

**§ 422.2267**

(ix) Accept compensation from the MA organization for any marketing or enrollment activities performed on behalf of the MA organization.

(2) During plan-initiated provider activities, the provider may do any of the following:

(i) Make available, distribute, and display communications materials, including in areas where care is being delivered.

(ii) Provide or make available marketing materials and enrollment forms in common areas.

(e) *MA organization activities in the health care setting.* MA organization activities in the health care setting are those activities, including marketing activities that are conducted by MA organization staff or on behalf of the MA organization, or by any downstream entity, but not by a provider. All marketing must comply with the requirements in paragraphs (a) and (b) of this section. However, during MA organization activities, the following is permitted:

(1) Accepting and collect Scope of Appointment forms.

(2) Accepting enrollment forms.

(3) Making available, distributing, and displaying communications materials, including in areas where care is being delivered.

(f) *Activities of Institutional Special Needs Plans (I-SNPs) Serving Long-Term Care Facility Residents* (1) Depending on the context of a given situation, I-SNP contracted with a long-term care facility can be viewed as both a provider and a plan.

(2) I-SNPs may use staff operating in a social worker capacity to provide information, including marketing materials (excluding enrollment forms), to residents of a long term care facility.

(3) Social workers of the I-SNP (whether employees, agents, or contracted providers) may not accept or collect a scope of appointment or enrollment form on behalf of the I-SNP.

(4) Unless the beneficiary or the beneficiary's authorized representative initiates additional contact with or by the plan, all other marketing and outreach activities in the beneficiary's room must follow the requirements for beneficiary contact under § 422.2264

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(5) All other activities with healthcare providers or in the healthcare setting must comply with §§ 422.2266(a), (b), (c), (d), and (e).

[86 FR 6108, Jan. 19, 2021]

**§ 422.2267 Required materials and content.**

For information CMS deems to be vital to the beneficiary, including information related to enrollment, benefits, health, and rights, the agency may develop materials or content that are either standardized or provided in a model form. Such materials and content are collectively referred to as required.

(a) *Standards for required materials and content.* All required materials and content, regardless of categorization as standardized in paragraph (b) of this section or model in paragraph (c) of this section, must meet the following:

(1) Be in a 12pt font, Times New Roman or equivalent.

(2) For markets with a significant non-English speaking population, be in the language of these individuals. Specifically, MA organizations must translate required materials into any non-English language that is the primary language of at least 5 percent of the individuals in a plan benefit package (PBP) service area.

(3) Be provided to enrollees on a standing basis in any non-English language identified in paragraphs (a)(2) and (4) of this section or accessible format upon receiving a request for the materials in a non-English language or accessible format or when otherwise learning of the enrollee's primary language or need for an accessible format. This requirement also applies to the individualized plans of care described in § 422.101(f)(1)(ii) for special needs plan enrollees.

(4) For any fully integrated dual eligible special needs plan or highly integrated dual eligible special needs plan, as defined at § 422.2, or applicable integrated plan, as defined at § 422.561, be translated into the language(s) required by the Medicaid translation standard as specified through their capitated Medicaid managed care contract in addition to the language(s) required by the Medicare translation

standard in paragraph (a)(2) of this section.

(5) Be provided to the beneficiary within CMS's specified timeframes.

(b) *Standardized materials.* Standardized materials and content are required materials and content that must be used in the form and manner provided by CMS.

(1) When CMS issues standardized material or content, an MA organization must use the document without alteration except for the following:

- (i) Populating variable fields.
- (ii) Correcting grammatical errors.
- (iii) Adding customer service phone numbers.
- (iv) Adding plan name, logo, or both.
- (v) Deleting content that does not pertain to the plan type (for example, removing Part D language for a MA-only plan).
- (vi) Adding the SMID.
- (vii) A Notice of Privacy Practices as required under the HIPAA Privacy Rule (45 CFR 164.520).

