Third Party Marketing Organization
Medicare Advantage and Prescription Drug Plan Marketing Material Guidelines

Note: The intended audience for this document is individuals authorized by UnitedHealthcare to submit marketing materials for prospective review and/or file those materials in HPMS and select its Medicare Advantage and Prescription Drug Plan contracts.

This document provides guidance related to multi-carrier marketing materials created, owned, operated, and/or used by a third-party marketing organization (TPMO), which includes multi-carrier agents and agencies (MCAs), that could lead to enrollment in a UnitedHealthcare Medicare Advantage (MA) Plan or Prescription Drug Plan (PDP). **Materials that only advertise Medicare Supplement plans are out of scope.**

Any TPMO contracted with UnitedHealthcare, including MCAs and their down-line agencies, agents, and solicitors, must comply with all applicable state and federal regulations and guidelines and UnitedHealthcare business rules, policies, and procedures when marketing (including any lead generation activities) and selling UnitedHealthcare MA plans, PDPs, and Medicare Supplement Insurance plans. This document is not a comprehensive guide to marketing activity and material requirements.

Third-party marketing organizations may have contractual agreements directly with UnitedHealthcare and/or with a TPMO contracted with UnitedHealthcare. UnitedHealthcare refers to a non-selling TPMO contracted directly with UnitedHealthcare as an affiliate partner.

Note: This document does not apply to:

- *TPMO materials that are deemed multi-carrier communications material, except as noted within.*
- *Communications or marketing materials that contain a UnitedHealthcare brand element and/or are intended to be used to promote only UnitedHealthcare, except for online enrollment tools.*

Submitting MA/PDP Marketing Materials to UnitedHealthcare for Prospective Review

Any marketing material (as defined by CMS) representing a UnitedHealthcare MA plan or PDP must be reviewed and approved by UnitedHealthcare prior to filing in HPMS and selecting any UnitedHealthcare MA/PDP contract. Refer to the section below for communications and marketing material definitions.

- New this year: Submitted materials owned and operated by a subcontracted entity that has not been reported to UnitedHealthcare through the subcontracted relationship disclosure process will be denied. *Note: Even organizations submitting identical materials that were already filed in HPMS by a partner organization ("clones") must ensure this requirement is met.*
    - CMS requires TPMOs to disclose to carriers with whom they are contracted any subcontracted relationship used for lead generation, marketing, and/or enrollment activities. Submitting entities must report a subcontracted relationship to UnitedHealthcare **prior** to submitting a material owned and operated by the subcontracted entity.

- Entities with access to Jarvis (all entities with an active Party ID), must fill out the web-form on Jarvis. *Note: eAlliance and Telephonic Addendum call centers may report their subcontracted relationships by requesting a disclosure worksheet through their eAlliance Oversight contact.*
- Affiliate partners must receive preapproval from UnitedHealthcare to use subcontracted relationships for lead generation, marketing, and/or enrollment activities. Affiliate partners who are approved to use subcontracted entities must fill out the provided disclosure worksheet and email it to your Account Manager.

- The individual submitting material for prospective review must ensure that the material is compliant with all applicable federal and state regulations and guidelines and UnitedHealthcare business rules, policies, and procedures **prior** to submitting to UnitedHealthcare. Submitting materials that cannot be approved without edits required will result in extended turnaround time and may result in rereview cycles.

- Initial Submissions:
  - A completed submission form must accompany materials submitted for prospective review.

Always use the current version of the submission form. Beginning June 1, 2024, UnitedHealthcare's PY24-25 submission form must be used to submit materials to UnitedHealthcare. Using a prior version of the form or failing to correctly fill-out the form will result in a denied submission.

- The applicable tab on the submission form must be used. One tab is for all media types except Websites and Website Landing Pages and the other for Websites and Website Landing Pages only.
- All materials listed on the submission form must be the same media type and therefore must be listed on the same tab. The other tab must remain blank. Up to 10 materials of the same media type may be listed on a single form.
- New this year: The submission form requires a page count for each material.

  - For all media types, UnitedHealthcare strongly prefers to receive materials in a Word file but will accept PDF or PowerPoint file types except for Websites and Website Landing Pages. *Note: Generally, attachments cannot exceed 15 MB (individually or in aggregate); therefore, consider file format and file size when deciding how many materials to submit in a single submission.* UnitedHealthcare will not accept links to materials housed in web applications, such as GoogleDocs, in lieu of an attached file.
  - Materials (except Websites and Website Landing Pages) listed on a submission form may be submitted in a single document in the order listed on the submission form or as separate files. Submit Websites and Website Landing Pages in individual Word files even if more than one is listed on the submission form.
  - Each material in a document must:

- Be identified by the SMID.
- Include written-out content. Screenshots (or other similar images) do not satisfy this requirement in and of themselves. The content must also be typed out above or below the screenshot or image.
- Include an image of how the material will look in publication.

- For Websites and Website Landing Pages, provide a link to the actual site or test site to permit review of the representation of the content. If neither a live site nor test site is available, screenshots are required.
- For all other media types, links (including links within an approved file format), URLs, audio, video, and similar formats are not permitted as a substitute for

  providing written content and image(s). For example, a video submission must include a written-out script with storyboard images. A link to watch the video is appreciated, but not required, and does not satisfy this requirement in and of itself.
- Refer to Appendix B for additional requirements based on media type. ○ Placeholders for

  variable content (formerly “template materials”):
  - That are not related to plan benefits or costs may be represented in the material by the data type in brackets (e.g., [date], [hours of operation], or [agent name]). This variable information does not need to be provided to UnitedHealthcare.
  - Related to plan benefits or costs may be represented in the material by the data type in brackets or carets (e.g., [dental] or <$500/yr>).
- This variable information must be provided to UnitedHealthcare. Table format is recommended, showing the information that will be populated within the placeholders on the material. The submitter must include within the copy deck, the data type along with a reference to where the data can be found in the spreadsheet or table (e.g. [Copay, see column “A”]). Spreadsheets or tables must only include the variable data found in the submitted material for the contracts/plans associated with the submitted material. When submitting to UnitedHealthcare for prospective review, tables may be included within the same document as the material or submitted with the material as a separate file.
- If the variable information is in a separate file, it must be zipped with the material file when submitted in HPMS. See the *Filing MA/PDP Marketing Materials in HPMS* section for HPMS filing instructions.

○ The naming convention for the submission form and document files is at the submitter’s discretion provided the number of characters (including spaces) does not exceed 80. Here is an example: “BEST_COMPANY_ENROLLMENT_SCRIPTS_07012024.”

