# Aetna Individual Medicare Producer Guidelines

Making it easy to do business and grow with Aetna

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# Welcome!

Thank you for contracting with Aetna and becoming Ready to Sell our Individual Medicare products.

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

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

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

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

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

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

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

# Broker Services: Resources

# Making it Easy to do Business with Aetna

| Agent/Broker Tools | Aetna-Specific Tools |
|---|---|
| **Aetna Agent Website** | *Aetna Producer World*: https://www.aetna.com/producer/Medicare/index.html (See next page) |
| **Marketing Materials** | *The Aetna Medicare Marketing Studio*: www.aetnahub.com/MMS |
| **Find In-Network Pharmacies** | www.aetnamedicare.com/findpharmacy<br>www.aetnamedicare.com/formulary |
| **BenefitsCheckUp® Site** | www.benefitscheckup.org/aetna |
| **Enrollment Kits** | *Aetna Producer World*: https://www.aetna.com/producer/Medicare/index.html |
| **Online Enrollment Tool** | The Ascend Virtual Sales Office app |
| **Reports** | Access on Aetna Producer World (see *How to Access Reports*) |
| **Find In-Network Doctors, Hospitals and Specialists** | www.aetnamedicare.com/findprovider |
| **Consumer/Member Tools** | |
| **Consumer-Facing Website** | www.aetnamedicare.com |
| **Find In-Network Doctors, Hospitals and Specialists** | www.aetnamedicare.com/findprovider |

# Making it Easy to do Business with Aetna

***Aetna Producer World***

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

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

Producer World® Log In

User Name:

Password:

SECURE LOG IN

Forgot Your Password Or User Name?

Register | [Your Privacy]

Why Register?

Aetna's online service center developed to meet the informational needs of our producers, general agents and firm employees including access to:

- Get quotes
- Find compensation information
- Check license status
- Set up direct deposit
- Get reporting
- And more

REGISTER NOW

About Producer World Security/Encryption

# Making it Easy to do Business with Aetna

***Aetna Producer World***

- **How to Access Reports**

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

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

  If you're the firm principal: On the *Principal – Manage Firm Access* page, you can designate up to four (4) people with different privilege levels so they too can view Medicare reports for your firm. Your designees must first register for Aetna Producer World as an employee or agent of the firm. After choosing your designees, assign them "Compensation" privileges so they can see the Medicare reports. For more information, review our *How to Register in Producer World* guide.

# Making it Easy to do Business with Aetna

## Aetna *Producer World*

- **Reports**

Log in to *Aetna Producer World* 24/7 to access reports on your Aetna Individual Medicare book of business. Just log in, click *Individual Medicare* at the top of the page, then click *Access Reporting*.

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

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

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# Ready to Sell

# What is “Ready to Sell”?

- **Definition:**
  - The term “Ready to Sell” means that an upline, principal, or agent has completed and maintains compliance with all Aetna, CMS, and applicable state law requirements for selling as specified in this document and has received a written confirmation (a Ready to Sell notice) from Aetna specifying that the upline, principal, or agent has completed all requirements and may commence selling a particular Medicare product in a particular state(s).
- **Overview:**
  - Here’s an overview of the requirements you need to complete in order to be Ready to Sell:

    To become Ready to Sell our 2020 Aetna Individual MA/MAPD and SilverScript PDP products and receive commissions, you’ll need to complete all of the below requirements prior to marketing or selling:

    1. **Certification** – you must pass annual Medicare certification
    2. **Contracting** – you must have an active contract with Aetna Medicare
    3. **Ready to Sell** – you must receive your Ready to Sell confirmation from Aetna
        1. **For LOA’s**: Your upline must also be Ready to Sell in the state(s) in which you wish to sell

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# Compensation

# Compensation Overview

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

**Definition of Compensation**

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

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

**Overview – How Aetna Pays**

The compensation year is January 1 through December 31. The commission schedule for each agent and the administrative fee schedule for each upline is outlined in his/her contract. How much Aetna pays is consistent with CMS requirements and the rate set in your contract.