(2) The MA organization may develop accompanying language for standardized material or content, provided that language does not conflict with the standardized material or content. For example, CMS may issue standardized content associated with an appeal notification and MA organizations may draft a letter that includes the standardized content in the body of the letter; the remaining language in the letter is at the plan's discretion, provided it does not conflict with the standardized content or other regulatory standards.

(c) *Model materials.* Model materials and content are those required materials and content created by CMS as an example of how to convey beneficiary information. When drafting required materials or content based on CMS models, MA organizations:

(1) Must accurately convey the vital information in the required material or content to the beneficiary, although the MA organization is not required to use CMS model materials or content verbatim; and

(2) Must follow CMS's specified order of content, when specified.

(d) *Delivery of required materials.* MA organizations must mail required materials in hard copy or provide them

electronically, following the requirements in paragraphs (d)(1) and (2) of this section.

(1) For hard copy mailed materials, each enrollee must receive his or her own copy, except in cases of non-beneficiary-specific material(s) where the MA organization has determined multiple enrollees are living in the same household and it has reason to believe the enrollees are related. In that case, the MA organization may mail one copy to the household. The MA organization must provide all enrollees an opt-out process so the enrollees can each receive his or her own copy, instead of a copy to the household. Materials specific to an individual beneficiary must always be mailed to that individual.

(2) Materials may be delivered electronically following the requirements in paragraphs (d)(2)(i) and (ii) of this section.

(i) Without prior authorization from the enrollee, MA organizations may mail new and current enrollees a notice informing enrollees how to electronically access the following required materials: the Evidence of Coverage, Provider and Pharmacy Directories, and Formulary. The following requirements apply:

(A) The MA organization may mail one notice for all materials or multiple notices.

(B) Notices for prospective year materials may not be mailed prior to September 1 of each year, but must be sent in time for an enrollee to access the specified materials by October 15 of each year.

(C) The MA organization may send the notice throughout the year to new enrollees.

(D) The notice must include the website address to access the materials, the date the materials will be available if not currently available, and a phone number to request that hard-copy materials be mailed.

(E) The notice must provide the enrollee with the option to request hardcopy materials. Requests may be material specific, and must have the option of a one-time request or a permanent request that must stay in place until the enrollee chooses to receive electronic materials again.

(F) Hard copies of requested materials must be sent within three business days of the request.

(ii) With prior authorization from the enrollee, MA organizations may provide any required material or content electronically. To do so, MA organizations must:

(A) Obtain prior consent from the enrollee. The consent must specify both the media type and the specific materials being provided in that media type.

(B) Provide instructions on how and when enrollees can access the materials.

(C) Have a process through which an enrollee can request hard copies be mailed, providing the beneficiary with the option of a one-time request or a permanent request (which must stay in place until the enrollee chooses to receive electronic materials again), and with the option of requesting hard copies for all or a subset of materials. Hard copies must be mailed within three business days of the request.

(D) Have a process for automatic mailing of hard copies when electronic versions or the chosen media type is undeliverable.

(e) *CMS required materials and content.* The following are required materials that must be provided to current and prospective enrollees, as applicable, in the form and manner outlined in this section. Unless otherwise noted or instructed by CMS and subject to § 422.2263(a) of this chapter, required materials may be sent once a fully executed contract is in place, but no later than the due dates listed for each material in this section.

(1) *Evidence of Coverage (EOC).* The EOC is a standardized communications material through which certain required information (under § 422.111(b)) must be provided annually and must be provided:

(i) To current enrollees of the plan by October 15, prior to the year to which the EOC applies.

(ii) To new enrollees within 10 calendar days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.

(2) *Part C explanation of benefits (EOB).* The EOB is a model communications material through which plans

must provide the information required under § 422.111(k). MA organizations may send this monthly or per claim with a quarterly summary.

(3) *Annual notice of change (ANOC).* The ANOC is a standardized marketing material through which plans must provide the information required under § 422.111(d)(2) annually.

