the law for its applicable small and large group products for new sales and renewals effective on or after July 1, 2014.

Cancer Treatment Fairness Act (Cancer Parity)

Effective July 1, 2014, non-grandfathered and HMO health plans in Florida that include coverage for cancer treatment medications must also cover prescribed, orally administered cancer treatment medications with cost sharing requirements that are no less favorable than intravenous or injected cancer treatment medications offered under the policy. This law establishes cost parity between cancer prescription drugs taken by mouth and cancer medications covered under the medical benefit. Florida Blue will include this benefit in its applicable Individual Under 65, Small Group and Large Group plans, per Florida Statutes.

NOTE: This does not apply to grandfathered health plans or to BlueMedicare Supplement, dental, vision, long-term care, disability, accident only, specified disease policies, or other supplemental limited-benefit plans.

Return to Agent Compliance Reference Guide By Section

Paper Applications

Paper Applications can only be used to apply for off-Marketplace coverage. There are no paper applications available for Marketplace enrollment--all enrollments are completed electronically.

Florida Blue requires agents to comply with timely application submission timelines and requires signed, dated and complete paper enrollment applications to be submitted with binder or premium payment. Failure to follow Florida Blue's requirements may result in non-compliant enrollment processes, including processing delays which can impact the enrollees' requested effective date of coverage and/or the agent's commission payments.

- Agents must sign and date every application.
- Paper applications received in-hand from the consumer should be reviewed to ensure all fields are completed and that the consumer has both signed and dated the form. If the consumer is still present, the agent should obtain any missing information. Otherwise, the agent can contact the consumer via phone or e-mail. A check should accompany all paper application submissions.
- Applications left with the consumer for future action should be signed by the agent, **but not dated**.
- Submit all paper enrollment applications to Florida Blue. The completed application should be sent via U.S. mail, overnight mail or hand delivered to Florida Blue at the following addresses. Agents can contact the Agent Service Center at 1-800-267-3156 to obtain the status of their paper application.

For Individual Under 65 Paper Applications:

U.S. Mail	Hand Delivery
Florida Blue P. O. Box 44236 Jacksonville, FL 32232	Florida Blue Enrollment, Maintenance & Billing Department 4800 Deerwood Campus Parkway, DC4-4 Jacksonville, Florida 32246

Return to Agent Compliance Reference Guide By Section

COMPLAINTS, ALLEGATIONS, MARKETING MISREPRESENTATIONS AND THE AGENT OVERSIGHT AND MONITORING PROCESS - COMMERCIAL

For general complaints, marketing misrepresentations, and oversight information, refer to Section I – General Compliance (Complaints, Allegations, Marketing Misrepresentations and the Agent Oversight and Monitoring Process).

Marketplace Complaints

HHS maintains a call center for consumers who need assistance and logs calls into its Health Insurance Casework System (HICS). Types of calls received include complaints about a specific person (agents) or entity (health insurance issuer).

Pursuant to federal guidelines, Florida Blue investigates, as appropriate, consumer complaint cases forwarded by HHS and works closely with its Account Manager to facilitate satisfactory resolution of cases in a timely manner. All cases are recorded in the Health Insurance Casework System and are assigned an Issue Level. If CMS receives a consumer complaint about an issuer's marketing activities or about an agent's, broker's, or Web-broker's conduct which is generally overseen by the state, CMS will send the complaint to the State Department of Insurance, as appropriate, for investigation. Following the state's investigation, CMS may take the necessary enforcement action against the issuer or agent, broker, or Web-broker. Florida Blue will utilize its Agent Corrective Action process when Marketplace complaints pertaining to sales and marketing activities that involve a specific agent(s) are received.

CMS will examine trends in complaint data to assist with evaluating the compliance of issuers and the performance of their QHPs. Florida Blue will perform analyses of complaint data in the Marketplace complaint process on an on-going basis to determine opportunities for improvement and will work with the appropriate area(s) to initiate corrective actions.

SECTION III – MEDICARE SUPPLEMENT PRODUCTS

The topics described in this section are specific to Medicare Supplement products. For information applicable to all product lines refer to Section I – General Compliance.

AGENT TRAINING, TESTING AND CERTIFICATION

For general agent training information, refer to Section I – General Compliance (Agent Training, Testing and Certification). This section is specific to Medicare Supplement products.

Florida Blue provides an effective training program with information about its BlueMedicare Supplement products. In addition, agents must successfully complete Florida Blue's CMS Certification/Re-certification Program which covers Medicare (overview, enrollment, disenrollment, communication and marketing requirements and regulations), Florida Blue's Code of Ethical Business Conduct (Compass Program) and all BlueMedicare specific product training.

NOTE: While not required by CMS or the OIR, Florida Blue does require agents to complete the CMS Certification/Re-certification Program before selling BlueMedicare Supplement Plans.

Florida Blue believes that each Medicare beneficiary should be able to understand the benefits of the plans they are reviewing and select the right health care and/or prescription drug coverage that meets their personal needs. The company recognizes that agents play a significant role in helping Medicare beneficiaries with their coverage choices.

Florida Blue expects each agent selling its BlueMedicare Supplement plans to be highly qualified and properly trained according to the company's mission, vision, values, policies, and procedures.

In accordance with Florida Blue policy:

- Appointed agents will not be authorized/certified to sell BlueMedicare Supplement plans until all training requirements are completed and documented.
- Initial and renewal sales commissions will not be paid for enrollments made by an agent who is not appropriately and fully certified.
- Agents must remain in good standing and complete re-certification training and testing annually to continue to be paid renewals.

- Florida Blue may require re-training and/or re-certification of any appointed agent at any time, if sales allegations, complaints and/or marketing misrepresentations are identified.

CMS Certification/Re-certification Program

Florida Blue provides its appointed agents with on-line modules that contain training and testing requirements, agent requirements and resource links. These modules are part of the CMS Certification/Re-certification Program. Agents must complete and pass an initial certification along with an annual re-certification in order to be authorized/certified to sell BlueMedicare Supplement plans.

Initial CMS Certification	Annual CMS Re-Certification
Florida Blue CMS Certification Program for the **current** contract year is valid from the date certification is completed/passed through December 31. The agent will be eligible to sell BlueMedicare Supplement plans with effective dates beginning the first of the month following the date the certification was completed/passed through December 1.	Florida Blue CMS Re-Certification Program for the **upcoming** contract year is valid from January 1 through December 31. Agent will be eligible to sell BlueMedicare Supplement plans with effective dates beginning January 1 through December 1.
Agents must complete all five modules of Florida Blue's CMS Certification/ Re-Certification Program (or the AHIP training modules for designated agents) with a passing score of 85% or higher in order to be issued a certificate of completion.	

The following five modules are part of the CMS Certification/Re-certification Program:

- Overview of Medicare to include Medicare basics, its parts and covered services for Original Medicare, Medicare Advantage (Part C), Medicare Prescription Drug Coverage (Part D), along with applicable premiums and beneficiary rights and protections.

- Enrollment and Disenrollment (Part C, D, and Section 1876 Cost Plans) consisting of enrollment periods and effective dates, enrollment procedures, processing enrollment requests, and disenrollment.