# Compensation Overview (continued)

**Commission**

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

Agents are paid a commission for each member they enroll for an Aetna Medicare product in accordance with CMS requirements and the terms of his/her contract. We pay directly to the agent, or to the payee, as specified upon contracting. Commissions for licensed-only agent (LOA) sales pay directly to the upline for any member with an effective date later than 1/1/2015.

**Administrative Fees**

Aetna pays administrative fees to uplines who complete the Aetna Marketing Agreement for Upline Agents and Agencies (the "Upline Agreement"). Administrative fees are paid to uplines for providing administrative services, such as agent recruiting, agent training, sales compliance, office administration related to Medicare sales/enrollment, and marketing

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

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

# Initial Sales

**Definition**

**"Initial Sale"** refers to beneficiaries enrolling in an Individual Medicare product who were not enrolled in a Like Plan in the month immediately preceding their Medicare product's enrollment effective date.

- A **"Like Plan"** refers to a "like plan type" as described by CMS in the applicable Medicare Communication and Marketing Guidelines
- An **"Unlike Plan"** refers to an "unlike plan type" as described by CMS in the applicable Medicare Communication and Marketing Guidelines

**Overview**

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

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

# Renewal Sales

**Definition**

**“Renewal”** refers to a sale to a Medicare beneficiary when the Medicare beneficiary was enrolled in a Like Plan offered by Aetna or its affiliates in the month immediately preceding the Medicare product’s enrollment effective date.

**Overview**

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

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# Replacement Sales

**Definition**

**“Replacement”** refers to a sale to a Medicare beneficiary when the Medicare beneficiary was enrolled in a Like Plan of someone other than Aetna in the month immediately preceding the Medicare product’s enrollment effective date.

**Overview**

- Replacements are payable only while your contract is in effect. For replacements, we will advance the “replacement rate” set forth on the Schedule 1 of your contract
  - Unless otherwise indicated in the Schedule 1 of your contract, the “replacement rate” is the same amount as the “renewal rate”
- If the replacement has an effective date other than January 1, a prorated amount of the replacement rate will be paid, based upon the number of months the Medicare beneficiary will be enrolled in such Medicare product within the initial calendar year. After the year in which the replacement occurs, if the Medicare beneficiary remains enrolled in a Medicare product that is a like plan, the replacement will become a renewal
- Aetna may choose, if permitted by applicable law, to pay commissions in advance of our receipt of premium from CMS
  - For example, if a renewal/replacement rate of $200 is payable, Aetna could pay $16.67 per month for such a renewal/replacement or pay the commission in a lump sum of $200 in January of the renewal/replacement year

# Chargebacks for Rapid Disenrollments

Any disenrollment occurring within three (3) months of the enrollment effective date is considered a "rapid disenrollment". Rapid disenrollments can be either voluntary or involuntary.

- Voluntary rapid disenrollments result in a chargeback of the full commission paid. Involuntary rapid disenrollments result in prorated commissions based on the number of months the beneficiary was active
- For both voluntary and involuntary disenrollments outside of the three (3) month rapid disenrollment period, you retain the commission earned for the length of time the policy was active. Aetna will charge back the unearned commission and it will be reflected on the commission statement.
- If Aetna pays compensation for a sale and a rapid disenrollment occurs thereafter for which CMS requires compensation recovery, then the upline and its agent(s) shall refund such compensation paid by Aetna for such beneficiary. Aetna may deduct any compensation amounts to be paid to the upline or agent(s) for a rapid disenrollment from amounts otherwise owed to the upline or agent(s)
- In order to not be subject to rapid disenrollment compensation recovery, the newly enrolled Medicare beneficiary must remained enrolled with Aetna into the fourth ($4^{th}$) month. An enrollment that occurs during the fourth ($4^{th}$) quarter of a calendar year and terminates 12/31 of the same calendar year is considered a rapid disenrollment unless the termination reason indicates a plan change
- No recoupment, chargeback, refund, or deduction shall be made if CMS guidance permits payment of commission for the rapid disenrollment with respect to the period that the Medicare product beneficiary was actually enrolled.