(i) Must send for enrollee receipt no later than September 30 of each year.

(ii) Enrollees with an October 1, November 1, or December 1 effective date must receive within 10 calendar days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.

(4) *Pre-Enrollment checklist (PECL).* The PECL is a standardized communications material that plans must provide to prospective enrollees with the enrollment form, so that the enrollees understand important plan benefits and rules. For telephonic enrollments, the contents of the PECL must be reviewed with the prospective enrollee prior to the completion of the enrollment. It references information on the following:

(i) The EOC.

(ii) Provider directory.

(iii) Pharmacy directory.

(iv) Formulary.

(v) Premiums/copayments/coinsurance.

(vi) Emergency/urgent coverage.

(vii) Plan-type rules.

(viii) Effect on current coverage.

(5) *Summary of Benefits (SB).* MA organizations must disseminate a summary of highly utilized coverage that include benefits and cost sharing to prospective enrollees, known as the SB. The SB is a model marketing material. It must be in a clear and accurate form.

(i) The SB must be provided with an enrollment form as follows:

(A) In hard copy with a paper enrollment form.

(B) For online enrollment, the SB must be made available electronically (for example, via a link) prior to the completion and submission of enrollment request.

(C) For telephonic enrollment, the beneficiary must be verbally told where the SB can be accessed.

(ii) The SB must include the following information:

(A) Information on the following medical benefits, starting in the top half of the first page and in the order as identified in paragraphs (A)(1) through (A)(10), including—

- (1) Monthly Plan Premium.
- (2) Deductible/Out-of-pocket limits.
- (3) Inpatient/Outpatient Hospital coverage.
- (4) Ambulatory Surgical Center (ASC).
- (5) Doctor Visits (Primary Care Providers and Specialists).
- (6) Preventive Care.
- (7) Emergency Care/Urgently Needed Services.
- (8) Diagnostic Services/Labs/Imaging.
- (9) Hearing Services/Dental Services/Vision Services.
- (10) Mental Health Services.

(B) Information on prescription drug expenses, including:

- (1) Deductible, the initial coverage phase, coverage gap, and catastrophic coverage.
- (2) A statement that costs may differ based on pharmacy type or status (for example, preferred/non-preferred, mail order, long-term care (LTC) or home infusion, and 30- or 90-day supply), when applicable.

(C) For Medicare Medical Savings Account Plans (MSAs), the SB must include the following:

- (1) The amount Medicare deposits into the beneficiaries MSA account.
- (2) A statement that the beneficiary pays nothing once the deductible is met.

(D) For dual eligible special needs plan (D-SNP)s, the SB must identify or describe the Medicaid benefits to prospective enrollees. This may be done by either of the following:

- (1) Including the Medicaid benefits in the SB.
- (2) Providing a separate document identifying the Medicaid benefits that accompanies the SB.

(E) For D-SNPs open to dually eligible enrollees with differing levels of cost, the SB must:

- (1) State how cost sharing and benefits differ depending on the level of Medicaid eligibility.
- (2) Describe the Medicaid benefits, if any, provided by the plan.

(F) Fully integrated dual eligible SNPs (FIDE SNPs) and highly integrated D-SNPs, as defined in § 422.2, that provide Medicaid benefits have the option to display integrated Medicare and Medicaid benefits in the SB.

(G) MA organizations may describe or identify other health related benefits in the SB.

(6) *Enrollment/Election form*. This is a model communications material through which plans must provide the information required under § 422.60(c).

(7) *Enrollment Notice*. This is a model communications material through which plans must provide the information required under § 422.60(e)(3).

(8) *Disenrollment Notice*. This is a model communications material through which plans must provide the information required under § 422.74(b).

(9) *Mid-Year Change Notification*. This is a model communications material through which plans must provide a notice to enrollees when there is a mid-year change in benefits or plan rules, under the following timelines:

(i) Notices of changes in plan rules, unless otherwise addressed elsewhere in this part, must be provided 30 days in advance.