○ Email the submission form and material file(s) to Sales_Oversight@uhc.com. Put “Initial Submission” in the subject line. **Only submit one submission form per email.** Do not split up document files across multiple emails. Instead, decrease the number of materials listed in a form to accommodate file size limits.

- Review outcomes will be indicated on the applicable submission form and the form returned to the submitter. Outcomes include: ○ Approved; no edits required ○ Not approved; edits required; “Fast Track” option eligible ○ Not approved; edits required; must submit for rereview
    - ○ Not approved; edits required; schedule conference before submitting for rereview (limited to rereview round 2 submissions)
        - A conference with UnitedHealthcare will be required prior to submitting materials for rereview round three. Instructions for scheduling the conference will be provided in the email sent to the submitter after rereview round two.
        - Materials submitted for rereview round three prior to the conference will be denied.
    - ○ Not approved; NO ADDITIONAL RESUBMISSIONS will be accepted; do NOT file in HPMS and select UnitedHealthcare contracts ○ Not considered marketing material
    - ○ On hold ○ Review terminated
- “Fast Track” is an outcome available at the discretion of the reviewer when edits are minimal and simple in nature, such as deleting a word, inserting a word, or adding a required disclaimer. When Fast Track is offered, it is strongly recommended that the submitter choose the Fast Track option. While the submitter may still choose to resubmit via the normal resubmission process (except after rereview round 3), rereviews are prioritized lower than initial reviews received on the same day, so turnaround time may be longer. To follow the Fast Track path, accept and make all edits exactly as indicated by the reviewer. Then, submit a final, clean copy to Sales_Oversight@uhc.com at the same time you file in HPMS. Put “Clean and Final” in the subject line.
- Resubmissions: **Work off the most recently reviewed document;** turn on “Track Changes;” **leave all comments open**; make the edits required; and respond to every reviewer comment. Only submit materials that have required edits. Email the updated document to Sales_Oversight@uhc.com with “Resubmission” in the subject line. ○ Do not submit materials that had an outcome of “Approved; no edits required” or when opting for “Fast Track.”
    - ○ Do not combine materials from multiple submission forms into a single resubmission email. Instead, send multiple emails, keeping the materials from each submission form separate from others.
- **UnitedHealthcare is not responsible for meeting any HPMS filing deadlines needed by the entity to put the marketing material into use and will not expedite submissions to meet HPMS filing deadlines. UnitedHealthcare will opt-out of materials filed in HPMS that have not been prospectively reviewed and approved by UnitedHealthcare.**
- All materials (including those submitted for rereview) will be reviewed on a first in, first out basis During peak season (June – October), hundreds of materials may be received each day. UnitedHealthcare will prioritize initial reviews over rereviews received the same day.

- Submitters will receive an estimated turnaround time in their submission acknowledgement email based on current volume. *Note: UnitedHealthcare may adjust turnaround times without notice based on volume and quality of materials submitted.*
- Hints for optimal turnaround time:
    - Submit materials to UnitedHealthcare only after performing an internal quality review with multiple people.
    - Apply feedback globally. After being informed of required edits on one material, ensure future materials are not submitted with the same errors or omissions.
    - Submit materials early. Peak season is June – October, with highest volume mid-July – October. Submitting materials before July 15 is highly recommended.
    - Submit materials that require a 45-day CMS review (instead of 5-day file-and-use) first.
    - Account for weekends and holidays. Turnaround times are communicated in business days, which do not include Saturdays, Sundays, or weekdays designated as UnitedHealth Group company holidays. ○ When several materials of the same media type have very similar content, choose one of the following options:
        - Rewrite the materials as a single material with placeholders for variable/dynamic content and one SMID.
        - Keep the materials separate (each with their own SMID) but submit one before submitting them all. Wait for the reviewer's feedback and apply it globally to all similar materials prior to their initial submission.

How does this apply to UnitedHealthcare's MA/PDP marketing material review?

- UnitedHealthcare will only process a marketing material submission or resubmission email that meets requirements outlined in this section.
- All submissions will be acknowledged. When a submission is denied, a reason will be provided in the notification.
- All accepted submissions and resubmissions will be processed in the order received and material reviews (including resubmissions) will be conducted on a first in, first out basis. Initial reviews are prioritized over rereviews when received on the same day.
- Submitters will be notified and receive their submission back with reviewer comments at the conclusion of each round of review. Do not upload a material into HPMS and select UnitedHealthcare MA/PDP contracts until directed by UnitedHealthcare.
- UnitedHealthcare may close out an open item (i.e., SMID) due to inactivity 45 calendar days after an email notification is sent to the submitter. Reasons include no receipt of a clean and final copy, no receipt of an edited material, and no upload to HPMS.
- Once UnitedHealthcare opts into a material in HPMS, the use of the approved material will presume to expire the earlier of:

- The date on which the material becomes non-compliant due to changes in applicable state or federal regulations or guidelines or UnitedHealthcare business rules, policies, and procedures; ○ The last day of the applicable election period; or
- The last day of the applicable plan year.

Filing MA/PDP Marketing Materials in HPMS

- All materials that meet the CMS definition of marketing, including those used by third-party and downstream entities, must be submitted in the HPMS marketing module. Refer to the section below for communications and marketing material definitions.
  - Any MA/PDP marketing material that is intended to generate leads and/or market/sell UnitedHealthcare plans must be reviewed and approved by UnitedHealthcare prior to filing in HPMS and selecting any UnitedHealthcare MA/PDP contract(s). Refer to UnitedHealthcare's submission process for details. As required by CMS, TPMOs must disclose to carriers any subcontracted relationships used by the TPMO for lead generation, marketing, and/or enrollment activities. UnitedHealthcare will not process submission requests if the material is owned and operated by a subcontractor that the TPMO has not disclosed to UnitedHealthcare.
  - UnitedHealthcare holds each entity that uses a material individually responsible for identifying the material as marketing and complying with all applicable state and federal regulations and guidelines and UnitedHealthcare business rules, policies, and procedures related to marketing materials.
- Each marketing material must have a unique SMID, as defined by CMS, associated with it in the following format: MULTI-PLAN_<*unique characters*>_M. The SMID:
  - Must begin with "MULTI-PLAN."
  - Must end with "_M" for marketing materials. *Note: SMID guidelines for Online Enrollment Tools are different. Refer to Appendix B for details.*
- HPMS does not permit multiple filings under the same SMID.
  - CMS expects that materials that require changes/updates be marked as "no longer in use" in HPMS and resubmitted with a new SMID. *Exception: Websites being updated for the same plan year. Additional details can be found on the next page.*
  - When multiple entities need to upload the same material with the same SMID (a "clone"), CMS instructs entering a modified SMID in the SMID field in HPMS. The original SMID follows the format MULTI-PLAN_<*unique characters*>_M and all other uploads of that material are to include the submitting organization's initials between the unique characters and the "_M." For example, if the original SMID of an uploaded material is "MULTI-PLAN_Mailer01_M" and an organization with initials ABC is later uploading a "clone" of the material on behalf of their entity, they would enter "MULTI-PLAN_Mailer01_ABC_M" in the SMID field. However, the material could display "MULTI-PLAN_Mailer01_M" for all entities using it.

