

(i) Plans may pay agents and brokers up-front or prorate compensation payments over 12 months or over months 4 through 12, but

(ii) When a beneficiary disenrolls from the plan, the plan must recover all compensation paid: for months in which the beneficiary is not enrolled; and during months 1 through 3 if the beneficiary disenrolls during the first three months.

(5) Organizations and sponsors must establish a compensation structure for new and replacement enrollments and renewals effective in a given plan year. Compensation structures must be in place by the beginning of the marketing period, October 1.

(6) Compensation structures must be available upon CMS request including for audits, investigations, and to resolve complaints.

(b) It must ensure agents selling Medicare products are trained annually on Medicare rules and regulations specific to the plan products they intend to sell.

(c) It must ensure agents selling Medicare products are tested annually, as specified in CMS guidance.

(d) Upon CMS' request, the organization must provide to CMS, in a form consistent with current CMS guidance, the information necessary for it to conduct oversight of marketing activities.

(e) It must comply with State requests for information about the performance of a licensed agent or broker as part of a state investigation into the individual's conduct. CMS will establish and maintain a memorandum of understanding (MOU) to share compliance and oversight information with States that agree to the MOU.

[73 FR 54253, Sept. 18, 2008, as amended at 73 FR 67413, Nov. 14, 2008]

**§ 423.2276 Employer group retiree marketing.**

Part D sponsors may develop marketing materials designed for members of an employer group who are eligible for employer-sponsored benefits through the Part D sponsor, and furnish these materials only to the group members. These materials are not subject to CMS prior review and approval.

**PART 424—CONDITIONS FOR MEDICARE PAYMENT**

**Subpart A—General Provisions**

Sec.

- 424.1 Basis and scope.
- 424.3 Definitions.
- 424.5 Basic conditions.
- 424.7 General limitations.

**Subpart B—Certification and Plan Requirements**

- 424.10 Purpose and scope.
- 424.11 General procedures.
- 424.13 Requirements for inpatient services of hospitals other than psychiatric hospitals.
- 424.14 Requirements for inpatient services of inpatient psychiatric facilities.
- 424.15 Requirements for inpatient CAH services.
- 424.16 Timing of certification for individual admitted to a hospital before entitlement to Medicare benefits.
- 424.20 Requirements for posthospital SNF care.
- 424.22 Requirements for home health services.
- 424.24 Requirements for medical and other health services furnished by providers under Medicare Part B.
- 424.27 Requirements for comprehensive outpatient rehabilitation facility (CORF) services.

**Subpart C—Claims for Payment**

- 424.30 Scope.
- 424.32 Basic requirements for all claims.
- 424.33 Additional requirements: Claims for services of providers and claims by suppliers and nonparticipating hospitals.
- 424.34 Additional requirements: Beneficiary's claim for direct payment.
- 424.36 Signature requirements.
- 424.37 Evidence of authority to sign on behalf of the beneficiary.
- 424.40 Request for payment effective for more than one claim.
- 424.44 Time limits for filing claims.

**Subpart D—To Whom Payment is Ordinarily Made**

- 424.50 Scope.
- 424.51 Payment to the provider.
- 424.52 Payment to a nonparticipating hospital.
- 424.53 Payment to the beneficiary.
- 424.54 Payment to the beneficiary's legal representative or representative payee.
- 424.55 Payment to the supplier.
- 424.56 Payment to a beneficiary and to a supplier.