(ii) For National Coverage Determination (NCD) changes announced or finalized less than 30 days before their effective date, a notification is required as soon as possible.

(iii) Mid-year NCD or legislative changes must be provided no later than 30 days after the NCD is announced or the legislative change is effective.

(A) Plans may include the change in next plan mass mailing (for example, newsletter), provided it is within 30 days.

(B) The notice must also appear on the MA organization's website.

(10) *Non-renewal Notice*. This is a standardized communications material through which plans must provide the information required under § 422.506.

(i) The Non-renewal Notice must be provided at least 90 calendar days before the date on which the nonrenewal is effective. For contracts ending on December 31, the notice must be dated October 2 to ensure national consistency in the application of Medigap Guaranteed Issue (GI) rights to all enrollees, except for those enrollees in

special needs plans (SNPs). Information about non-renewals or service area reductions may not be released to the public, including the Non-renewal Notice, until CMS provides notification to the plan.

(ii) The Non-renewal Notice must do all of the following:

(A) Inform the enrollee that the plan will no longer be offered and the date the plan will end.

(B) Provide information about any applicable open enrollment periods or special election periods or both (for example, Medicare open enrollment, non-renewal special election period), including the last day the enrollee has to make a Medicare health plan selection.

(C) Explain what the enrollee must do to continue receiving Medicare coverage and what will happen if the enrollee chooses to do nothing.

(D) As required under § 422.506(a)(2)(ii)(A), provide a CMS-approved written description of alternative MA plan, MA–PD plan, and PDP options available for obtaining qualified Medicare services within the beneficiary's region in the enrollee's notice.

(E) Specify when coverage will start after a new Medicare plan is chosen.

(F) List 1–800–MEDICARE contact information together with other organizations that may be able to assist with comparing plans (for example, SHIPs).

(G) Explain Medigap to applicable enrollees and the special right to buy a Medigap policy, and include a Medigap fact sheet with the non-renewal notice that explains Medigap coverage, policy, options to compare Medigap policies, and options to buy a Medigap policy.

(H) Include the MA organization's call center telephone number, TTY number, and hours and days of operation.

(11) *Provider Directory*. This is a model communications material through which plans must provide the information under § 422.111(b)(3). The Provider Directory must:

(i) Be provided to current enrollees of the plan by October 15 of the year prior to the applicable year.

(ii) Be provided to new enrollees within 10 calendar days from receipt of CMS confirmation of enrollment or by

last day of month prior to effective date, whichever is later.

(iii) Be provided to current enrollees upon request, within three business days of the request.

(iv) Be updated any time the MA organization becomes aware of changes.

(A) Updates to the online provider directories must be completed within 30 days of receiving information requiring update.

(B)(1) Updates to hardcopy provider directories must be completed within 30 days.

(2) Hard copy directories that include separate updates via addenda are considered up-to-date.

(12) *Provider Termination Notice*. This is a model communications material through which plans must provide the information required under § 422.111(e).

(i) The written Provider Termination Notice must be provided in hard copy via U.S. mail (first class postage is recommended, but not required).

(ii) The written Provider Termination Notice must do all of the following:

(A) Inform the enrollee that the provider will no longer be in the network and the date the provider will leave the network.

(B) Include names and phone numbers of in-network providers that the enrollee may access for continued care (this information may be supplemented with information for accessing a current provider directory, including both online and direct mail options).

(C) Explain how the enrollee may request a continuation of ongoing medical treatment or therapies with their current provider.

(D) Provide information about the annual coordinated election period and the MA open enrollment period, as well as explain that an enrollee who is impacted by the provider termination may contact 1–800–MEDICARE to request assistance in identifying and switching to other coverage, or to request consideration for a special election period, as specified in § 422.62(b)(26), based on the individual's unique circumstances and consistent with existing parameters for this SEP.

(E) Include the MA organization's call center telephone number, TTY

number, and hours and days of operation.