- When UnitedHealthcare MA/PDP contracts are selected when a material is filed in HPMS, the material must match the material reviewed and approved by UnitedHealthcare. ○ Marketing material must be filed in HPMS in an approved file format (e.g., Word, PDF, or PowerPoint). Links (including links within an approved file format), URLs, audio, video, and similar formats are not permitted as a substitute for providing written content. Refer to Appendix B for specific format requirements based on media type. ○ Each file may only include one marketing material, with the SMID noted in the file name. ○ Each HPMS filing should only include one file. Exceptions include:

    - Materials that include placeholders for variable content. The submission for materials with placeholders consists of a zipped file that contains the material and a spreadsheet or table identifying the actual data for each variable field. Spreadsheets or tables must only include the variable data found in the submitted material for the contracts/plans associated with the submitted material. *Note: When using placeholders that include nonmarketing content, (e.g. [date], [hours of operation], [agent name]), a table containing the actual data is not required with the submission, however, such data must be made available upon request.*
    - Materials that include a Medicare card image. Permission to use the Medicare card image must be obtained from CMS prior to filing and the approval email granting permission must be submitted in HPMS with the material in a zipped file.

  - The SMID filed in HPMS must match the SMID submitted to and approved by UnitedHealthcare and the SMID displayed on the marketing material (when required). Exceptions include:

    - Updated website materials refiled in HPMS for the same plan year. These materials must have the same SMID as the original material along with a suffix such as _A or _B after the _M when submitted to UnitedHealthcare for prospective review and when filed in HPMS. The suffix does not need to appear on the material.
    - SMIDs for identical materials, which UnitedHealthcare refers to as “clones.” These materials must be submitted to UnitedHealthcare and filed in HPMS with the submitting organization’s initials before the _M. The submitting organization’s initials do not need to appear on the material.

  - UnitedHealthcare uses the SMID for tracking and matching up prospective submissions with HPMS submissions. Therefore, it is critical that all SMIDs be submitted accurately.

    - Pay close attention to characters (especially hyphens, underscores, spaces) and capitalization when typing a SMID on the submission form and in HPMS.
    - Submitters who need to inform UnitedHealthcare of a SMID edit due to error must email Sales_Oversight@uhc.com with both the errant and updated SMID. *Note: This does not apply to website refiles or material “clones,” which must be treated as new submissions. See above for SMID instructions for these types of materials.*

- The Media Type selected in HPMS must match the media type indicated on the submission form.

- Generally, one Media Type is selected per marketing material based on content and intended use.
- If more than one Media Type is selected, it must be clear how the marketing material can be used for each type selected. For example, it may be appropriate to select Snail Mail and Email, but not Billboard and Hold Time Message.

- Once a material is submitted into HPMS and UnitedHealthcare contracts are selected, UnitedHealthcare will automatically be notified. Please refrain from sending filing notification emails or requests to opt in to Sales_Oversight@uhc.com.
  - Typically, UnitedHealthcare receives notification from HPMS on the 6th day for 5-day fileanduse materials and on the day after CMS approval for materials that require it.
  - Once notification is received, UnitedHealthcare will typically opt in or out of materials in HPMS within 2 business days. *Note: UnitedHealthcare may adjust turnaround times without notice based on volume and quality of materials submitted.*

How does this apply to UnitedHealthcare's MA/PDP marketing material review?

- UnitedHealthcare will opt-out of materials filed in HPMS when:
  - The material was not prospectively reviewed and approved by UnitedHealthcare. ○ The material does not match the approved version and/or is an abbreviated version (such as a list of changes) of the approved version.
  - The file uploaded is not a clean copy (e.g., it contains strikethrough edits and/or reviewer comments).
  - More than one material is uploaded or included in an uploaded file.
  - The material was deemed communications during the prospective review process (unless it is an Online Enrollment Tool). UnitedHealthcare does not review communications material on a prospective basis (unless we communicate the requirement to do so directly to a TPMO) or retrospectively if filed in HPMS. The entity that uses communications material is responsible for ensuring the material and the use of the material complies with applicable state and federal regulations and guidelines and UnitedHealthcare business rules, policies, and procedures prior to use. ○ More than one Media Type is selected, and it is not clear how the marketing material could be used as each type selected.
- UnitedHealthcare may assign corrective and/or disciplinary action if it is discovered that marketing material used is different from the version filed in HPMS.

Distinguishing Between MA/PDP Communications and MA/PDP Marketing Material

Communications Material Definition

Communications material provides information to consumers and/or members. While marketing materials are a subset of communications materials, the general practice is to refer to materials that do not meet the CMS definition of "marketing" as "communications" materials. In only very limited circumstances does CMS require a communications material be filed in HPMS. Refer to CMS regulations for guidance.

Marketing Material Definition

Marketing materials are communications materials that meet both of the following standards for intent and content. If a material does not meet both standards of intent and content, it is not considered marketing material.

Intent: The purpose of the material is to do any of the following:

- Draw a consumer or member's attention to an MA plan or PDP or group of MA plans or PDPs.
- Influence a consumer or member's decision-making process when selecting an MA plan or PDP.
- Influence a consumer or member's decision to stay enrolled in an MA plan or PDP (i.e., retention).

Content: Includes and/or addresses any of the following:

- Plan specific information about benefits or benefit structure. Per CMS, any material or activity that is distributed via any means that mentions any benefit is considered marketing and must be submitted into HPMS.
    - According to CMS, high level mention of plan benefits such as "vision," "dental," and "hearing" are considered marketing.
    - The use of "prescription drugs" depends on context. When listed as a benefit, it is marketing. However, there may be instances in which its use is deemed communications (for example, when defining a PDP as a "Prescription Drug Plan."
- Information about premiums and cost sharing (e.g., no premium, $0 copays, and "get money back in your Social Security check").
- Rankings or measurements (e.g., Information on Star Ratings or comparisons to other Plan(s))
- Mention of Rewards and Incentives

How does this apply to UnitedHealthcare's MA/PDP marketing material review?