- Communication and Marketing Requirements and Regulations which covers an overview of Medicare marketing, sales and events, along with agent and broker compensation.

Return to Agent Compliance Reference Guide By Section

- Business Ethics, Integrity and Compliance (Compass Program) which includes GuideWell's Compliance monitoring, Compass Code of Ethical Business Conduct, Fraud, Waste and Abuse, along with privacy and security.

- Florida Blue's comprehensive Medicare product information and training, to include the Medicare Supplement, Medicare Advantage (Part C) and Prescription Drug coverage (Part D) lines of business.

Florida Blue maintains its training records in accordance with Records Retention requirements outlined in Section I – General Compliance (Records Retention)

On-Going Communications

Sales Bulletins and Agent Bulletins are utilized to inform and educate agents on new or relevant topics. Regular calls and/or meetings are held with agents to answer questions about benefits, network, and to obtain insight regarding the public's reaction to the products being offered.

Return to Agent Compliance Reference Guide By Section

ELIGIBILITY AND ENROLLMENT

This section is specific to Medicare Supplement eligibility and enrollment.

Eligibility for Medicare Supplement

During the open enrollment period, individuals who become eligible for Medicare Part A and B due to age or disability, including end stage renal disease (ESRD), have an opportunity to apply for a Medicare Supplement plan without discrimination in the pricing of the policy, regardless of their medical history, health status, or claims experience. This period last 6 months and begins the first day of the month in which an individual is both 65 or older and enrolled in Medicare Part B. After the Medicare Supplement open enrollment period, an individual would undergo medical underwriting unless qualified for a guaranteed issue right.

Enrollment Time Periods

The chart below summaries the open enrollment periods for Medicare Supplement:

Age 65 or Older	Under Age 65
The open-enrollment period for Medicare Supplement insurance begins the first day of the month a person turns 65 and is enrolled in Medicare Part B. If a birthday falls on the first day of the month, Medicare Part B coverage and Medicare supplement insurance open enrollment begins the first day of the previous month. If the individual did not enroll in Medicare Part B upon becoming age 65 and chooses to do so at a later date, they will have 6 months from the Medicare Part B effective date in which to obtain a guaranteed issue Medicare Supplement policy. In addition, there is a 2-month period following termination of employer-based group health coverage for an individual to have the same guaranteed issue rights.	Individuals that become eligible for Medicare Part A and B due to disability, including ESRD, have an open enrollment period in which they have 6 months to obtain a guaranteed issue Medicare Supplement plan. They will have another open enrollment period when they turn 65 years old. They must apply for a new plan in order to receive a lower premium. Medicare Supplement rates for individuals with ESRD or on disability are higher than for those eligible for Medicare due to age. The individual will be eligible for the lower rate after turning 65 years of age. Additionally, there is a 2-month period following termination of employer-based group health coverage for an individual to have the same guaranteed issue rights.

Return to Agent Compliance Reference Guide By Section

Enrollment

In order to meet consumers' needs, Florida Blue provides its agents with the following commonly used methods for completing BlueMedicare Supplement Plan applications:

- Telephone Enrollment
- SalesConnect Online Enrollments
- Paper Enrollment

NOTE: Any other method of enrollment needs to be approved by Florida Blue.

In addition, Florida Blue also offers beneficiaries the option to complete an enrollment without agent assistance on Florida Blue's dedicated Medicare website, www.floridablue.com/Medicare. Note: If the beneficiary needs help and calls the 800-number provided in the application portal on the website, a licensed agent is available to provide assistance.

Medicare Supplement Guaranteed Issue

Florida Blue follows all federal and state guidance for guaranteed issue of its plans, as appropriate.

Medicare Supplement Guaranteed Issue is granted to eligible persons who seek to enroll in a Medicare Supplement policy during the appropriate guaranteed issue time periods and submit with their application for a Medicare Supplement policy, evidence of their date of termination or disenrollment from other health care coverage.

Guaranteed Renewability

Florida Blue provides guaranteed renewability of coverage for its individual members. The company will only cancel, non-renew or discontinue a contract if the member has failed to pay premiums, committed fraud or made a material misrepresentation, failed to comply with a material provision of the plan, the plan will no longer offer coverage in a market, and/or no enrollees live or work in the service area.

If a plan will no longer be offered, Florida Blue will provide notice to members at least 90 days prior to the date of the non-renewal of coverage and will offer any other available coverage in that market and uniformly apply this to all contract holders regardless of their claims experience.

BlueMedicare Supplement Enrollments

Per Florida statutes, Medicare Supplement insurance may not be issued or sold to an individual unless the individual signs a written statement indicating what Medicare Supplement policies the individual has, from what source, and whether he/she has applied for and been determined to be entitled to Medicaid. This written statement must be accompanied by a written acknowledgement signed by the selling agent of the request for

and receipt of the statement. This is met by completing Florida Blue's BlueMedicare Supplement applications which include the required components.

If the individual states he/she currently has Medicare Supplement coverage, new coverage cannot be issued or sold unless the individual provides a written statement indicating that the new policy will replace the other policy and intends to terminate the existing policy when the new policy becomes effective. This is met by completing Florida Blue's BlueMedicare Supplement applications. In this instance, Florida Blue is required to forward the individual's statement to the insurer whose policy is being replaced.

Additionally, Medicare Supplement insurance may not be issued or sold if an individual is entitled to Medicaid. For existing policyholders who become eligible for Medicaid, upon request, Florida Blue must suspend the benefits and premiums of the Medicare Supplement policy during the period entitled to Medicaid, not to exceed 24 months. If Medicaid entitlement is lost and the policyholder provides notice within 90 days after the loss of entitlement, the policy will be automatically reinstated as of the termination of Medicaid entitlement. This language is included in Florida Blue's BlueMedicare Supplement applications.

Enrollment Channels

Florida Blue provides its agents with the following three commonly used methods for completing Medicare Supplement enrollment requests:

- Telephone Enrollment
- SalesConnect Online Enrollment
- Paper Enrollment

Note: Agency/Agent should obtain approval from Florida Blue for enrollment methods not described in this section.

Beneficiaries also have the option to complete enrollment by utilizing:

- Florida Blue's Website

Telephone Enrollments

Florida Blue operates a year-round telephone enrollment service for all of its agents. Other than face-to-face appointments, agents should use this preferred method for enrolling a member. Paper applications should only be used when the situation dictates its use (e.g., after a sales seminar, walk-ins) and use of the telephonic enrollment process (for telephone enrollments conducted by agents) or SalesConnect (for face-to-face ONLY) is not practical.

SalesConnect Online Enrollments

SalesConnect is a Florida Blue developed web-based enrollment tool that is used by both internal and external agents. SalesConnect method of enrollment is also

Return to Agent Compliance Reference Guide By Section

considered an electronic enrollment. As such, agents should:

- Ensure the beneficiary has all of the appropriate plan and benefit information **prior** to enrolling;
- Advise each individual at the beginning of the online enrollment process that he/she is sending an actual enrollment request to Florida Blue;
- Ensure the beneficiary physically clicks on the Consent to Contract acknowledgement page that indicates his/her intent to enroll. This serves as a legal and valid signature that is enforceable by law.