# Compliance & Agent Oversight

# Compliance Overview

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

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

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

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

# How to Stay Compliant

All of the materials mentioned below are available on *Aetna Producer World*.

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

# Fraud, Waste, and Abuse (FWA)

**Medicare Marketing Code of Conduct**

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

**How to Report Compliance or Fraud, Waste, & Abuse (FWA) Concerns**

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

You can report your concern or issue in the following ways:

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

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

# Agent Oversight

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

**Our Agent Oversight team has a responsibility to:**

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

# Agent Oversight

**Agent Monitoring**

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

- **Cancellation Rates**
- **Rapid Disenrollment Rates**
- **Enrollment Application Turnaround Time**
- **Scope of Appointment (SOA) Forms**
- **Third-Party Secret Shopper Surveillance Program of Formal & Informal Marketing/Sales Events**
- **Complaints and Marketing Incidents**
- **Marketing/Sales Seminar Reporting, Cancellations, and Updates**

# Agent Oversight

**Disciplinary Action**

Agent Oversight will implement disciplinary or corrective action when CMS infractions and/or prohibited tactics are identified.

Disciplinary or corrective action may include:

- **Focused Training or Monitoring Sessions (*i.e.,* ride-along assessments)**
- **Increased Surveillance**
- **Verbal or Written Warnings**
- **Full Re-training and Re-testing**
- **Placement on an Agent "Watch List"**
- **Suspension or Probationary Period, with or without Commissions**
- **Contract Termination, with or without Cause and Appointment Termination**
- **Formal Reporting to Applicable State Department(s) of Insurance**

# Complaints Against Agents & Marketing Incidents

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

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

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

- Other Aetna Departments/Processes
    - Customer Service, Broker Services, Appeals and Grievances, Enrollment
- State Departments of Insurance (DOI)
- CMS, Medicare Integrity Contractor (MEDIC), Federal or State Representatives/Agencies
- Member or Member's Representative

# Complaints Against Agents & Marketing Incidents

**Complaint and Marketing Incident Process**

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

1. Notice of Investigation letter sent to the involved agent
2. Full investigation completed
3. Determination made that complaint is either founded or unfounded, with recommended disciplinary or corrective action, as noted on previous Agent Oversight page

**NOTE:** Failure to respond within the required timeframe to Aetna or CMS requests for information may result in suspension or termination of an agent's, broker's, or producer's ability to market, sell, and receive commissions. This information is in the agent's/broker's/producer's contract with Aetna. In the case of a licensed-only agent, language is in the upline's Aetna contract.

# Marketing/Sales Events

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

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

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

# Marketing/Sales Events

**Key Requirements**

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

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# Marketing/Sales Events

**Prohibited Activities:**

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

# Scope of Appointment (SOA) Requirements

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

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

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

# Scope of Appointment (SOA) Requirements

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

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

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

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

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

# Scope of Appointment (SOA) Requirements

**You may NOT:**

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

# Permission to Contact Form

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

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

**Prohibited Actions**

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

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

# Contact with Medicare Beneficiaries

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

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

**Outbound Calls**

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

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

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

# Contact with Medicare Beneficiaries

**Electronic Communication**

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

**Direct Marketing**

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

**Telephone**

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

For detailed information on acceptable and prohibited actions, refer to the document entitled "Contact with Medicare Beneficiaries" in *Aetna Producer World*.