- Even though communication materials are generally not submitted to UnitedHealthcare for review and approval prior to use and are not filed in HPMS unless required by CMS, only compliant communications materials may be used to represent UnitedHealthcare. UnitedHealthcare will not review non-carrier branded communication materials unless filing in HPMS is required (unless we specifically require a TPMO to submit these materials to us). Refer to the Agent Guide and job aids available on ***Jarvis*** for more information.
- UnitedHealthcare will only approve materials if at least one UnitedHealthcare plan with one or more of the indicated benefits and/or costs is available to the targeted consumer audience in the anticipated material distribution area.
- Per CMS, dual eligible consumers may no longer switch to a non-integrated Dual Special Needs Plan (D-SNP) or other MA plan mid-year under the dual/LIS special enrollment period (SEP). As

such, UnitedHealthcare will not approve TPMO marketing materials that target a D-SNP audience outside of AEP.

- UnitedHealthcare will only approve TPMO marketing materials that list benefits at a high level. For example, it is permissible to advertise “dental,” “hearing,” and/or “vision.” However, it is prohibited to market specific products or services such as “root canals,” “hearing aids,” and/or “eyeglasses.”
- UnitedHealthcare prohibits featuring any benefit that is an SSBCI (Special Supplement Benefit for the Chronically Ill) in TPMO marketing materials. As such, the CMS required SSBCI disclaimer is moot and must not be present.
- Per CMS, mentions of Value-Added Items and Services (VAIS) must not be included in any marketing materials. VAIS are non-Medicare covered services or items, typically discounts, offered by a VAIS provider to members of an MA plan. They are not part of the plan’s benefit package and may not be marketed to consumers or used as an inducement or incentive for enrollment.
- When listing multiple benefits in a single material, UnitedHealthcare requires the use of “or,” “and/or,” or similar so it is clear to the consumer that not all plans may have all of the advertised benefits. *Exception: “And” or implied “and” (such as a list with no conjunctions) is allowed in geotargeted materials that truly offer at least one plan with all of the advertised benefits to the targeted consumer audience in the anticipated material distribution area.*

- When UnitedHealthcare has concerns related to how a material will be used in the market, the reviewer will enter a comment related to the concern and remind the submitter of compliant marketing/sales activities. UnitedHealthcare does not permit compliant material to be used in a non-compliant manner.

Marketing Material Disclaimers

Appendix A lists disclaimers required on TPMO marketing materials.

- Disclaimers must be displayed in a font size, color (contrast with background), and style that is reasonably readable by the average consumer in the intended audience. UnitedHealthcare considers size 12-point Times New Roman (or equivalent) to be the minimum standard for disclaimer text.
- Standardized disclaimers must be used verbatim.
- Model disclaimers must convey the vital information in the required content created by CMS and follow specified order of content, if applicable.

How does this apply to UnitedHealthcare's MA/PDP marketing material review?

If during the prospective review process, UnitedHealthcare determines that the marketing material submitted is missing one or more required disclaimers, or a required disclaimer is not correctly displayed in the material, UnitedHealthcare will identify the disclaimer and the required edit.

Questions

UnitedHealthcare provides numerous resources to guide agents/agencies. Valuable resources include the Agent Guide, EDC Operations Guide, and job aids on ***Jarvis*** and your UnitedHealthcare market manager or account director.

Submit compliance related questions to Compliance_Questions@uhc.com.

Appendix A: Disclaimers

Table 1: CMS Required Disclaimers (Disclaimers inside quote marks are standardized disclaimers and must be used verbatim.)

Disclaimer	Instructions	Required Text or Content

Federal Contracting Statement (FCS)	Required on all marketing materials except banner and banner-like advertisements, envelopes, outdoor advertisements, social media posts, digital/search ads and text messages.	Plans are insured or covered by a Medicare Advantage (HMO, PPO and PFFS) organization with a Medicare contract and/or a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare. The Federal Contracting Statement must include all of the following: -Legal or marketing name of the organization. -Type of plan (for example, HMO, HMO SNP, PPO, PFFS, PDP). -A statement that the organization has a contract with Medicare (when applicable, MA organizations may incorporate a statement that the organization has a contract with the state/Medicaid program). -A statement that enrollment depends on contract renewal.
Star Ratings	Required on any marketing material that references Star Ratings *Note: If space is limited with electronic media, it is acceptable to provide the Star Ratings disclaimer to the viewer when the viewer clicks on the ad.*	"Every year, Medicare evaluates plans based on a 5-star rating system."
Materials Developed by a Third Party	• Disclaimer must be prominently displayed on TPMO websites and marketing materials, including all print materials and television advertising that meets the definition of marketing. • Disclaimer must be provided verbally, electronically, or in writing,	If the TPMO does not sell for all MA organizations and/or Part D sponsors in the service area: "We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact

Disclaimer	Instructions	Required Text or Content

	depending on how the TPMO is interacting with the Medicare beneficiary. If telephonic interaction, disclaimer must be provided verbally within the first minute of the sales call.	Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options." If the TPMO sells for all MA organizations and/or Part D sponsors in the service area: "Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) for help with plan choices."
Promoting Drawings, Prizes, or Free Gifts	Required on materials when promoting drawings, prizes, or free gifts.	Eligible for <a free drawing, gift, or prizes> with no obligation to enroll.
Accommodations	Required on all invitations to events, including educational and marketing/sales events	For accommodations of persons with special needs at meetings, call <insert phone and TTY number>.

TPMO Lead Generation Notification	• TPMOs conducting lead generation activities must inform the Medicare beneficiary that their information will be provided to a licensed sales agent for future contact, or that the Medicare beneficiary is being transferred to a licensed sales agent who can enroll them into a new plan. • To be done verbally, electronically, or in writing, depending on how the TPMO is interacting with the Medicare beneficiary.	• On all Business Reply Cards (paper, electronic, or telephonic), it must clearly state that a licensed sales agent will be contacting the Medicare beneficiary. • On call scripts, when transferring the call to a licensed sales agent, the individual speaking to the Medicare beneficiary must clearly state the call is being transferred to a licensed sales agent. • **Effective October 1, 2024:** If leads will be shared with another TPMO, the material must contain a clear and conspicuous disclosure that lists each entity receiving the data and allows the Medicare beneficiary to consent or

Disclaimer	Instructions	Required Text or Content
		reject to the sharing of their data with each individual TPMO.
Product Endorsements and Testimonials	Organizations may use individuals to endorse an MA organization's product provided the endorsement or testimonial adheres to the following requirements: • The speaker must identify the MA organization's product or company by name. • Medicare beneficiaries endorsing or promoting MA plans must have been a member of the plan at the time the endorsement or testimonial was created. • The endorsement or testimonial must clearly state that the individual was paid for the endorsement or testimonial, if applicable. • If an individual is used (for example, an actor) to portray a real or fictitious situation, the endorsement or testimonial must state that it is an actor portrayal.	"Paid endorsement" or "Paid actor portrayal" *Note: Place the disclaimer in the body copy or in the disclaimer/footnote.*

Not Affiliated with Medicare or Government	CMS prohibits the use of the Medicare name, logo, or products in a misleading manner when used to market MA and/or Part D plans. Disclaimers or taglines that are prominently placed, in a font size and color to be readily noticed, and that clearly explain that an entity or website is not affiliated with, endorsed by, or otherwise somehow related to the federal government, CMS, HHS, and/or Medicare are essential. Examples include, but are not limited to: ▯Using the U.S. flag very similar to images seen on government offices	Not affiliated with or endorsed by any government agency. *Note: If a material includes the word "Medicare" in the organization's name or logo, "a non-government entity", must be directly below the name or logo.*
Disclaimer	**Instructions**	**Required Text or Content**
	• Using a red, white, and blue color scheme appearing to be associated with the government. • Including the word "Medicare" in the organization's name, logo, or URL (e.g., Medicare Helpline, Medicare Benefits Hotline). • Use of the Medicare card image is only permitted with CMS authorization.	

Carrier Notification	The names of MA organizations or Part D sponsors being advertised must be clearly displayed. • Must be in 12-point font in print and may not be in the form of a disclaimer or in fine print. • For television, online, or social media, must be either read at the same pace as the phone number or must be displayed throughout the entire advertisement in a font size equivalent to the advertised phone number, contact information or benefits. • For radio or other voice-based advertisements, must be read at the same pace as phone numbers or contact information.	UnitedHealthcare must be identified in marketing materials as "UnitedHealthcare®" - one word, capital U and H, registration mark, black font. *Note:* Logo requests will only be entertained for websites to announce affiliation. Logos are not to be used to identify UnitedHealthcare as a carrier represented by the marketing content.
SSBCI	UnitedHealthcare prohibits featuring any benefit that is an SSBCI (Special Supplement Benefit for the Chronically Ill) in TPMO marketing materials. As such, the CMS required SSBCI disclaimer is moot and must not be present.	While CMS provides specific guidelines for this disclaimer, they are out of scope because UnitedHealthcare prohibits featuring any benefit that is an SSBCI in TPMO marketing materials.

Table 2: UnitedHealthcare Required Disclaimers

Disclaimer	Instructions	Required Text or Content

Disclaimer	Instructions	Required Text or Content
Lead Generation / Permission to Contact Mechanism	In addition to other applicable permission to contact guidelines, lead generation mechanisms: • May only collect information for one individual. For example, the mechanism must not provide fields for both spouses, such as two signature fields. • May include fields or ask questions related Medicare beneficiary's date of birth (DOB), gender, and tobacco use **only** if the lead generation mechanism includes Medicare Supplement Insurance in addition to Medicare Advantage and/or Prescription Drug plans. **All field(s) must be optional and there must be a note clearly indicating that information related to DOB, gender, and tobacco use questions is not needed for MA and Part D plans.**	The following content must be included within reasonable proximity of the Business Reply Card (BRC) / Electronic Business Reply Card (eBRC) in such a way that the consumer must see it **prior** to consenting: • Must clearly inform the Medicare beneficiary that their information will be provided to a licensed sales agent for future contact or that the Medicare beneficiary is being transferred to a licensed sales agent who can enroll them into a Medicare Advantage or Prescription Drug plan. • Must include scope of product with products identified in an accurate and complete manner, such as Medicare Advantage, Prescription Drug (Part D), and Medicare Supplement Insurance plans. • Must include the statement, "This is a solicitation for insurance.", for any permission to contact (PTC) linked to Medicare Supplement products. • Must include contact methods (e.g., telephone and email) to provide a mechanism for consumers to identify the methods of contact they are consenting to receive. The contact methods listed in the PTC statement must match the form fields in the BRC/eBRC. • **Effective October 1, 2024:** If leads will be shared with another TPMO, the material must contain a clear and conspicuous disclosure that lists each entity receiving the data and allows the Medicare beneficiary to consent or reject to the sharing of their data with each individual TPMO.
5 Star Rating Special	Include whenever a marketing material mentions the potential	A 5-star Special Enrollment Period may be used one time between December 8 and

Election Period (SEP)	availability to enroll in a 5-star rated plan.	November 30 of the following year, provided you meet the plan's enrollment requirement.
Benefits Across Plans	Include when referencing benefits.	Not all plans offer all of these benefits. Benefits may vary by carrier and location. Limitations and exclusions may apply.
Part B Giveback	UnitedHealthcare strongly discourages the mention of a specific dollar amount when advertising the Part B Giveback benefit. However, whether or not a dollar amount is included will determine which disclaimer is required.	*When no dollar amount is listed:* Part B Premium giveback is not available with all plans. Availability varies by carrier and location. Actual Part B premium reduction could be lower. *When a specific dollar amount is listed:* The standard Part B premium for <year> is <amount>. Monthly savings varies and may be subject to processing delays and may not be immediate. Not available with all plans. Availability varies by carrier and location.
Special Enrollment Period (SEP)	A disclaimer is required when advertising outside of the Annual Enrollment Period (AEP)	Enrollment in a plan may be limited to certain times of the year unless you qualify for a Special Enrollment Period or you are in your Medicare Initial Enrollment Period.

Appendix B: Specific Guidelines by Media Type

Reference Resources (click on document to link)

- Contract Year 2025 Final Rule (Published 04/23/2024)
- Medicare Communications and Marketing Guidelines
- 42 CFR Part 422 Subpart V
- 42 CFR Part 423 Subpart V
- 2024 Agent and Broker Training & Testing Guidelines (#4)
- MA Enrollment and Disenrollment Guidance
- PDP Enrollment and Disenrollment Guidance

Media Type Category

Review guidelines specific to the media type.

"Snail" Mail, Brochures, Newsletters, Newspaper/Magazine, Posters/Flyers/Signs

The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable.

Banners/Billboards/Outdoor Advertisements

- The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable.
- Specific Exceptions:
    - Federal Contracting Statement (FCS).
    - Standardized Material Identification (SMID) when in use.
    - Hours and days of operation where 1-800-MEDICARE or Medicare TTY appears.

Email

- The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable.
- Per the CAN-SPAM Act, the following rules apply to marketing emails sent to a consumer/member who has provided permission to be emailed: ○ The header information must clearly and accurately identify the person or business sending the email and must not contain false or misleading information.
    - The subject line must accurately reflect the content of the email message and must not be deceptive.
    - The email message must identify the message as an advertisement, such as, "This is a promotional email." or "This is an advertisement." ○ The email message must provide the sender's mailing and/or physical address.
    - Must include an opt-out mechanism. As a reminder, UnitedHealthcare's policy does not permit open-ended permission to email. Therefore, permission to email expires after an email covered under the consumer/member's explicit permission to email is sent.