Paper Applications

BlueMedicare Supplements enrollments can be submitted via paper.

Florida Blue requires agents to comply with timely application submission timelines and requires signed, dated and complete paper enrollment applications to be submitted with binder or premium payment. Failure to follow Florida Blue's requirements may result in non-compliant enrollment processes, including processing delays which can impact the enrollees' requested effective date of coverage and/or the agent's commission payments.

- Agents must sign and date every application.
- Paper applications received in-hand from the consumer should be reviewed to ensure all fields are completed and that the consumer has both signed and dated the form. If the consumer is still present, the agent should obtain any missing information. Otherwise, the agent can contact the consumer via phone or e-mail. A check should accompany all paper application submissions.
- Applications left with the consumer for future action should be signed by the agent.
- Submit all paper enrollment applications to Florida Blue. The completed application should be sent via U.S. mail, overnight mail or hand delivered to Florida Blue at the addresses listed below. Agents can contact the Agent Service Center at 1-800-267-3156 to obtain the status of their paper application.

Send Medicare Supplement paper applications (in the appropriate envelope) to:

U.S. Mail (Regular) and Overnight Mail

Florida Blue
Attn: CCR
Building 100, 5th Floor
4800 Deerwood Campus Parkway
Jacksonville, Florida 32246

Return to Agent Compliance Reference Guide By Section

Florida Blue Website

Medicare Supplement applications can be completed without agent assistance on Florida Blue's dedicated website, www.floridablue.com/Medicare. Note: If assistance is needed by an enrollee and he/she calls the 800 number provided in the application portal on the website, a licensed agent is available to provide assistance.

Return to Agent Compliance Reference Guide By Section

SECTION IV – MEDICARE ADVANTAGE PLAN (PART C) AND PRESRIPTION DRUG PLAN (PART D) PRODUCTS

The topics described in this section are specific to Medicare Advantage Plan (also referred to as "MA-MAPD Plan") and Prescription Drug Plan (also referred to as "Part D Sponsor") products. For information applicable to all product lines refer to Section I – General Compliance.

AGENT TRAINING, TESTING AND CERTIFICATION

For general agent training information, refer to Section I – General Compliance (Agent Training, Testing and Certification). This section is specific to Medicare Advantage Plan (also referred to as "MA-MAPD Plan") and Prescription Drug Plan (also referred to as "Part D Sponsor") products.

To help agents sell BlueMedicare plans, and as part of Florida Blue's contractual obligations with CMS, an effective training program is provided with information about Medicare (overview, enrollment, disenrollment, communication and marketing requirements and regulations), Florida Blue's Code of Ethical Business Conduct (Compass Program) and BlueMedicare specific product training.

Florida Blue believes that each Medicare beneficiary should be able to understand the benefits of the plans they are reviewing and select the right health care and/or prescription drug coverage that meets their personal needs. The company recognizes that agents play a significant role in helping Medicare beneficiaries with their coverage choices.

Florida Blue expects each agent selling its BlueMedicare plans to be highly qualified and properly trained according to the company's mission, vision, values, policies, and procedures. Florida Blue must notify beneficiaries who were enrolled in their plans by an unqualified agent (unlicensed or failure to comply with training or testing requirements) and advise those beneficiaries of the agent's status. Upon notification, the beneficiaries may request to make a plan change (special enrollment period).

In accordance with CMS guidance and Florida Blue policy:

- Appointed agents will not be authorized/certified to sell BlueMedicare plans until all training requirements are completed and documented.
- Initial and renewal sales commissions will not be paid for enrollments made by an agent who is not appropriately and fully certified.
- Agents must remain in good standing and complete re-certification training and testing annually to continue to be paid renewals.

- Florida Blue may require re-training and/or re-certification of any appointed agent at any time, if sales allegations, complaints and/or marketing misrepresentations are identified.

CMS Certification/Re-certification Program

Florida Blue provides its appointed agents with on-line modules that contain training and testing requirements, agent requirements and resource links. These modules are part of the CMS Certification/Re-certification Program. Agents must complete and pass an initial certification along with an annual re-certification in order to be authorized/certified to sell BlueMedicare plans.

Initial CMS Certification	Annual CMS Re-Certification
Florida Blue CMS Certification Program for the **current** contract year is valid from the date certification is completed/passed through December 31. The agent will be eligible to sell BlueMedicare plans with effective dates beginning the first of the month following the date the certification was completed/passed through December 1.	Florida Blue CMS Re-Certification Program for the **upcoming** contract year is valid from January 1 through December 31. Agent will be eligible to sell BlueMedicare plans with effective dates beginning January 1 through December 1.
Agents must complete all five modules of Florida Blue's CMS Certification/ Re-Certification Program (or the AHIP training modules for designated agents) with a passing score of 85% or higher in order to be issued a certificate of completion.	

The following five modules are part of the CMS Certification/Re-certification Program:

- Overview of Medicare to include Medicare basics, its parts and covered services for Original Medicare, Medicare Advantage (Part C), Medicare Prescription Drug Coverage (Part D), along with applicable premiums and beneficiary rights and protections.

- Enrollment and Disenrollment (Part C, D, and Section 1876 Cost Plans) consisting of enrollment periods and effective dates, enrollment procedures, processing enrollment requests, and disenrollment.

- Communication and Marketing Requirements and Regulations which covers an overview of Medicare marketing, sales and events, along with agent and broker compensation.

Return to Agent Compliance Reference Guide By Section

- Business Ethics, Integrity and Compliance (Compass Program) which includes GuideWell's Compliance monitoring, Compass Code of Ethical Business Conduct, Fraud, Waste and Abuse, along with privacy and security.

- Florida Blue's comprehensive Medicare product information and training, to include the Medicare Supplement, Medicare Advantage (Part C) and Prescription Drug coverage (Part D) lines of business.

Florida Blue maintains its training records in accordance with Records Retention requirements outlined in Section I – General Compliance (Records Retention).

Ongoing Communications

Florida Blue will issue Agent Bulletins to inform and educate its agents on new or relevant topics. Conference calls with agents are held to answer questions about benefits, network, and to obtain insight regarding the public's reaction to the BlueMedicare plans offering for the coming year.

Return to Agent Compliance Reference Guide By Section

SALES

For general sales information, refer to Section I – General Compliance (Sales). This section is specific to Medicare Advantage Plan (also referred to as "MA-MAPD Plan") and Prescription Drug Plan (also referred to as "Part D Sponsor") products.

Contacting Beneficiaries

MA-MAPD Plans and Part D Sponsors may make unsolicited direct contact with potential enrollees using the following methods:

- Conventional mail and other print media (e.g., advertisements, direct mail)
- Email provided all emails contain an opt-out function

MA-MAPD Plans/Part D Sponsors may not:

- Use door-to-door solicitation, including leaving information such as a leaflet or flyer at a residence;
- Approach potential enrollees in common areas (e.g., parking lots, hallways, lobbies, sidewalks, etc.); or,
- Use telephonic solicitation, including text messages and leaving electronic voicemail messages.