# Marketing Materials

# Marketing Policy Overview

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

- You're required to follow all Aetna and CMS marketing requirements. You can find and review the CMS Medicare Communication and Marketing Guidelines on *Aetna Producer World* and www.cms.gov.
- You may only use CMS and Aetna-approved marketing materials when discussing Aetna Medicare plans. To be clear, you may only use materials that have been created by Aetna's marketing team, approved by Aetna, and, as necessary, filed with CMS by Aetna. Note that this includes Multi-plan Materials (as described in the Medicare Marketing Guidelines).
- You may not alter CMS-approved materials in any way, other than to add personal information like agent name, phone number, email, or even date, when permitted, on an approved piece.
- Materials must be used as intended. For example, you can't copy a newspaper ad and mail it to beneficiaries. This is due to specific filing guidelines with CMS based on material type.
- Under CMS guidelines, the official marketing period for AEP for the upcoming benefit year begins October 1. You must **not** market or advertise Aetna products for the upcoming benefit year prior to October 1, even if you have marketing/sales events scheduled in early October. Furthermore, once you begin marketing 2020 products, you must cease marketing 2019 products. Prior-year materials may be provided upon request and enrollment applications may be processed.

# Marketing Policy Overview (continued)

- See the Compliance & Agent Oversight section for marketing rules and requirements for the Scope of Appointment form, Permission to Contact form, sales presentations, and other specific marketing materials. Please direct any questions to your Aetna representative.
- Use of senior-specific designations: You are responsible for ensuring compliance with state laws pertaining to the use of "senior-specific designations" when marketing Aetna Medicare products. For example, in New York, a senior-specific designation is a title, professional designation, credential, certification, or other professional description that indicates the person has expertise or training in issues specifically related to Medicare beneficiaries in their field. If you do not know whether you are in full compliance with state laws concerning the use of senior-specific designations, do not use such designations in marketing Aetna Medicare products.
- Third-party websites that market MA/MAPD and PDP must meet all applicable CMS marketing guidance, including that found in the CMS Medicare Communications and Marketing Guidelines (MCMG).
- You may not solicit or accept an enrollment application for a January 1 effective date prior to the start of AEP on October 15 unless the beneficiary is entitled to another enrollment period.

# Sales Presentations

Keep in mind:

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

Aetna MA/MAPD and SilverScript PDP sales presentations and notes/talking points are available on *Aetna Producer World* under the Marketing heading.

# Enrollment

# How to Order Sales Kits

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

There is a single point of entry to order Aetna-branded kits. You can find the link on *Aetna Producer World*. Click on *Individual Medicare*, then on *Order Enrollment Kits*.

Once you access the kit-ordering site, you'll need to use your National Producer Number (NPN) to log in. Once logged in, you will be prompted to select the plan benefit year and plan type (MA or PDP).

**Requirements**

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

**Kit Personalization**

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

# How to Order Sales Kits (continued)

**Kit Limits**

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

**Order Confirmation**

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

**Delivery**

Once processed, you should get your kits within 7-10 business days, depending on the size of order and shipping location.  Kits are sent by UPS Ground.  Overnight shipping and P.O. Box delivery are not available.

# Enrollment Process

# Election Periods Overview

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

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

- **New to Medicare (Initial Enrollment)**

| IEP | Second IEP | ICEP | ICEP Notes |
| --- | --- | --- | --- |
| ▪ 7 months around initial eligibility<br>▪ Parts A, B, and D<br>▪ 3-1-3 | ▪ 65th birthday<br>▪ 7 months | ▪ Delay in Part B coverage<br>▪ 3 months before Part B start date | ▪ PDP enrollment is separate<br>▪ Part B awarded after effective date; requires document action |

**Open Enrollment Period (OEP)**

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

# Election Periods Overview (continued)

**Special Election Period (SEP)**

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

**Annual Election Period (AEP)**

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

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

# Enrollment Application Turnaround Time

A signed Medicare enrollment application must reach us within **two (2) calendar days** of when you receive it from the beneficiary. This information is covered in your contract with us. The two-calendar-day requirement ensures sufficient time to review applications and send them to CMS for processing within the CMS-required timeframe.

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

- For Aetna Medicare applications: Email or Fax
- For Innovation Health, Allina, Migrating, and Expansion applications: Fax

**Please refer to enrollment application turnaround time (TAT) in *Producer World*.**

**Duplicate Enrollment Applications**

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

# Aetna Enrollment Options

| Paper Applications | |
|---|---|
| **Online** | **Aetna's *Ascend Virtual Sales Office* application**<br>Available for use on any device – including your laptop or tablet – that runs with an iPad platform (iPad3 or newer model running on iOS 10 or higher) or a Windows platform (Windows 8 or later x86 processor).<br>Once you're Ready to Sell, you can request access to the app in *Producer World*. After logging in, simply click *Tools*, and then click the *Ascend Virtual Sales Office App* link. Click the *Request Access* radio button, verify your information, and then submit your request. Please allow 2-7 business days for processing |
| **Mail** | **Aetna Medicare Broker Enrollment Team**<br>P.O. Box 14088<br>Lexington, KY 40512-4088<br>Please mail the application to the address listed on the enrollment form. |
| **Fax** | **1-866-441-2341 or 1-888-665-6296**<br>Please fax the application to the fax number listed on the enrollment form |

# Aetna Enrollment Options (continued)

| Paper Applications | |
|---|---|
| Email | MedicareEnrollmentTransactions@aetna.com<br>Scan and save the paper application, Scope of Appointment (SOA), and any required paperwork as a single document in an approved file format. The preferred format is PDF. Other acceptable formats include .bmp, .csv, .doc, .docm, .docx, .htm, .html, .jpg, .mdi, .msg, .ppt, .pptm, .pptx, .rtf, .tif, .xls, .xlsm, .xlsx, and .xps. Attach the file to an email message and send it to the above address.<br><br>We recommend one applicant (and one attachment) per email. However, for greater efficiency, up to five (5) applicants/attachments per email are allowed. Email attachments cannot exceed seven (7) pages each. Write the name of each applicant in the subject link so that the names appear on your email confirmation. Note: The subject line cannot contain numbers and the email body cannot contain embedded images, graphics, or logos.<br>Note: Please see additional email requirements on the next page. |
| Phone | You can assist a beneficiary with contacting us by phone, but telephonic enrollment requests must be initiated entirely by the beneficiary or his/her authorized representative. You **cannot** be physically present with the beneficiary at the time of the telephonic enrollment process per CMS guidance. |

# Aetna Enrollment Options (continued)

**Enrollment Application Email Requirements:**

- Subject line should include the enrollee name(s) only
- Save documents with the enrollee name only
- DO NOT use enrollee's Social Security number or HICN/MBI or any other type of number in subject line
- DO NOT use enrollee's Social Security number or HICN/MBI or any other type of number when saving documents

If all requirements are met, you'll receive an automated email confirmation of receipt. Confirmations will include a date and time stamp from your original email, the name(s) of the enrollees you placed in the subject line, and the total number of attachments sent. If all requirements are not met, you'll receive an automatic email rejection. The email will indicate why the transaction was rejected so that you can make corrections and resubmit.

# The Enrollment Process: What You Need to Know

**Before Completing an Enrollment Application with a Beneficiary:**

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

# The Enrollment Process: What You Need to Know

**Confirming Eligibility:**

- To be eligible to elect an MA plan, a beneficiary must be entitled to Part A and enrolled in Part B, and continue to pay his/her Part B premium. The beneficiary must be entitled to Medicare Part A and Part B benefits as of the effective date of coverage under the plan. Exceptions for a Part B-only grandfathered beneficiary are outlined in the CMS Medicare Managed Care Manual. Part B-only beneficiaries currently enrolled in a plan created under Section 1833 or 1876 of the Social Security Act are not considered grandfathered beneficiaries and must purchase Medicare Part A through the Social Security Administration to become eligible to enroll in an MA plan.
- At the time he/she enrolls in an MA plan, the beneficiary must have Medicare Parts A and B. You should always verify this. Here are some examples of acceptable proof of eligibility:
  - Copy of Medicare Card
  - Copy of Medicaid Award Letter for Dual-Eligible Special Needs Plans
  - Social Security Administration Award Notice
  - Railroad Retirement Board Letter of Verification
  - Statement from the Social Security Administration or Railroad Retirement Board verifying the beneficiary's Medicare Eligibility

# The Enrollment Process: What You Need to Know

**Explaining Benefits, Rules, and Member Rights:**

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

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

# The Enrollment Process: What You Need to Know (continued)

**An Important Reminder:**

Aetna enrollment applications (MA/MAPD) include the "Proposed Effective Date". You must:

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

# The Enrollment Process: What You Need to Know (continued)

**Completing the Enrollment Application**

You may proceed with the enrollment only after thoroughly explaining all plan benefits, limitations, and rules to the beneficiary and receiving consent from him/her.

- Ensure that all required information is provided on the application
- Ensure the MBI is entered in the correct format:
  - #, A, # or A, #, A, # or A, #, A, A, #, #
    - # = Numbers 0-9
    - A – Alpha Character (excludes: S, L, O, I, B, and Z)
- If the applicant is using a Special Election Period (SEP) to enroll, make sure you complete the Enrollment Checklist portion of the enrollment form to confirm your client's eligibility to enroll
  - **During AEP (10/15-12/7), if your client wants an effective date other than 1/1, an SEP must be provided. If an SEP is not provided, the enrollee could be enrolled for a 1/1 effective date**
- Provide a phone number for the applicant

# The Enrollment Process: What You Need to Know (continued)

**Completing the Enrollment Application (continued)**

- Be sure that the applicant is aware that the effective date of the enrollment will be determined based on when the Plan receives the enrollment application request and/or election period/SEP indicated on the application. The prospective member can note the proposed effective date he/she would like, but the Plan will make the final determination of effective date of enrollment for the plan the applicant has selected.
- Ensure that the application is signed and dated by the applicant
  - If an authorized representative signs the enrollment application, the record of attestation of authority must be maintained as part of the record of the enrollment election and must include contact information
- Agent is required to sign and date page 8 of the application. This information is used to determine the receipt date of the application by Aetna

# The Enrollment Process: What You Need to Know (continued)

**Completing the Enrollment Application (continued)**

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

# Referral-Only Sales

**If you participate in the referral program, you must comply with the program requirements outlined below:**

1. **You may only leave approved referral materials with qualified individuals.**
    1. For a referral on an MA plan, a qualified individual is an eligible Medicare beneficiary who meets the following requirements:
        1. Has both Medicare Parts A and B
        2. Resides in an Aetna Medicare Advantage service area
        3. Is qualified to enroll in a Medicare Advantage plan
        4. Has a relationship with the agent
        5. Has expressed interest in a Medicare Advantage plan
        6. Understands that he/she must contact Aetna by phone or on the website
    2. For a referral on a SilverScript PDP plan, a qualified individual is an eligible Medicare beneficiary who meets the following requirements:
        1. Is entitled to Medicare benefits under Part A or enrollment in Medicare Part B
        2. Resides in a SilverScript Medicare Part D service area
        3. Is qualified to enroll in a SilverScript Medicare Part D plan
        4. Has a relationship with the agent
        5. Has expressed interest in a SilverScript Medicare Part D plan
        6. Understands that he/she must contact Aetna by phone or on the website

# Referral-Only Sales (continued)

2. **You must adhere to CMS Medicare regulations and guidelines and all state insurance laws:**
    1. You can't engage in sales presentations or market the Aetna MA/MAPD products  being referred to the qualified individual
    2. You may only confirm the client is a qualified individual, provide the client with Aetna referral materials, and inform the client he/she is responsible for contacting Aetna about enrolling in a Medicare plan
    3. The referring agent must only use Aetna CMS-approved materials
    4. The referring agent cannot contact the client for follow-up on Aetna MA/MAPD products

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

# Member Experience

# After Submitting the Application

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

| Material Name | Description |
| --- | --- |
| **Plan Confirmation/ Acceptance/RFI/ Denial/Rejection Letters** | Encourage your clients to complete all required fields on the enrollment application to ensure their timely and accurate enrollment with our plan.<br>We're not able to submit to the Centers for Medicare & Medicaid Services (CMS) enrollment applications if required information is missing or incomplete. Our enrollment processing team will make an attempt to contact your client to obtain the missing data. Your clients may also receive a Request for Information (RFI) letter indicating what is needed in order to complete the application and a time to return this information. If the information is not received in time to complete the enrollment process, the application will be denied.<br>CMS may reject the enrollment if your client has Employer Group Health Coverage. Your client will need to confirm his/her intent to enroll in the Individual Medicare Advantage plan. He/she will receive a call as well as a letter with instructions. If the confirmation is not received prior to the expiration of the 30-day timeframe, the application will be denied.<br>We'll send an acceptance letter to your client once CMS accepts his/her enrollment This letter will include information to help him/her understand how to use his/her plan. In the event that CMS is unable to approve the enrollment request, your client will receive a letter of denial or a letter of rejection into the plan. |

# After Submitting the Application (continued)

| Material Name | Description |
|---|---|
| **Monthly Plan Premium** | Remind your client about the premium payment option he/she chose on his/her enrollment application. |
| **Member ID Card** | After we've received confirmation from CMS that your client can be enrolled in the plan, we'll mail him/her materials:<br>• Member ID Card<br>• Evidence of Coverage (EOC)<br>• Directory Notice<br>• Formulary (Drug List) |
| **Doctor Visit** (MA Only) | Be sure to remind your client to see his/her doctor to take advantage of the annual health care services available to him/her. Remind him/her to list his/her current PCP on the enrollment form. Even if members choose a PPO plan that does not require them to select a PCP, it is helpful for us to know who they see to coordinate their care. |
| **Medical Transition of Care** (MA Only) | Our transition of care program works to get members the care they need. New members should let us know if they're getting active treatments from or have an upcoming surgery scheduled with a doctor that's not in our network. For us to cover their care, they need to complete a Transition of Care form. There are time frames in which we need to receive the information, so it's important they connect with us as soon as possible. |

# After Submitting the Application (continued)

| Material Name | Description |
| --- | --- |
| **Prescription Drug Transition of Care** | It is critical to review clients' current medications against the plan's formulary to confirm coverage. Also review special coverage rules (e.g. prior authorization, step therapy, quantity limits) prior to enrolling them in a plan. *One of the leading reasons for members to disenroll from their plan is that one or more of their current drugs are not covered by their plan.* Transition prescription fills let members get one-time, short-term coverage for prescription drugs that are not on their plan's formulary or that have coverage rules. Member are encouraged to work with their providers to see if changing to another drug that is on the plan's formulary is right for them. Or they should work with their provider to request a coverage determination. The provider will need to show that the member meets the criteria for one of our coverage rules.<br>Even with approval, sometimes the prescription is only covered at a Tier 4 cost share. This means the member will pay more for the drug than if they switched to an alternative drug that's covered on their plan's formulary.<br>Transition prescription fills are not for new prescriptions. Members can only get transition prescription fills for drugs they were taking before switching plans or before their plan changed its coverage. |
| **Health Needs Assessment** (MA Only) | We'll contact your client to learn about his/her health history. The information won't affect his/her enrollment in the plan. |

# Enrollment Applications: Cancellation, Withdrawal, or Disenrollment

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

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

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

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

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

# Enrollment Applications: Cancellation, Withdrawal, or Disenrollment (continued)

**Reminder**

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

An application can be denied for the following reasons:

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

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

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

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