Reminders related to email messaging activities:

- Agents may send unsolicited emails. However, unsolicited emails must not appear to be coming from or on behalf of UnitedHealthcare and must not contain any UnitedHealthcare brand name or elements (except as required to comply with CMS requirements to identify carriers in multicarrier marketing materials).
- All material rules and requirements apply. Emails must have an opt-out/unsubscribe function and must comply with all federal and state laws and regulations, including but not limited to CAN-SPAM requirements.

Enrollment Scripts

- The requirements from Enrollment and Disenrollment Guidance (Chapter 2 of the Medicare Managed Care Manual (MMCM) and Chapter 3 of the Prescription Drug Benefit Manual (PDBM), Medicare Communications and Marketing Guidelines (MCMG) and CFR (Part 422 and Part 423) are applicable. *Note: CMS may update Chapter 2 of the MMCM and Chapter 3 of the PDBM for contract year 2025.*
- For telephonic enrollment, the Medicare beneficiary must be verbally told:
    - Where the Star Ratings Document can be accessed. ○ Where the Summary of Benefits can be accessed.
- All requirements outlined in *Section 40.1.3 – Enrollment via Telephone* in Chapter 2 of the MMCM and Chapter 3 of the PDBM must be included in an enrollment script.
- All required elements from the following models must be included in an enrollment script, unless otherwise noted in Appendix 2 (see below).
    - For MA (and PFFS): CY 2024 Model MA Individual Enrollment Form 0938-1378 (PDF) *Note: CMS may update this document for contract year 2025.*
    - For PFFS: Exhibit 1c: Model PFFS Individual Enrollment Request Form from Chapter 2 of the MMCM
    - For PDP: CY 2024 Model PDP Individual Enrollment Request Form 0938-1378 (PDF)*: Note: CMS may update this document for contract year 2025.*
- All required elements described in *Appendix 2 – Summary of Data Elements Required for Plan Enrollment Mechanisms and Completed Enrollment Requests* in Chapter 2 of the MMCM and Chapter 3 of the PDBM must be included in an enrollment script.
- All applicable elements in *Appendix 1 – Standardized Pre-Enrollment Checklist in the MCMG* must be included in an enrollment script. *Note: Until the updated PECL model is released by CMS, plans are required to add a check box under the "Important Rules" header with the following information:*
    - Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- Optional: Include specific statements from *Exhibit 1a – Information to Include on or with Enrollment Mechanism – Attestation of Eligibility for an Enrollment Period* in Chapter 2 of the MMCM and Chapter 3 of the PDBM.

Envelopes

- The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable.

- Specific Exceptions:
  - Federal Contracting Statement (FCS).
  - Standardized Material Identification (SMID) when in use.

Hold Time Messages

The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable.

Mobile Applications

The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable.

Online Enrollment (OLE) Tools

- An OLE must be submitted as an individual material in HPMS using the 5-day File & Use process.
- An OLE is a communications material as defined in the MCMG; therefore, the SMID will end with "_C." For example, MULTI-PLAN_ABC2023OLE_C.
- In HPMS, under New Material, select "Required" and then "Online Enrollment Form."
- All requirements outlined in Chapter 2 and Chapter 3 Enrollment and Disenrollment Guidance Section 40.1.2 – Electronic Enrollment must be included in the OLE.
- The required statements and data elements from Appendix C of this document and elements from Appendix 2 of Chapter 2 of the MMCM and Chapter 3 of the PDBM based on plan types (e.g., MA, Private Fee-for-Service (PFFS), and PDP) apply. *Note: CMS may update Chapter 2 and Chapter 3 as well as the MA and PDP Model Enrollment Forms for contract year 2025.*

Provider Office

The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable.

Radio

- Radio segments and advertisements must be submitted to CMS as a 45-day review.
- The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable.
- Specific Exceptions:
  - Standardized Material Identification (SMID) when in use.
  - Hours and days of operation where 1-800-MEDICARE or Medicare TTY appears.

Sales Presentations

- Sales Presentations must be submitted to CMS as a 45-day review.
- The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable.

Social Media

- The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable.
- Specific Exceptions:
  - Federal Contracting Statement (FCS) on social media posts.
  - Standardized Material Identification (SMID) when in use. ○ YouTube videos must be filed as “Television/Online Videos,” not social media.

Telephonic Messages (Voice Messages)

The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable.

Telephonic Sales Scripts

- The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable.
- The Medicare beneficiary must consent to being transferred to a sales/enrollment department and the consent must be obtained using a yes/no question.
- If a sales call progresses to a telephonic enrollment, the licensed agent must clearly inform the Medicare beneficiary that they are enrolling in the Plan, using the specific plan name and type.
- Specific Requirements:
  - Identify the plan representative as a licensed sales agent or appropriate agent title. ○ Identify the licensed sales agent’s organization (i.e., agency, not carrier).
  - Explain when the call transitions to an enrollment in a Medicare Advantage or Prescription Drug plan.
  - Explain how enrollment will affect current coverage.
  - Ask needs assessment questions based on the 2024 Agent and Broker Training & Testing Guidelines (#4) during the marketing and sale of an MA or Part D plan, prior to the beginning of the enrollment process. *Note: CMS may update this document for contract year 2025.*
  - Include language to conduct a complete presentation of the plan recommended, including but not limited to plan premiums, benefits, cost-sharing, and network requirements.
  - Include language to resolve Medicare beneficiary comprehension issues, including but not limited to asking if the consumer has an authorized legal representative or other party that assists with insurance decisions.
- Call flow structure example: ○ Greeting, including HIPAA authentication and statement of recording ○ FCS and TPMO disclaimer ○ Eligibility determination ○ Needs assessment

- Plan presentation, comparison, and recommendation ○ Transfer to sales/enrollment department for enrollment

Television/Online Videos

- Television ads and online videos must be submitted to CMS as a 45-day review.
- The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable.
- YouTube videos must be filed in this category.

Text Messages

- The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable. Texting must also comply with applicable federal and state laws regulating telephonic contact (e.g., Telephonic Consumer Protection Act (TCPA) and related laws).
- Text messages must include an opt-out option to stop receiving future text messages.
- Specific Exceptions:
  - Federal Contracting Statement (FCS).
  - Standardized Material Identification (SMID) when in use.