*NOTE**:** Agents/brokers who have a pre-scheduled appointment with a potential enrollee who is a "no-show" may leave information at that potential enrollee's residence.*

Sales Leads

CMS permits leads to be generated through mailings, emails, websites, advertising and public sales events. Plans should not make unsolicited telephone calls to market BlueMedicare Plans.

Sending information to leads via conventional mail and email are the only CMS-approved contact methods. The exception to this requirement is if the beneficiary has given their express permission to be contacted in that manner.

Agent Referrals

Agents can receive referrals but must not solicit them. This means agents cannot ask their current clients, friends, relatives, neighbors, etc. for referral business or leads.

If an individual would like to refer a friend or relative to an agent, the agent should provide their contact information (i.e., business card), to the individual so it can be given to the friend/relative. ***In all cases, a referred beneficiary must contact the agent directly.***

Return to Agent Compliance Reference Guide By Section

Sales Appointment

The only plans allowed to be discussed during a BlueMedicare sales appointment is based on the selection of plans made by the beneficiary prior to the meeting. Non-health care related products are not allowed during these meetings so as to protect beneficiaries from being subjected to lengthy sales appointments reviewing plans that are of no interest. CMS refers to this as cross-selling. Therefore, CMS requires:

- Beneficiaries must designate in advance of the sales appointment which plans they want to discuss during their sales appointment (documented on a Scope of Appointment (SOA) form).

- Cross-selling of non-health care related products is not allowed during a sales appointment to discuss Medicare Advantage and/or Part D plans (i.e., BlueMedicare plans).

Scope of Appointment (SOA)

The Scope of Appointment concept was introduced as one of several methods to help CMS ensure beneficiary protections against deceptive marketing practices. The SOA form is only used for BlueMedicare HMO, PPO, and Rx (PDP) plans.

Agents selling products (including Medicare Advantage plans and/or Prescription Drug plans) as well as outreach to existing or potential beneficiaries and answering or potentially answering questions from existing or potential beneficiaries must secure and document a SOA prior to meeting with potential enrollees. The SOA form must be signed by the beneficiary.

Agents may only discuss the plans that are documented on the SOA form. If the beneficiary requests to discuss a plan(s) not originally indicated on the SOA that is not a Medicare Supplement plan or non-health care related product (cross-selling), a second SOA MUST be completed for the additional product type and signed by the beneficiary before proceeding.

SOA documentation is not required for sales and marketing events/presentations, as the products to be discussed are mentioned in the advertising and/or presentation materials for the event. SOAs are required to be maintained for 11 years.

Telephonic Scope of Appointments - Florida Blue utilizes a telephonic SOA process which is the preferred method for documenting the plans to be discussed during the sales appointment. CMS only allows MA-MAPD Plans and Part D Sponsors such as Florida Blue to perform and record telephonic SOAs. Agencies/agents are not permitted to use their own independent system to perform telephonic SOAs.

Paper Scope of Appointments - Paper SOA forms are available for use and should generally be used in those situations where obtaining a telephonic SOA is not feasible. Agents should use the most current version of the SOA form which is available on the AgentPoint website.

Return to Agent Compliance Reference Guide By Section

Cross-Selling Prohibition

Florida Blue, in accordance with CMS guidelines, prohibits agents from cross-selling non-health care related products during any sales/marketing activity of our BlueMedicare products. Examples of non-health care related products include:

- Accident-only policies
- Life insurance policies
- Annuities

If during a sales appointment, the beneficiary wants to discuss a non-health care related product, agents must arrange for another appointment with the beneficiary.

CMS also requires that hold time messages (recorded information played to a caller while waiting on hold) may not include information on non-health related services (e.g., financial service information, life and variable annuities information, etc.) Hold time messages that discuss health-education features and other general information (e.g., hours of operation, flu shot reminders) are allowed. Agencies/agents must adhere to this requirement.

Enrollment Guide and Sales Appointment Channels

Florida Blue produces an enrollment guide in accordance with CMS guidance. Agents must review and discuss the materials so the beneficiary will understand the information provided in the enrollment guide. Note: CMS requires that when a beneficiary enrolls online, Florida Blue must make these materials available electronically (i.e., via website link) to the beneficiary PRIOR to the completion and submission of the enrollment request.

The enrollment guide must include the following:

- Pre-Enrollment Checklist – It is a list of important disclaimers to ensure the beneficiary fully understands the selected plans' benefits and rules.
- Summary of Benefits – The Summary of Benefits (SB) document provides BlueMedicare plan information (benefits, co-insurance, co-pays, monthly plan premium, etc.) compared to Original Medicare benefits.

  Enrollment Form – This includes the actual enrollment form along with the instructions the beneficiary can follow for completing their enrollment request. *CMS requires that whenever a beneficiary is provided with an enrollment form/instructions, he/she MUST ALSO RECEIVE a CMS Star Ratings Sheet and the Summary of Benefits document.*

  CMS Star Rating Sheet – The Star Rating Sheet (*also known as the CMS Plan Rating Sheet)* is a CMS-issued document given to Florida Blue that provides its overall quality performance rating based on several different factors, such as beneficiary surveys, number of complaints, call center performance, service

performance metrics, etc. Florida Blue also posts its CMS Star Rating Sheet on its website, www.floridablue.com/medicare, per CMS requirements.

NOTE: Pharmacy and Provider directories are available upon request. Agents should ensure they can access the directories online or have a hard copy of each directory on hand when meeting with a beneficiary in order to determine if the prospect's providers are available in Florida Blue's networks. For the most up-to-date information about in-network providers, refer to, and select the Doctors & Prescriptions tab.

Face-to-Face Appointments

When meeting with beneficiaries, agents must ensure they have copies of the required enrollment guide materials listed above. The enrollment guide materials should also be available for the beneficiary to take after the sales appointment.

Telephone Sales Calls (Applicable to ALL Calls Regarding BlueMedicare Plans)

Agents may conduct sales activities from inbound calls or from an outbound call placed in response to a permission to contact, or from returning a prospect's phone call.

NOTE: All calls must be recorded with beneficiaries in their entirety, including the enrollment process.

Florida Blue provides agents with telephone sales scripts (inbound and outbound) that have been approved by CMS and must be for all inbound or outbound telephone sales calls. Sales scripts must be spoken verbatim for the applicable product(s).

As previously stated, marketing or enrolling other lines of business (cross-selling of non-health care related products) is prohibited.

When a sales call results in the beneficiary making a decision to purchase, the beneficiary must be informed and agree to the nature of the call changing from sales to telephonic enrollment (recorded confirmation of intent to enroll). *Enrollment requests must be initiated entirely by the beneficiary.*

Authorized Representatives

Consumers who are unable to sign an enrollment form or disenrollment request or complete an enrollment request mechanism due to reasons such as physical limitations or illiteracy may have a legally authorized representative who can make health care decisions on their behalf. Generally, a court-appointed legal guardian, persons having Durable Power of Attorney for health care decisions or individuals authorized to make health care decisions under Florida surrogate consent laws (i.e., health care surrogate) are authorized to act on the consumer's behalf in this capacity. *See Florida Laws: FL Statutes - Title XLIV Chapter 765 Health Care Advance Directives, Part II - Health Care Surrogate (ss. 765.201-765.205).*

Return to Agent Compliance Reference Guide By Section

Enrollment and Verification (EV) Checklist

Florida Blue requires that agents utilize the EV Checklist during every sales appointment to ensure that all required information has been discussed with the beneficiary. The EV Checklist also helps ensure the beneficiary understands the plan he/she has purchased. After the agent has reviewed the checklist with the beneficiary, the beneficiary receives a copy and the agent keeps a copy for his/her records. Florida Blue expects that proper use of the EV Checklist will reduce beneficiary complaints about not understanding the plan they purchased as well as agent misrepresentations. The EV form has been updated to allow the agent to capture the providers and prescriptions verified for the client during the appointment.

CMS Medicare Communications and Marketing Guidelines

Agents must comply with the most current CMS Medicare Marketing Guidelines while representing, soliciting and selling BlueMedicare plans. The chart below provides guidance on the prohibited marketing and sales activities as well as recommendations of permissible activities and solutions. NOTE: This is not an all-inclusive list.

Prohibited Marketing Activities	**Allowed Marketing Activities**
• Do not use any means of direct, unsolicited contact of a beneficiary without the beneficiary initiating the contact or giving express permission to be contacted. This includes: 1. Door-to-door solicitation 2. Any outbound telemarketing • Contact through any other unsolicited means of direct contact, including calling a beneficiary without the beneficiary initiating the contact or giving express permission to be called (example – contacting a beneficiary who attended a sales event and did not give permission for contact); • Leaving a voice-mail message or sending a text message.	• Mail (USPS, etc.) information to beneficiaries to determine their interest in BlueMedicare plans. • Contact beneficiaries by phone who have given their permission to be contacted by providing their phone number. *Note: This assumes the beneficiary is aware that by providing their phone number and/or e-mail address, they will be contacted by a Florida Blue agent.* • Return a beneficiary's phone call • May initiate contact via email to prospective enrollees and to retain enrollment for current enrollees provided an opt-out mechanism is on each communication.

Return to Agent Compliance Reference Guide By Section

<u>**Prohibited**</u> **Marketing Activities**	<u>**Allowed**</u> **Marketing Activities**
• Agents must never approach beneficiaries in common areas such as: ○ Parking lots ○ Hallways ○ Hobbies ○ Sidewalks ○ Leaving information (leaflets) at a residence or on someone's car	
• Claim within their marketing materials or make statements that they are recommended or endorsed by CMS, Medicare, or the Department of Health & Human Services (HHS). 1. *"endorsed or employed by Medicare"* 2. *"calling on behalf of Medicare"* 3. *"calling for Medicare"* 4. *"Medicare certified"* 5. *"Medicare recommends that beneficiaries enroll in a BlueMedicare plan."*	• Agents can state that Florida Blue is contracted to administer Medicare benefits. • Agent can state that Florida Blue is approved for participation in Medicare programs. • Agents can state that their sales/marketing materials are approved by CMS. *Note: This assumes that the material has been submitted/approved by CMS. This statement is true if the material has a material ID number in the lower left or right position on the first page of the material. If a material ID number does not appear at the bottom with either "Accepted" or "Approved", do not state the material is CMS-approved.*
• Use unsubstantiated absolute or qualified superlatives or pejoratives. (Exception: CMS notes that unsubstantiated absolute and/or qualified superlatives may be used in logos/taglines.)	• Agents who are appointed with Florida Blue and sell BlueMedicare plans are employed or contracted with Florida Blue, not Medicare and should state *"I am a contracted Florida Blue agent" or "I am employed with Florida Blue".* • Agents who sell BlueMedicare are certified by Florida Blue, not Medicare

Return to Agent Compliance Reference Guide By Section

Prohibited Marketing Activities	**Allowed Marketing Activities**
	• Should state *"I am an agent certified by Florida Blue to sell BlueMedicare plans".* • Agents can describe BlueMedicare benefits and services as *"Medicare-approved"* and should use statements such as *"Our plans are Medicare-approved by CMS".*
• Use the term "free" to describe a zero-dollar premium, reduction in premiums (including Part B buy-down), reduction in deductibles or cost sharing, low-income subsidy, cost sharing for individuals with dual eligibility.	• May compare MA-MAPD Plan/Part D Sponsor to another MA-MAPD Plan/Part D Sponsor, provided the MA-MAPD Plans/Part D Sponsors can support and such comparisons are factually based and not misleading.
• Distributing marketing materials and making verbal statements at all sales presentations and/or meetings that are materially inaccurate, misleading, or otherwise make material misrepresentations.	• Agents should thoroughly review all sales and marketing materials prior to any sales presentations and/or meetings to ensure they are making true and accurate statements about information contained in BlueMedicare materials.

Medicare Advantage and Prescription Drug Communication Requirements for Third Party Marketing Organizations (TPMO)

CMS defines TPMOs as 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 (the steps taken by a beneficiary from becoming aware of an MA plan or plans to making an enrollment decision). TPMOs may be a first tier, downstream or related entity (FDRs), but may also be entities that are not FDRs but provide services to an MA plan or an MA plan's FDR.

Return to Agent Compliance Reference Guide By Section

Agent, Broker, and Other Third-Party Requirements
TPMO must disclose to Florida Blue any subcontracted relationships used for marketing, lead generation, and enrollment.
TPMO must record all calls with beneficiaries in their entirety, including the enrollment process.
TPMO must report monthly any staff disciplinary actions or violations of any requirements that apply to the MA plan associated with beneficiary interaction to the plan.
TPMO must use the standardized TPMO disclaimer as required. The following disclaimer must be used by any TPMO that sells plans on behalf of more than one MA organization, unless the TPMO sells all commercially available MA plans in a given service area: ‘‘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 of your options.’’ The disclaimer must be: • Verbally conveyed within the first minute of a sales call. • Electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication. • Prominently displayed on TPMO websites. • Included in any marketing materials, including print materials and television advertisements, developed, used or distributed by the TPMO.
If conducting lead generating activities for Florida Blue, either directly or indirectly, the TPMO must disclose to the beneficiary that his or her information will be provided to a licensed agent for future contact. This disclosure must be provided as follows: • Verbally when communicating with a beneficiary through telephone. • In writing when communicating with a beneficiary through mail or other paper. • Electronically when communicating with a beneficiary through email, online chat, or other electronic messaging platform. When applicable, the TPMO must also disclose to the beneficiary that he or she is being transferred to a licensed agent who can enroll him or her into a new plan.
When a TPMO is not otherwise a FDR, the TPMO must adhere to any requirement that applies to the MA plan.

Return to Agent Compliance Reference Guide By Section

SALES MATERIALS

For general sales information, refer to Section I – General Compliance (Sales Materials). This section is specific to Medicare Advantage Plan (also referred to as "MA-MAPD Plan") and Prescription Drug Plan (also referred to as "Part D Sponsor") products.

CMS and Florida Blue's Material Approval Requirements

This section describes CMS and Florida Blue's material approval requirements regarding MA-MAPD Plan and Part D Sponsor advertising and sales/marketing materials to ensure compliance and prevent misrepresentations or violations of CMS' communication and marketing regulations and guidance.

According to the Code of Federal Regulations and the Medicare Communications and Marketing Guidelines, communications and marketing are defined as follows:

Communications	Marketing
Activities and use of materials created or administered by the plans or any downstream entity to provide information to current and prospective enrollees. All activities and materials aimed at prospective and current enrollees, including their caregivers are "communications" within the scope of the regulation. Where the term enrollee is used, whether a current or prospective enrollee, the term encompasses representatives of the enrollee who are authorized to act on the enrollee's behalf.	Subset of communications and must, unless otherwise noted, adhere to all communication requirements. To be considered marketing, communications materials must meet both intent and content standards. In evaluating the intent of an activity or material, CMS will consider objective information including, but not limited to, the audience, timing, and other context of the activities or material, as well as other information communicated by the activity or material. The organization's intent stated intent will be reviewed but not solely relied upon.

As outlined above, communication activities and materials are distinguished from marketing activities and materials based on both ***intent*** and ***content***.

Intent

Material or activities that CMS determines, as described above, are intended to:

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

Return to Agent Compliance Reference Guide By Section

Content

Materials or activities that include or address content regarding:

- The plan's benefits, benefits structure, premiums, or cost sharing;
- Measuring or ranking standards (for example, Star Ratings or plan comparisons); or
- Rewards and incentives as defined under 42 CFR § 422.134(a) (for MA and section 1876cost plans only)

To identify marketing activities and materials, CMS guidance indicates both the intent and content of the activities and materials should be evaluated to determine if the definition of marketing is met.

Agency/Agent Marketing Materials

Agencies/agents or other third parties are not permitted to submit materials directly to CMS. Only entities contracted with CMS (i.e., Florida Blue) may submit materials to CMS for approval. Florida Blue makes available advertising material templates, containing variable fields that can be customized by each agency. Agencies/agents must use these pre-approved templates for advertising purposes. *Electronic Marketing Organizations (EMOs) and Field Marketing Organizations (FMOs)* are an exception when marketing materials are submitted using the multi-plan marketing material submission process in the Health Plan Management System (HPMS) Marketing module.

- Pre-approved agency/agent template materials in Custom Docs will be stored on Agent Point.
  - Agents can use any of the approved template materials and only make edits to the bracketed sections of the PDF. Non-bracketed areas of the material are locked to prevent unauthorized edits to the material.
- Translated materials – translated versions of the template materials will also be available on Agent Point.
  - CMS requires certain materials to be translated into the language(s) that is/are the primary language of more than five percent (5%) of the plan's geographic service area. As of this writing, CMS has identified the Spanish language as meeting the 5% population requirement for the state of Florida.

Agency/Agent Ad Hoc Materials

Any other ad hoc agency/agent marketing materials that include the Florida Blue name, logo and/or specific BlueMedicare plan information must be sent to Florida Blue for review and approval before Florida Blue will submit the materials to CMS.

NOTE: Marketing materials should not be used by an Agency/agent prior to approval.

Return to Agent Compliance Reference Guide By Section

- Agency/agent must coordinate with their area manager/director to submit the ad hoc advertising materials to Florida Blue's Marketing Department.
    - Florida Blue's Marketing Department will follow the established internal process for material development and its review/approval process for submission to CMS.
    - Once approved by CMS, the agency/agent will be notified of the first date of approved distribution by Florida Blue.

No changes should be made to Florida Blue and CMS approved ad hoc advertising materials by the agency/agent without seeking reapproval of changes by Florida Blue. The final consumer facing CMS-approved material must be on file with Florida Blue.

Agency/Agent Websites

Any agency/agent website containing Florida Blue marketing content must be sent to Florida Blue for review and approval before Florida Blue will submit the materials to CMS. The initial website must be submitted as a Word document and contain the website's URL. Subsequent submissions with website updates must include the website's URL on a Word document and a summary of the changes.

NOTE: Marketing content should not be used on the website by an agency/agent prior to approval. Electronic Marketing Organizations (EMOs) and Field Marketing Organizations (FMOs) should submit marketing materials using the multi-plan marketing material submission process in the Health Plan Management System (HPMS) Marketing module.

- Agency/agent must coordinate with their area manager/director to submit the website content to Florida Blue's Marketing Department.
    - Florida Blue's Marketing Department will follow the established internal process for its review/approval process for submission to CMS.
    - Once approved by CMS, the agency/agent will be notified of the first date of approved distribution by Florida Blue.

No changes should be made to Florida Blue and CMS approved ad hoc advertising materials by the agency/agent without seeking reapproval of changes by Florida Blue. The final consumer facing CMS-approved material must be on file with Florida Blue.

Open Enrollment Period Marketing

Open enrollment period is the yearly period (January 1 through March 31) when a beneficiary can enroll in another Medicare Advantage plan or disenroll from their Medicare Advantage plan and return to Original Medicare. During the open enrollment period, Florida Blue can do the following:

- Market to age-ins;
- Market our 5-star plans (If Applicable);

Return to Agent Compliance Reference Guide By Section

- Market to LIS beneficiaries who have a quarterly SEP for the first 9 months of the year;
- If a beneficiary makes a request, we can provide them with marketing materials or discuss via an inbound call to member services, should they ask about it.

Additionally, Florida Blue is prohibited from doing the following during the open enrollment period:

- Send unsolicited marketing materials which either reference the OEP or the ability to make an enrollment change;
- Target prospects who are in OEP;
- Call or otherwise contact former members who made a new plan selection during the AEP.

Nominal Gifts

Florida Blue may offer nominal gifts ($15 or less, $75 aggregate, per person, per year) to beneficiaries for marketing purposes, provided the gift is given regardless of whether they enroll, and without discrimination.

The following rules apply to nominal gifts:

- If a nominal gift is a chance to receive one large gift or a communal experience (e.g., a concert, raffle, drawing), the total fair market value must not exceed the nominal per person value based on anticipated attendance. For example, if 10 people are expected to attend an event, the nominal gift may not be worth more than $150 ($15 for each of the 10 anticipated attendees). Anticipated attendance must be based on venue size, response rate, and/or advertisement circulation.
- Nominal gifts may not be in the form of cash or other monetary rebates even if their worth is $15 or less.

Note: Florida Blue should refer to the Office of Inspector General's website for advisory opinions and guidance on gifts and gift cards. In the recent 2022 MCMG, CMS noted that its interpretation of "cash equivalents" mirrors OIG's interpretation subject to the additional guidance listed below.

- A general gift card that is not restricted to specific retail chains or to specific items and categories would fall under those types that would be considered a cash equivalent (e.g. Visa gift card).
- Gift cards for retailers or online vendors that sell a wide variety of consumer products would also fall under this prohibition (e.g., Walmart and Amazon).
- A gift card that can be used for a more limited selection of items or food would not be considered a cash equivalent (e.g. Starbucks or a Shell Gas giftcard).

Return to Agent Compliance Reference Guide By Section

Marketing of Rewards and Incentives Programs

MA Plans may include information about rewards and incentives programs in marketing materials for potential enrollees. Marketing of rewards and incentives programs must:

- Not be used in exchange for enrollment;
- Be provided to all potential enrollees without discrimination;

Part D plans are not permitted to develop or use rewards and incentives programs. Therefore, Part D sponsors may not market reward and incentive programs.

Marketing Material Obsolescence

Agencies/agents are required to destroy all outdated/revised BlueMedicare marketing materials. Area Managers will coordinate with the Director of Consumer Sales and agencies/agents in their respective territory to ensure these type materials are no longer being used. Written verification of materials destroyed may be requested.

Materials Auditing

Florida Blue will periodically request copies of an Agency's/Agent's marketing materials to help ensure only current, valid CMS-approved materials are being used and the CMS-approved content was not modified by the Agency/Agent.

Additionally, random audits of Agency/Agent websites are conducted to ensure the most current Florida Blue and CMS-approved materials are being used in accordance with CMS guidance and Florida Blue's requirements.

Return to Agent Compliance Reference Guide By Section

SALES/MARKETING & EDUCATIONAL EVENTS

This section provides agents with CMS rules/guidance and Florida Blue requirements when conducting sales/marketing events; collecting and submitting sales/marketing event data; reporting changes and/or cancellations of sales/marketing events; and notifying beneficiaries of any cancelled events. Additionally, this section informs agents of CMS educational event requirements and the use of these type events.

Sales/Marketing Events

Florida Blue utilizes sales and marketing events to promote and educate Medicare beneficiaries about the merits of BlueMedicare plans. Agents presenting at these events play an important role in communicating this message. Therefore, it is essential for agents to understand the compliance requirements associated with sales and marketing events. CMS categorizes sales/marketing events into two main types: formal and informal. Formal events are usually structured in an audience/presenter style while informal events are less structured or in a less formal environment such as a table, kiosk or RV where a licensed agent may discuss plan and benefit information.

Information about non-health care related products such as annuities and life insurance must not be displayed or discussed at BlueMedicare sale/marketing events as these are considered cross-selling activities and prohibited by CMS.

Note: If an event is scheduled as a sales/marketing event, all compliance requirements for that event must be met, even if only one person attends the event.

CMS requires Florida Blue to disclose certain information to beneficiaries in attendance at sales/marketing events and/or while conducting sales activities. This information is provided in the company's CMS-approved sales presentations and enrollment materials distributed at sales/marketing events. Agents are required to make these specific verbal disclosures and ensure presentations including these disclosures are distributed to those in attendance at BlueMedicare sales seminars.

Marketing/Sales Events are designed to steer or attempt to steer potential enrollees, or the retention of current enrollees, toward a plan or limited set of plans. The following requirements apply to all marketing/sales events:

- Scripts and presentations must be submitted to CMS prior to use, including those to be used by agents/brokers;
- Sign in sheets must clearly be labeled as optional;
- Health screenings or other activities that may be perceived as, or used for, "cherry picking" are not permitted;
- Attendees cannot be required to provide contact information as a prerequisite for attending an event; and
- Contact information provided for raffles or drawings may only be used for that purpose.

Return to Agent Compliance Reference Guide By Section

- Refreshments and light snacks may be provided. It is important that the items provided could not be reasonably considered a meal and/or that multiple items are not being "bundled" and provided as if a meal.

Educational Events

CMS defines an educational event as an event designed to inform Medicare beneficiaries about Medicare Advantage, Prescription Drug and/or other Medicare programs that do not steer or attempt to steer potential enrollees toward a specific plan or limited number of plans. Educational events MUST meet the requirements of an educational event; otherwise, the event is considered a sale/marketing event.

CMS makes a distinction between educating beneficiaries about Medicare versus plans educating beneficiaries about their products. CMS' intent is to ensure that events advertised as "educational" comply with CMS' definition of education.

Shown below are activities that can and cannot be done at an educational event:

The following activities are allowed at an educational event:

- Must be explicitly advertised as educational;
- Must not include marketing or sales activities or distribution of marketing materials or enrollment forms;
- Must not discuss benefits unless specifically asked a question about benefits;
- Must not include a sales presentation (with benefit information);
- May distribute business cards and contact information for beneficiaries to initiate contact, which includes completing and collecting a Scope of Appointment (SOA) form;
- May conduct a marketing/sales event immediately following an educational event in the same general location;
- Must not be held with the intention to steer beneficiaries to a specific plan;
- Meals may be provided at CMS-defined educational events and other events that would fall under the definition of communications.

Return to Agent Compliance Reference Guide By Section

ELIGIBILITY AND ENROLLMENT

This section describes eligibility for Medicare and the requirements Florida Blue agents must follow to help ensure enrollments specific to Medicare Advantage Plan (also referred to as “MA-MAPD Plan”) and Prescription Drug Plan (also referred to as “Part D Sponsor”) products are compliant with CMS guidance. It is important for agents to ensure they are utilizing the proper enrollment periods. **Florida Blue reminds agents that beneficiaries must have a qualifying life event in order to utilize the Special Enrollment Period (SEP).** (Refer to the SEP section below for further information).

Eligibility for Medicare

Medicare is available for people age 65 or older, younger people with disabilities and people with ESRD (permanent kidney failure requiring dialysis or transplant). Original Medicare has two parts, Part A (Hospital Insurance) and Part B (Medicare Insurance).

Enrollment Time Periods

The chart below outlines the enrollment time periods for Medicare:

Enrollment Period	Time Period
Initial Enrollment Period (IEP)	The 7-month period that begins 3 months before the month turning 65, includes the month a beneficiary turns 65, and ends 3 months after the month turning 65.
Annual Enrollment Period (AEP)	October 15 – December 7
General Enrollment Period (GEP)	January 1 – March 31
Medicare Advantage Open Enrollment Period	January 1 – March 31
Special Enrollment Period	Qualifying Life Event
5-Star Special Enrollment Period	December 8 – November 30

For additional information, please refer to each enrollment periods listed below.

Initial Enrollment Period

The IEP is when a beneficiary first becomes eligible for Medicare. A beneficiary can first sign up for Part A and/or Part B during the 7-month period that begins 3 months before the month turning 65, includes the month a beneficiary turns 65, and ends 3 months after the month turning 65.

If a beneficiary enrolls in Part A and/or Part B during the first 3 months of the IEP, in most cases, coverage begins the first day of the birthday month. However, if a beneficiary’s birthday is on the first day of the month, coverage will start the first day of the prior month.

Return to Agent Compliance Reference Guide By Section

If a beneficiary enrolls in and pays for Part A and/or Part B the month he/she turns 65 or during the last 3 months of the IEP, the start date for the beneficiary Part B coverage will be delayed.

If a beneficiary enrolled in a Medicare Advantage Plan during the IEP, he/she can change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without a separate Medicare drug plan) within the first 3 months the individual has Medicare.

Annual Enrollment Period

The AEP is a set time each year (October 15 through December 7) for a beneficiary to change Medicare coverage choices. New coverage choices will go into effect on January 1 (as long as the plan gets the request by December 7).

General Enrollment Period

The GEP is a chance for a beneficiary to get coverage when he/she did not sign up for Medicare when first eligible (during the IEP) and did not qualify for a SEP. It takes place from January 1 through March 31 of every year. Coverage won't start until July 1 of that year, and he/she may have to pay a higher Part A and/or Part B premium for late enrollment.

Medicare Advantage Open Enrollment Period

From January 1 through March 31 of each year, if a beneficiary is enrolled in a Medicare Advantage Plan, he/she can switch to a different Medicare Advantage Plan (with or without drug coverage) or switch to Original Medicare (and join a separate Medicare drug plan) once during this period.

Beneficiary cannot switch from Original Medicare to a Medicare Advantage Plan, join a separate Medicare drug plan if in Original Medicare, nor switch from one Medicare drug plan to another if in Original Medicare.

Any changes made during this OEP will be effective the first of the month after the plan gets the beneficiary's request. If a beneficiary is returning to Original Medicare and joining a separate Medicare drug plan, contact with the Medicare Advantage Plan doesn't need to be made to disenroll. The disenrollment will happen automatically when the beneficiary joins the drug plan.

Special Enrollment Period

Generally, a beneficiary must stay enrolled in a plan for an entire year unless a qualifying life event occurs. Special enrollment periods constitute periods outside of the usual IEP, AEP or MA OEP when a beneficiary may elect a plan or change his or her current plan election. There are various types of SEPs, including SEPs for dual eligibles, and for individuals whose current plan terminates, who change residence or who meet exceptional conditions as determined by CMS.

Return to Agent Compliance Reference Guide By Section

Rules about when a change can be made and the type of changes that can be made are different for each SEP. **Agents need to ensure that Medicare beneficiaries meet the requirements for each type of change before enrolling them in a Florida Blue product.**

Enrollment Channels

Florida Blue provides its agents with the following three commonly used methods for completing beneficiary enrollment requests:

- Telephone Enrollment
- SalesConnect Online Enrollment
- Paper Enrollment

Note: Agency/Agent should obtain approval from Florida Blue for enrollment methods not described in this section.

Beneficiaries also have the option to complete enrollment by utilizing:

- Florida Blue's Website
- CMS' Online Enrollment Center
- Third Party Marketing Organizations (TPMOs), to include Electronic Marketing Organizations (EMOs) and Field Marketing Organizations (FMOs).

Telephone Enrollments

CMS allows MA-MAPD Plans and Part D Sponsors to accept telephone enrollments as a method to enroll beneficiaries. As such, Florida Blue operates a year-round telephone enrollment service for all its agents.
Florida Blue provides CMS-approved scripting to agents for inbound sales calls that may lead to telephone enrollments. CMS allows a telephone enrollment in the following instances:

- Florida Blue may accept requests for enrollment into their MA plans via an incoming (in-bound) telephone call to a plan representative or agent. Florida Blue may also accept enrollment requests during communications initiated by the organization when, during the course of outreach to provide information about their Medicare plan offerings to individuals with whom they have an existing business relationship, the individual expresses a desire to enroll in one of the organization's MA plans.
- Enrollment requests from individuals with whom the organization does not have an existing business relationship may be accepted only during an

incoming (or in-bound) telephone call from a beneficiary. This includes inbound calls to an incorrect department or extension transferred internally.

- Telephonic enrollments must be recorded and beneficiaries or their authorized representatives must provide their consent to be recorded.

  Note: Agents need to follow the CMS approved telephone enrollment script.

- Ensure that the telephonic enrollment request is effectuated entirely by the beneficiary or his/her authorized representative.

- Individuals must be advised they are completing an enrollment request and acknowledge (verbal attestation) this is their intent. If an authorized representative is completing the enrollment request on behalf of the beneficiary, he/she must verbally attest to their authority under Florida law to complete the request. These attestations must be included on the telephone enrollment recording.

- Provide a tracking number (i.e., confirmation number) upon completion of the telephone enrollment.

SalesConnect Online Enrollments

SalesConnect is a Florida Blue developed web-based enrollment tool that is used by both internal and external agents. Based on CMS guidance, the SalesConnect method of enrollment is considered an electronic enrollment. As such, there are specific CMS requirements for electronic enrollments such as:

- Ensuring the beneficiary has all the appropriate plan and benefit information **prior** to enrolling;

- Advising each individual at the beginning of the online enrollment process that he/she is sending an actual enrollment request to Florida Blue;

- Ensuring the beneficiary physically clicks on the Consent to Contract acknowledgement page that indicates his/her intent to enroll. This serves as a legal and valid signature that is enforceable by law.

Paper Applications

Florida Blue requires agents to comply with timely application submission timelines and requires signed, dated and complete paper enrollment applications to be submitted to Florida Blue no later than the next calendar day of receipt from the Medicare beneficiary. Failure to follow Florida Blue's requirements may result in non-compliant enrollment processes, including processing delays which can impact the enrollees' requested effective date of coverage.

Return to Agent Compliance Reference Guide By Section

- Agents must sign and date every application received from the Medicare beneficiary as prescribed by Florida Blue and CMS regulation.

- Paper applications received in-hand from the beneficiary should be reviewed to ensure all fields are completed and that the beneficiary has both signed and dated the form. If the beneficiary is still present, the agent should obtain any missing information. Otherwise, the agent can contact the beneficiary via phone (or e-mail-as long as the beneficiary has provided his/her e-mail address) if no longer present.

  In any case, agents **MUST NOT** hold the application to obtain the missing information. Florida Blue follows CMS guidance to obtain the missing information directly from the beneficiary. Applications must be sent to Florida Blue within 24 hours of receipt.

- Submit all paper enrollment applications (in appropriate envelope) to Florida Blue within 24 hours of receipt from the beneficiary. The completed application should be sent via overnight mail to Florida Blue at the following address:

  U.S. Mail (Regular) and Overnight Mail

  Florida Blue
  Attn: CCR
  Building 100, 5th Floor
  4800 Deerwood Campus Parkway
  Jacksonville, Florida 32246

Florida Blue Website

Beneficiaries have the option to complete an enrollment without agent assistance on Florida Blue's dedicated website, www.floridablue.com/Medicare. Note: If a beneficiary needs help and calls the 800 number provided in the application portal on the website, a licensed agent is available to provide assistance.

CMS' Online Enrollment Center

CMS provides an online enrollment center (OEC) via www.Medicare.gov that allows beneficiaries to apply for enrollment in Medicare Advantage and Prescription Drug plans. Florida Blue monitors the enrollment activity daily within the OEC and ensures timely processing of enrollment requests received for BlueMedicare plans.

Third Party Marketing Organization (TPMO)

Additionally, Florida Blue receives enrollments from beneficiaries through TPMOs which includes Electronic Marketing Organizations (EMOs) and Field Marketing

Return to Agent Compliance Reference Guide By Section

Organizations (FMOs). TPMOs obtain enrollments through telephonic and online channels. Florida Blue requires TPMOs, as defined by regulation, to ensure that all activities related to lead generation, marketing, sales and especially enrollment related functions (which includes those steps taken by a beneficiary from becoming aware of a MA plan or plans to making an enrollment decision) comply with the Agent, Broker, and Other Third-Party Requirements outlined in the Sales section above.

Return to Agent Compliance Reference Guide By Section