(iii) The telephonic Provider Termination Notice specified in § 422.111(e)(1)(i) must relay the same information as the written Provider Termination Notice as described in paragraph (e)(12)(ii) of this section.

(13) *Star Ratings Document*. This is a standardized marketing material through which Star Ratings information is conveyed to prospective enrollees.

(i) The Star Ratings Document is generated through HPMS.

(ii) The Star Ratings Document must be provided with an enrollment form, as follows:

(A) In hard copy with a paper enrollment form.

(B) For online enrollment, made available electronically (for example, via a link) prior to the completion and submission of enrollment request.

(C) For telephonic enrollment, the beneficiary must be verbally told where they can access the Star Ratings Document.

(iii) New MA organizations that have no Star Ratings are not required to provide the Star Ratings Document until the following contract year.

(iv) Updated Star Ratings must be used within 21 calendar days of release of updated information on Medicare Plan Finder.

(v) Updated Star Ratings must not be used until CMS releases Star Ratings on Medicare Plan Finder.

(14) *Organization Determination Notice*. This is a model communications material through which plans must provide the information under § 422.568.

(15) *Excluded Provider Notice*. This is a model communications material through which plans must notify enrollees when a provider they visit or consult has been excluded from participating in the Medicare program based on an OIG exclusion or the CMS preclusion list.

(16) *Notice of Denial of Medical Coverage or Payment (NDMCP) (also known as the Integrated Denial Notice (IDN))*. This is a standardized communications material used to convey beneficiary appeal rights when a plan has denied a service as non-covered or excluded from benefits.

(17) *Notice of Medicare Non-Coverage (NOMNC)*. This is a standardized communications material used to convey beneficiary appeal rights when a plan is terminating previously-approved coverage in a Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF), or Home Health setting (HHA).

(18) *Detailed Explanation of Non-Coverage (DENC)*. This is a standardized communications material used to convey to a beneficiary why their current Medicare covered SNF, CORF or HHA services should end.

(19) *Appointment of Representative (AOR)*. This is a standardized communications material used to authorize or appoint an individual to act on behalf of a beneficiary for the purpose of a specific appeal, grievance, or organization determination.

(20) *An Important Message From Medicare About Your Rights (IM)*. This is a standardized communications material used to convey a beneficiary's rights as a hospital inpatient and appeal rights when their covered inpatient hospital stay is ending.

(21) *Detailed Notice of Discharge Form (DND)*. This is a standardized communications material, as required under § 422.622(e), used to convey to a beneficiary why their current Medicare covered inpatient hospital stay should end.

(22) *Medicare Outpatient Observation Notice (MOON)*. This is a standardized communications material used to inform a beneficiary that he or she is an outpatient receiving observation services.

(23) *Appeal and Grievance Data Form*. This is a standardized communications material used to convey organization-specific grievance and appeals data.

(24) *Request for Administrative Law Judge (ALJ) Hearing*. This is a standardized communications material used to formally request a reconsideration of the independent review entity's determination.

(25) *Attorney Adjudicator Review in Lieu of ALJ Hearing*. This is a standardized communications material used to request that an attorney adjudicator review a previously determined decision rather than having an ALJ do so.

(26) *Notice of Right to an Expedited Grievance.* This is a model communications material used to convey a Medicare enrollee's rights to request that a decision be made on a grievance or appeal within a shorter timeframe.

(27) *Waiver of Liability Statement.* This is a model communications material used by non-contracted providers to waive beneficiary liability for payment for denied services while utilizing the enrollee appeals process under subpart M of part 422.

(28) *Notice of Appeal Status.* This is a model communications material used to inform a beneficiary of the denial of an appeal and additional appeal rights.

(29) *Notice of Dismissal of Appeal.* This is a model communications material used to convey the rationale by an MA organization to dismiss beneficiary's appeal.