Reminders related to text messaging activities:

- **UnitedHealthcare sales policy does not permit sending an unsolicited text message to a consumer/member, even if an opt-out statement appears on each text message.**
- Explicit permission from the consumer/member must be received to send a text message to the consumer/member. Permission to text message is not open-ended. Permission to contact expires 12 months from the date of the consumer signature date or the date of their initial request for information or when the consumer requests no future contact, whichever comes first, unless an exception applies. ○ Exceptions include but are not limited to, consumers on the Do-Not-Call registry, consumers who request information for Medicare Supplement insurance plans, or consumers on a Medicaid list. For consumers on the Do-Not-Call registry or requesting information on Medicare Supplement insurance plans, PTC expires 90 days after the date of the consumer signature date or the date of their initial request for information.
  - If agents are receiving PTC from UnitedHealthcare, their up-line, or other third-party sources, the date of the consumer signature or the date of their initial request for information may be prior to the date the agent obtains the PTC.

Websites (Includes Website Landing Pages)

UnitedHealthcare policy requires agencies and affiliated third-party entities (e.g., multi-carrier enrollment websites) to obtain permission to operate a website that contains marketing content prior to submitting the website for prospective review. Generally, only eAlliance agencies, Telephonic Addendum agencies,

agencies contracted at the NMA or SMO level, and pre-approved multi-carrier enrollment website entities will be approved. UnitedHealthcare does not permit downline agencies, agents, and solicitors to operate a website that contains marketing content.

In addition to all other applicable guidelines, the following guidelines are specific to TPMO and multicarrier websites that are considered marketing material:

- The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable.
- Specific Requirements:
    - **For initial review and all subsequent plan year annual reviews, UnitedHealthcare requires the submission of a comprehensive copy deck in Word.** UnitedHealthcare recognizes that many websites are utilized year after year with updates made annually prior to AEP. Technically, these annual updates cannot be considered a refile because they span multiple plan years. **A comprehensive copy deck is required for each plan year;** partial comprehensive copy decks showing edits and/or stand-alone lists of changes are unacceptable.
        - All subpages displaying the same SMID must be included in the copy deck in comprehensive text form. Screenshots are not an acceptable substitute for written out text.
        - Subpages displaying a different SMID must be submitted separately for prospective review and approval prior to filing separately in HPMS.
        - Subpages of marketing websites that contain steps leading to an electronic business reply card (eBRC) and/or steps leading to plan search results must be included in comprehensive text form and must display the same SMID as the homepage, unless the eBRC and/or plan search websites are part of a separate filing with a unique SMID.
        - All subpages with a UnitedHealthcare brand element must be included in the copy deck in comprehensive text form.
        - Subpages that contain only non-Medicare content or Medicare communications content, and as such do not display the marketing website's SMID, do not need to be included in the copy deck in comprehensive text form. The link to these subpages (where it appears on the website) is sufficient.
    - **When submitting refiles** (including additions and deletions) of previously reviewed and approved websites for use during the same plan year, UnitedHealthcare prefers to receive the currently approved comprehensive website in an approved format with edits listed and highlighted. However, if that is not possible, at minimum, the entire webpage with edits noted must be submitted to UnitedHealthcare in an approved format for UnitedHealthcare prospective review. A stand-alone list of changes is not acceptable. UnitedHealthcare will opt out of HPMS filings that contain only a list of changes.
    - The following requirements apply to all website submissions:
        - Submit the website final URL (written out in text) within the comprehensive copy deck near the top.

- All website copy decks must be compared against their corresponding website. If a future website has not been released (i.e., it is not live), a test site with access credentials must be provided. If neither a live site nor a test site is available, screenshots must be provided.
- Marketing content for non-MA fand/or PDP plans, such as Medicare Supplement Insurance, must be separated and distinct from MA and/or PDP plan marketing content.
- Other lines of business must be kept separate and distinct from MA and/or PDP plan marketing content.

- Affiliation Announcements:
  - UnitedHealthcare permits contracted entities to announce on their owned and operated website an affiliation with UnitedHealthcare by using our name, UnitedHealthcare® (capital "U" and "H", one-word, registration mark, and black font), or an approved logo. *Note: The CMS requirement to identify the carrier represented by the marketing material is not the same as an affiliation announcement. The UnitedHealthcare logo must not be used to meet the CMS requirement*.
  - Each URL containing an affiliation announcement must be registered. ○ To register a website and request a logo file, submit a completed Website Registration and Logo Request form according to the instructions on the form.

Other (Digital or Search Ads)

- HPMS does not identify digital and search ads as specific media types. However, when submitting materials to UnitedHealthcare, select Other (Digital or Search Ad) in the Media Type drop-down list when applicable. When filing in HPMS, select Other (Specify) and in the field provided indicate Digital Ad or Search Ad as applicable.
- The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable.
- Specific Exceptions:
  - Federal Contracting Statement (FCS). ○ Standardized Material Identification (SMID) when in use. ○ Hours and days of operation where 1-800-MEDICARE or Medicare TTY appears.
- All other applicable guidelines must be applied based on the media type.

Other (Specify)

- If HPMS does not provide a Media Type for the material created, select "Other" and then enter in the field provided an applicable description.
- The marketing and communications requirements from MCMG and regulatory requirements in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V are applicable.

- All other applicable guidelines must be applied based on the media type.

Appendix C: MA/PDP Enrollment Form/Tool Requirements

Note: CMS may update Chapter 2 of the MMCM and Chapter 3 of the PDBM as well as the MA and PDP Model Enrollment Forms for contract year 2025.

The following statements and data elements are required based on plan type.

Required Statements for Enrollment Form/Tools

Important Information Statement – MA/MAPD

- I must keep both Hospital (Part A) and Medical (Part B) to stay in <Plan Name>.
- By joining this Medicare Advantage Plan, I acknowledge that <Plan Name> will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my <Plan Name> coverage begins, I must get all of my medical and prescription drug benefits from <Plan Name>. Benefits and services provided by <Plan Name> and contained in my <Plan Name> “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor <Plan Name> will pay for benefits or services that are not covered. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that: 1) This person is authorized under State law to complete this enrollment, and 2) Documentation of this authority is available upon request by Medicare.
- **PRIVACY ACT STATEMENT:** The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track Medicare beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Important Information Statement – PFFS

- <Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan as well as other Medicare Advantage plans. Your doctor or hospital isn't required to agree to accept our plan's terms and conditions, and may choose not to treat you,

  except in emergencies. You should verify that your provider(s) will accept <plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.

- [***Omit the following paragraph*** *if Medicare beneficiary is switching from one PFFS plan to another PFFS plan offered by the same MAO*: Once <plan name> has your enrollment form, you will get a call from a plan representative. This call is to make sure that you understand how a Private FeeforService plan works and to confirm your intent to enroll in <plan name>. If <plan name> isn't able to reach you by telephone, then you will get a letter by mail that contains similar information.]

- [***PFFS-PD plans insert****:* If you currently have health coverage from an employer or union, joining <PFFS-PD Name> could affect your employer or union health benefits. If you have health coverage from an employer or union, joining <PFFS-PD Name> may change how your current coverage works. You or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.]

- **By completing this enrollment application, I agree to the following:**

  - <Plan Name> is a Medicare Private Fee-For-Service plan and has a contract with the federal government. I will need to keep my Medicare Parts A and B. I understand that this plan is a Medicare Advantage Private-Fee-For-Service plan, and I can be in only one Medicare health plan at a time. I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan [***PFFS w/PD insert***: or Medicare prescription drug plan.]. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. [***PFFS w/o PD only plans insert:*** I understand that since this plan does not offer Medicare prescription drug coverage, I may get coverage from another Medicare prescription drug plan. If I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.] Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7 of every year), or under certain special circumstances.
  - As a Medicare Private Fee-For-Service plan, <plan name> works differently than a Medicare supplement plan as well as other Medicare Advantage plans. <Plan name> pays instead of Medicare, and I will be responsible for the amounts that <plan name> doesn't cover, such as copayments and coinsurances. Original Medicare won't pay for my health care while I am enrolled in <plan name>. Before seeing a provider, I should verify that the provider will accept <plan name>. I understand that my health care providers have the right to choose whether to accept <plan name>'s payment terms and conditions every time I see them. I understand that if my provider doesn't accept <plan name>, I will need to find another provider that will. <Plan name> serves a specific service area. If I move out of the area that <plan name> serves, I need

to notify <plan name> so I can disenroll and find a new plan in my new area. Once I am a member of <plan name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from <plan name> when I get it to know which rules I must follow in to get

coverage with this Private Fee-For-Service plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

- I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with <plan name>, he/she may be paid based on my enrollment in<plan name>.

- **Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that <plan name> will release my information [***PFFS-PD plans insert*:** including my prescription drug event data] to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

- I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this

  signature certifies that: 1) this person is authorized under State law to complete this enrollment, and 2) documentation of this authority is available upon request from Medicare.

<u>Important Information Statement – PDP</u>

- I must keep Hospital (Part A) or Medical (Part B) to stay in <Plan Name>.
- By joining this Medicare Prescription Drug Plan, I acknowledge that <Plan Name> will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that: 1) This person is authorized under State law to complete this enrollment, and 2) Documentation of this authority is available upon request by Medicare.

- **PRIVACY ACT STATEMENT:** The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track Medicare beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Required Data Elements for Enrollment Form/Tools

Data Fields

Required data fields listed as **"Yes" must** be included on enrollment form. Fields listed as "No" are Optional Fields.

Medicare Beneficiary Responses

All Medicare beneficiary responses with a "Yes" in the **"**Medicare Beneficiary Response Required" column are required in order for the enrollment to be considered complete. Any item marked **"No" cannot** be a "Required" Medicare beneficiary response field, only an "Optional" Medicare beneficiary response field.

Enrollment Data Elements	Required Field	Medicare Beneficiary Response Required
MA or PDP Plan name[1]	**Yes**	Yes
Medicare beneficiary name	**Yes**	Yes
Medicare beneficiary date of birth	**Yes**	Yes
Medicare beneficiary sex	**Yes**	Yes
Medicare beneficiary telephone number	**Yes**	**No**
Permanent residence address (with the exception of "County")	**Yes**	Yes
Mailing address	**Yes**	**No**
Name of person to contact in emergency, including phone number and relationship to Medicare beneficiary	No	**No**
Email address	No	**No**

Medicare beneficiary Medicare number	**Yes**	Yes
Additional Medicare information contained on Medicare card, or copy of card	No	**No**
Plan premium payment option (not a required field on zero premium MAonly plan or PDP-only enrollment forms)	**Yes**	**No**
Long term care question	No	**No**
Other insurance COB information (not a required field on PDP-only enrollment forms)	**Yes**	Yes
Medicare beneficiary ethnicity: Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.	**Yes**	**No**

Enrollment Data Elements	Required Field	Medicare Beneficiary Response Required
• No, not of Hispanic, Latino/a, or Spanish origin • Yes, Mexican, Mexican American, Chicano/a • Yes, Puerto Rican • Yes, Cuban • Yes, another Hispanic, Latino/a, or Spanish origin I choose not to answer.		

Medicare beneficiary race: What's your race? Select all that apply. • American Indian or Alaska Native ☐ Asian: ○ Asian Indian ○ Chinese ○ Filipino ○ Japanese ○ Korean ○ Vietnamese ○ Other Asian • Native Hawaiian and Pacific Islander: ○ Guamanian or Chamorro ○ Native Hawaiian ○ Samoan ○ Other Pacific Islander • White • Member/Citizen of a federal or state recognized Tribe (name of Tribe) _____ *(UnitedHealthcare requests that this be pr* *required element)* ☐ Black or African American ☐	**Yes**	**No**
Option to request materials in language other than English or in accessible formats	**Yes**	**No**
Name of chosen Primary Care Physician, clinic, or health center (optional field)	**No**	**No**
Medicare beneficiary signature and/or authorized representative signature	**Yes**	**Yes**
Date of signature	**Yes**	**No**[2]
Authorized representative contact information	**Yes**	**Yes**
Description of SNP eligibility (required only on Special Needs Plans)	**Yes**	**Yes**
Information provided under "please read and sign below": All elements provided in model language must be included on enrollment request	**Yes**	**Yes**

Enrollment Data Elements	Required Field	Medicare Beneficiary Response Required
mechanisms. (option: can be provided as narrative or listed as statements of understanding)		
Release of Information: All elements provided in model language must be included on enrollment request mechanisms.	**Yes**	**Yes**
Notification of receiving plan materials electronically and ability to opt out	**No**	**No**

[1] If enrollment mechanism will be used for multiple plans, all plan names must be listed in a way that permits the applicant to clearly indicate his/her plan choice.

[2] The Medicare beneficiary and/or legal representative should write the date enrollment form signed, however, if s/he inadvertently fails to include the date on the enrollment form, then the stamped date of receipt that the MA organization places on the enrollment form may serve as the signature date of the form. Therefore, the signature date is **not** a necessary element.

Resources

CY2024 MA Enrollment and Disenrollment Guidance – Chapter 2

CY2024 PDP Enrollment and Disenrollment Guidance – Chapter 3

CY 2024 Exhibit 1: Model MA Indiv Enrollment Request Form 0938-1378 (PDF)

CY 2024 Exhibit 1: Model PDP Indiv Enrollment Request Form 0938-1378 (PDF)