(30) *Member ID card.* The member ID card is a model communications material that plans must provide to enrollees as required under § 422.111(i). The member ID card—

(i) Must be provided to new enrollees within ten calendars days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the plan effective date, whichever is later;

(ii) Must include the plan's—

(A) Website address;

(B) Customer service number (the member ID card is excluded from the hours of operations requirement under § 422.2262(c)(1)(i)); and

(C) Contract/PBP number;

(iii) Must include, if issued for a PPO and PFFS plan, the phrase “Medicare limiting charges apply.”;

(iv) May not use a member's Social Security number (SSN), in whole or in part;

(v) Must be updated whenever information on a member's existing card changes; in such cases an updated card must be provided to the member;

(vi) Is excluded from the translation requirement under paragraphs (a)(2) through (4) of this section; and

(vii) Is excluded from the 12-point font size requirement under paragraph (a)(1) of this section.

(31) *Multi-language insert (MLI).* This is a standardized communications material which states, “We have free in-

terpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at [1-xxx-xxx-xxxx]. Someone who speaks [language] can help you. This is a free service.” in the following languages: Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, and Japanese.

(i) Additional languages that meet the 5-percent service area threshold, as required under paragraph (a)(2) of this section, must be added to the MLI used in that service area. A plan may also opt to include in the MLI any additional language that do not meet the 5-percent service area threshold, where it determines that this inclusion would be appropriate.

(ii) The MLI must be provided with all required materials under paragraph (e) of this section.

(iii) The MLI may be included as a part of the required material or as a standalone material in conjunction with the required material.

(iv) When used as a standalone material, the MLI may include organization name and logo.

(v) When mailing multiple required materials together, only one MLI is required.

(vi) The MLI may be provided electronically when a required material is provided electronically as permitted under paragraph (d)(2) of this section.

(32) *Federal Contracting Statement.* This is model content through which plans must convey that they have a contract with Medicare and that enrollment in the plan depends on contract renewal.

(i) The Federal Contracting Statement must include all of the following:

(A) Legal or marketing name of the organization.

(B) Type of plan (for example, HMO, HMO SNP, PPO, PFFS, PDP).

(C) 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).

(D) A statement that enrollment depends on contract renewal.

(ii) MA organizations must include the Federal Contracting Statement on all marketing materials with the exception of the following:

(A) Banners and banner-like advertisements.

(B) Outdoor advertisements.

(C) Text messages.

(D) Social media.

(E) Envelopes.

(33) *Star Ratings Disclaimer*. This is model content through which plans must:

(i) Convey that MA organizations are evaluated yearly by Medicare.

(ii) Convey that the ratings are based on a 5-star rating system.

(iii) Include the model content in disclaimer form or within the material whenever Star Ratings are mentioned in marketing materials, with the exception of when Star Ratings are published on small objects (that is, a give-away items such as a pens or rulers).

(34) *SSBCI Disclaimer*. This is model content through which MA organizations must:

(i) Convey the benefits mentioned are a part of special supplemental benefits.

(ii) Convey that not all members will qualify.

(iii) Include the model content in the material copy which mentions SSBCI benefits.

(35) *Accommodations Disclaimer*. This is model content through which MA organizations must:

(i) Convey that accommodations for persons with special needs are available.

(ii) Provide a telephone number and TTY number.

(iii) Include the model content in disclaimer form or within the body of the material on any advertisement of invitation to all events described under § 422.2264(c).

(36) *Mailing Statements*. This is standardized content. It consists of statements on envelopes that MA organizations must include when mailing information to current members, as follows:

(i) MA organizations must include the following statement when mailing information about the enrollee's current plan: "Important [Insert Plan Name] information."

(ii) MA organizations must include the following statement when mailing

health and wellness information: "Health and wellness or prevention information."

(iii) The MA organization must include the plan name; however, if the plan name is elsewhere on the envelope, the plan name does not need to be repeated in the disclaimer.

(iv) Delegated or sub-contracted entities and downstream entities that conduct mailings on behalf of a multiple MA organizations must also comply with this requirement; however, they do not have to include a plan name.

(37) *Promotional Give-Away Disclaimer*. This is model content. The disclaimer consists of a statement that must make clear that there is no obligation to enroll in a plan, and must be included when offering a promotional give-away such as a drawing, prizes, or a free gift.

(38) *Provider Co-branded Material Disclaimer*. This is model content through which MA organizations must:

(i) Convey, as applicable, that other pharmacies, physicians or providers are available in the plan's network.

(ii) Include the model content in disclaimer form or within the material whenever co-branding relationships with network provider are mentioned, unless the co-branding is with a provider network or health system that represents 90 percent or more of the network as a whole.

(39) *Out of Network Non-Contracted Provider Disclaimer*. This is standardized content. The disclaimer consists of the statement: "Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services," and must be included whenever materials reference out-of-network/non-contracted providers.

(40) *NCQA SNP Approval Statement*. This is model content and must be used by SNPs who have received NCQA approval. MA organizations must:

(i) Convey that MA organization has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP).



(ii) Include the last contract year of NCQA approval.

(iii) Convey that the approval is based on a review of [insert Plan Name's] Model of Care.

(iv) Not include numeric SNP approval scores.

(41) *Third-party marketing organization disclaimer.* This is standardized content. If a TPMO does not sell for all MA organizations in the service area the disclaimer consists of the statement: “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 *Medicare.gov*, 1-800-MEDICARE, or your local State Health Insurance Program to get information on all of your options.” If the TPMO sells for all MA organizations in the service area the disclaimer consists of the statement: “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 for help with plan choices.” The MA organization must ensure that the disclaimer is as follows:

(i) Used by any TPMO, as defined under § 422.2260, that sells plans on behalf of more than one MA organization.

(ii) Verbally conveyed within the first minute of a sales call.

(iii) Electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication.

(iv) Prominently displayed on TPMO websites.

(v) Included in any marketing materials, including print materials and television advertisements, developed, used or distributed by the TPMO.

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**§ 422.2272 Licensing of marketing representatives and confirmation of marketing resources.**

In its marketing, the MA organization must:

(a) Demonstrate to CMS' satisfaction that marketing resources are allocated

to marketing to the disabled Medicare population as well as beneficiaries age 65 and over.

(b) Establish and maintain a system for confirming that enrolled beneficiaries have, in fact, enrolled in the MA plan, and understand the rules applicable under the plan.

(c) Employ as marketing representatives only individuals who are licensed by the State to conduct marketing activities (as defined in the Medicare Marketing Guidelines) in that State, and whom the organization has informed that State it has appointed, consistent with the appointment process provided for under State law.

(d) Report to the State in which the MAO appoints an agent or broker, the termination of any such agent or broker, including the reasons for such termination if State law requires that the reasons for the termination be reported.

(e) Establish and implement an oversight plan that monitors agent and broker activities, identifies non-compliance with CMS requirements, and reports non-compliance to CMS.

[73 FR 54220, Sept. 18, 2008, as amended at 73 FR 54250, Sept. 18, 2008; 76 FR 21569, Apr. 15, 2011; 83 FR 16735, Apr. 16, 2018; 88 FR 22337, Apr. 12, 2023]

**§ 422.2274 Agent, broker, and other third-party requirements.**

If an MA organization uses agents and brokers to sell its Medicare plans, the requirements in paragraphs (a) through (e) of this section are applicable. If an MA organization makes payments to third parties, the requirements in paragraph (f) of this section are applicable.

(a) *Definitions.* For purposes of this section, the following definitions are applicable:

*Compensation.* (i) Includes monetary or non-monetary remuneration of any kind relating to the sale or renewal of a plan or product offered by an MA organization including, but not limited to the following:

(A) Commissions.

(B) Bonuses.

(C) Gifts.

(D) Prizes or Awards.

(ii) Does not include any of the following: