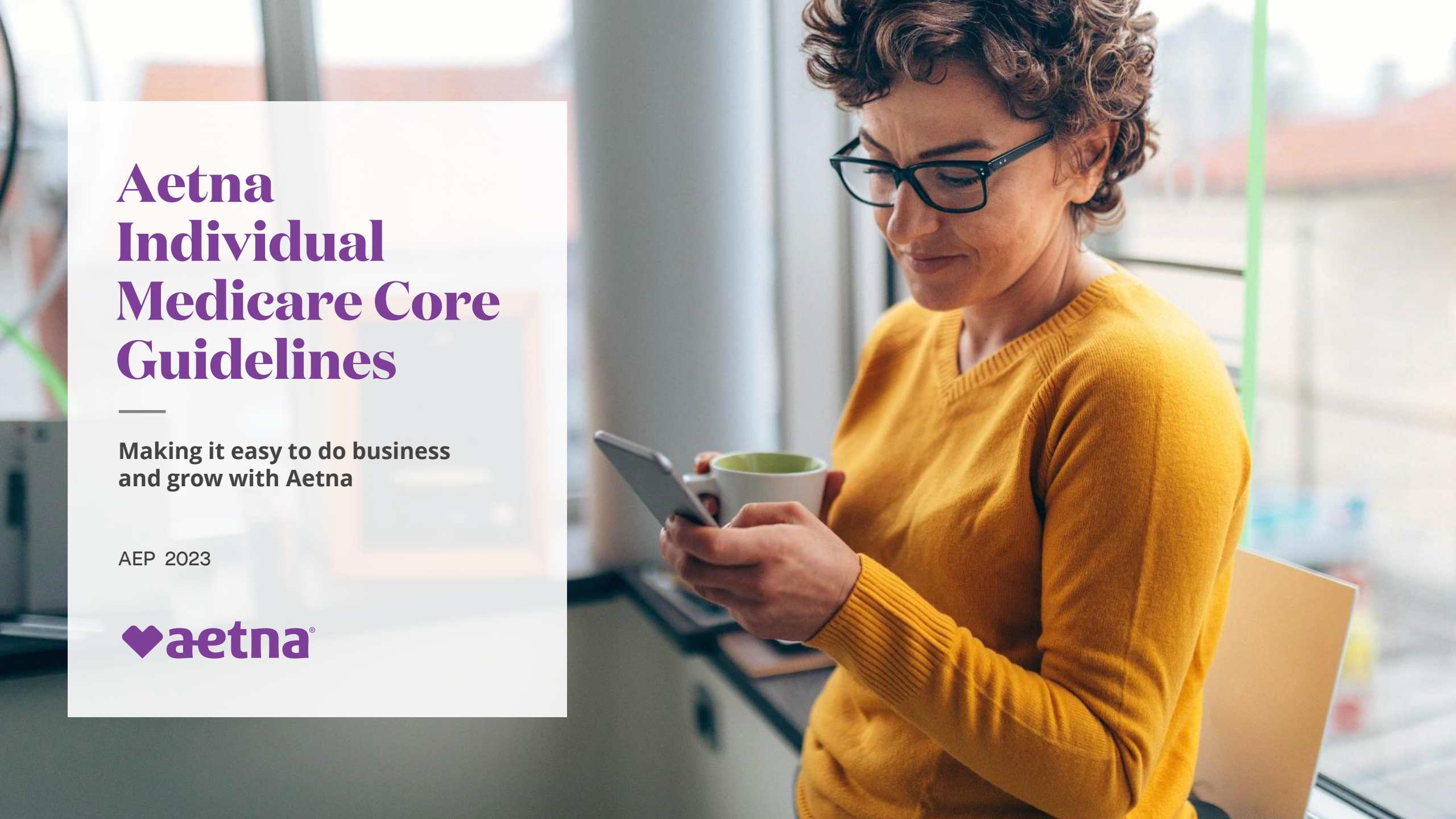

Aetna Individual Medicare Core Guidelines

Making it easy to do business and grow with Aetna

AEP 2023

aetna®

Aetna policy statement

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Table of Contents

Welcome!

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

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

This is an exciting time to be working with Aetna, a CVS company. In 2022, we've experienced industry-leading membership growth and historic service area expansion. With your input, we're continuing to build an innovative portfolio of Medicare products and benefits that can help meet your clients' needs. With both the retirement of the Ascend tool and the introduction of the new and improved Think Agent tool, we continue to optimize our resources and processes to make our products easier to sell.
Plus, with CVS Health's recent acquisition of Aetna, the future looks extremely bright. We're very excited about the opportunities that our combined company will bring. Together, we will continue working to create a simpler, more affordable health care experience that puts consumers at the center of their care.

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

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

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

Broker Services Resources

Making it Easy to do Business with Aetna

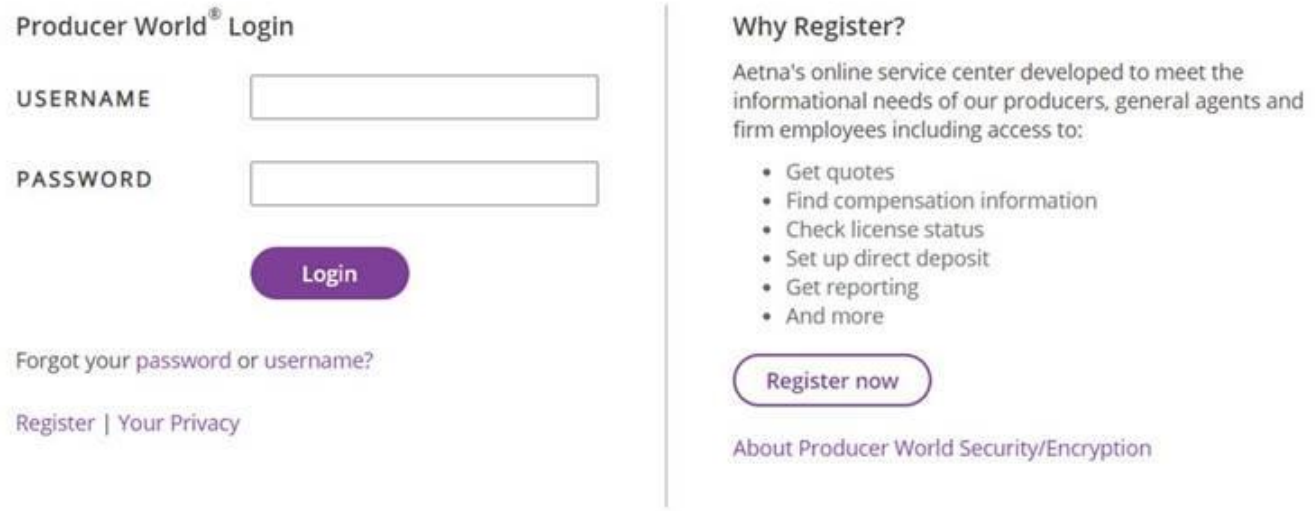
Agent/Broker Tools	Aetna-Specific Tools
Aetna Agent Website	*Aetna Producer World*: https://www.aetna.com/producer/Medicare/index.html (See next page)
Marketing Materials	*The Aetna Medicare Marketing Studio*: www.aetnahub.com/MMS
Find In-Network Pharmacies	www.aetnamedicare.com/findpharmacy www.aetnamedicare.com/formulary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

Aetna Producer World

Aetna Producer World

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

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



Reporting

Aetna Producer World

➢How to Access Reports

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

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

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

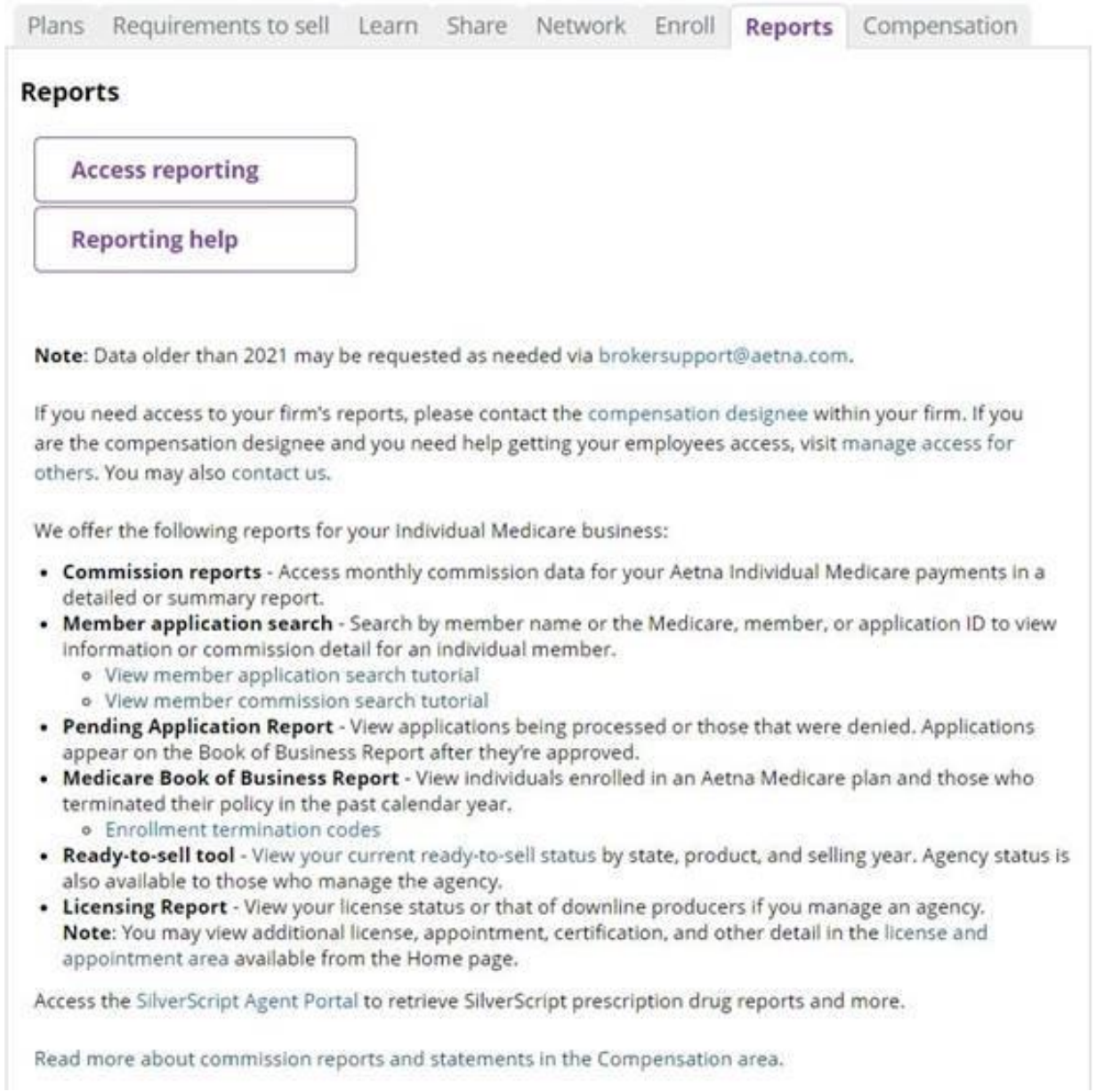
Reporting

Aetna *Producer World*

➢**Reports**

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

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



General Reporting Help Page

Medicare Reporting Help

Note: Data older than 2021 may be requested via brokersupport@aetna.com.

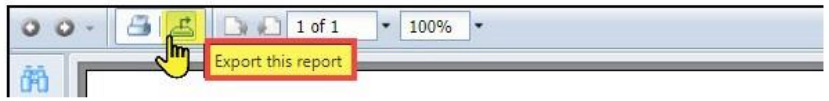
Need help? We can help. Contact Aetna Medicare Broker Services at 1-866-714-9301 or use our contact us form. Normal business hours are 8 AM to 8 PM ET, Monday through Friday. Read more about commission reports and statements in the Compensation area.

Why am I unable to access my agency reporting?
The principal must register the firm on Producer World and assign designees to perform functions on behalf of the agency. Other individuals must be granted the privilege to view agency reports. Contact your firm's Compensation or Multi-Firm Designee for help. If you are the designee and you need help granting access for your employees, visit manage access for others.

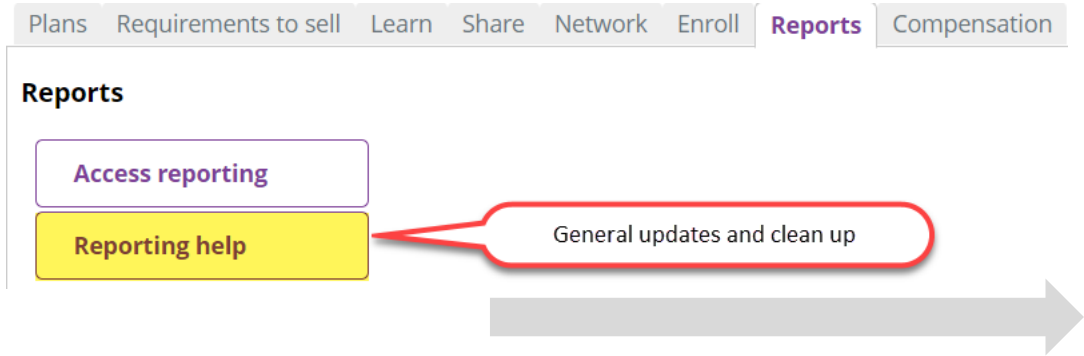
How do I register my firm?
Register here and select "I am the principal of a firm." Next, choose "I want to designate an employee(s) in my firm (or myself) to setup access for other employees to register for Producer World." Then complete the required information. Please note firm name, TIN, and zip code must be an exact match to our records. Contact the Broker Services Department at 1-866-714-9301 or brokersupport@aetna.com if you need to verify your information on file.

How do I grant someone permission to view agency reports?
A Multi-Firm Individual Medicare Reports or Compensation Designee may manage agency report access for others. This may include a licensed agent with the firm or a non-licensed firm employee. Visit the Manage Access for Others area for instruction.

How do I export a report?
Click the export icon in the upper left hand area of your screen. For best results select the "Excel Workbook Data Only".



Why does my report time out?
In the event a report exceeds the size limit or another technical issue occurs, contact us for help.



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Ready to Sell

aetna®

What is “Ready to Sell”?

➢**Definition:**
Prior to selling Medicare Products, Producer must be “Ready to Sell.” Producer shall be Ready to Sell only if Producer (i) has completed, and is currently compliant with, all applicable Company and Centers for Medicare and Medicaid Services (“CMS”) requirements, including having the appropriate licenses and being appointed by the legal entity applicable to the Medicare Products being sold by Producer and (ii) has verified Ready to Sell status with Company. Producer shall cease all selling activities immediately and notify Company in the event Producer ceases to meet any of the Ready to Sell requirements. If Producer is an upline, Producer shall also be Ready to Sell in each state in which its agents are selling.

➢**Overview:**

➢Here’s an overview of the requirements you need to complete in order to be Ready to Sell:

To become Ready to Sell our 2023 Aetna Individual MA/MAPD and Aetna Medicare PDP products and receive commissions, you’ll need to complete all of the below requirements prior to marketing or selling:

1. **Certification** – pass the Aetna Individual Medicare certification process for the product(s) you intend to sell.

2. **Contracting** – **new producers** need to complete onboarding. **Current producers** need to maintain their licenses and meet our requirements as outlined on Producer World.

3. **Ready to Sell** – you must **actively verify** your RTS status.

For LOA’s: Your upline must also be Ready to Sell in the state(s) in which you wish to sell

Verifying “Ready to Sell”

Before selling Aetna Medicare products, please remember that you must complete all certification and licensing requirements and verify with us that you’re “ready to sell” (RTS).

3-ways to verify your RTS status:
- Log in to Producer World and visit the Individual Medicare page
- By contacting your recruiter
- By contacting Aetna Medicare Broker Services at 1-866-714-9301 or brokersupport@aetna.com

What you need to know:

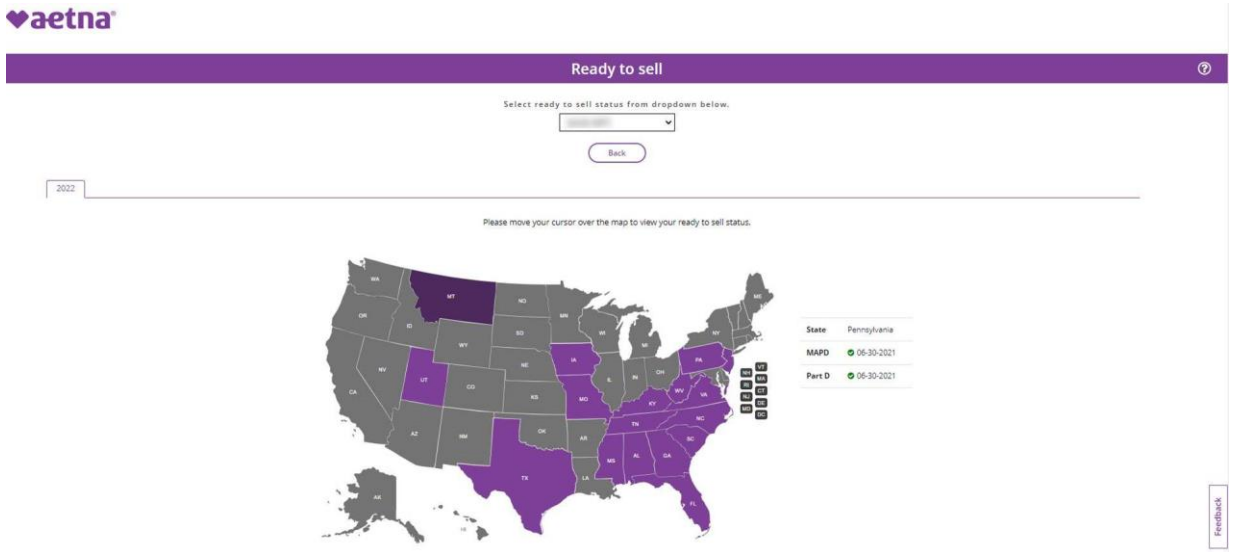
You should actively verify your RTS status prior to selling in each state where you conduct business. Your RTS status is subject to change based on your continuing to meet RTS requirements as outlined on Producer World.

If, at any point, you fail meet any licensing requirement, including a lapse, expiration, suspension, revocation, termination, or any other action taken by the Department of Insurance (DOI) or other entity, you must stop all selling activities and notify Aetna immediately.

Ready to sell tool

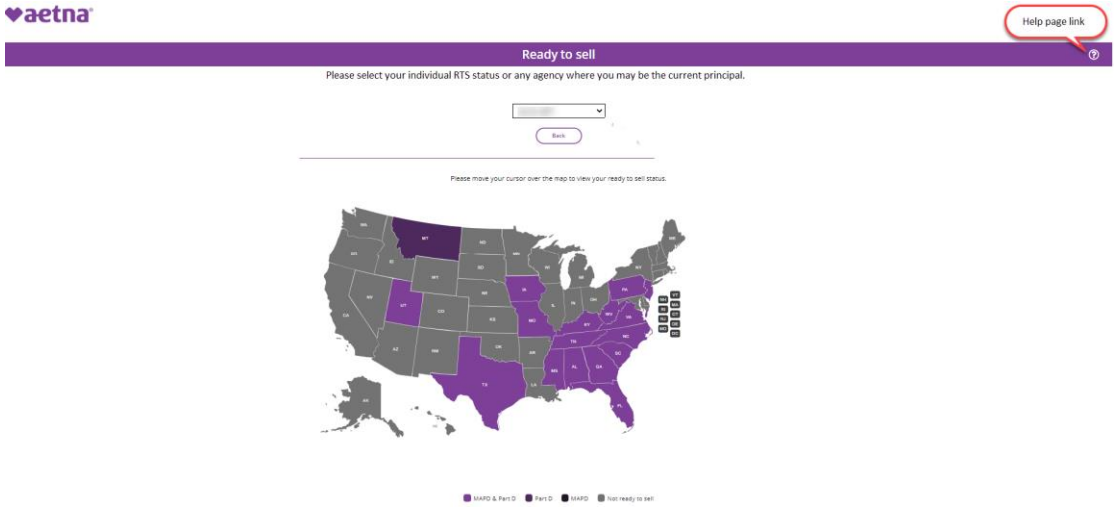
The ready to sell tool is where you can check your active ready to sell status.

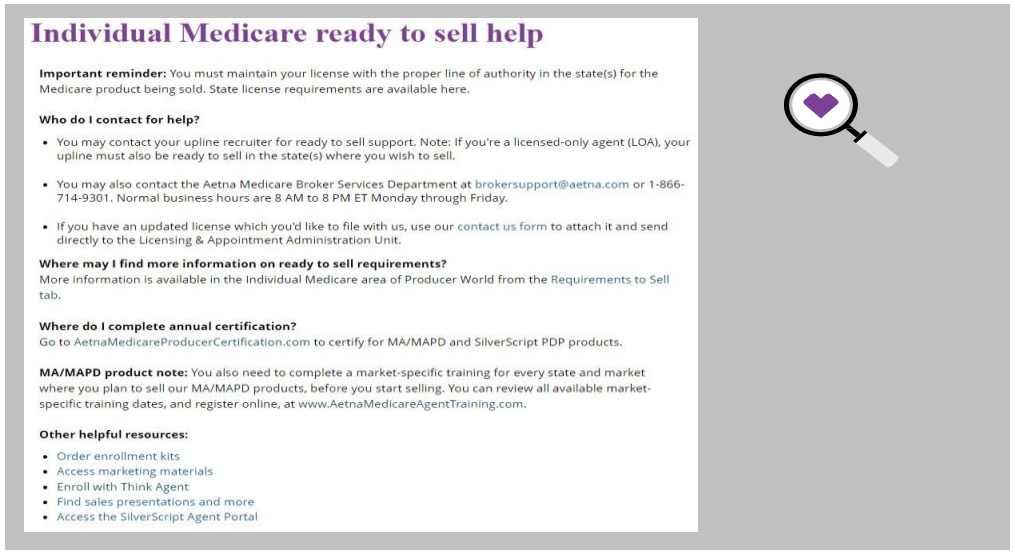
- Hover your mouse of the map to see status for the plan year.



RTS UI Help Page

- For more information and assistance with the RTS tool click on the question mark in the upper right-hand corner.





Compensation

Compensation Overview

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

Definition of Compensation

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

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

Compensation Overview (continued)

Commission

Producers are only entitled to compensation as outlined in the Producer Agreement and are not considered Aetna employees. The Aetna Medicare Agent Commission and Upline Administrative Fee Schedule is a compensation schedule made binding under the Producer Agreement. How much Aetna pays is consistent with CMS requirements.

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

Administrative Fees

Administrative fees are paid to uplines for providing administrative services, such as agent recruiting, agent training, sales compliance, office administration related to Medicare sales/enrollment, and marketing. If a policy has an effective date other than January 1, a prorated administrative fee will be paid, based upon the number of months the Medicare beneficiary will be enrolled in such Medicare product within the initial calendar year.

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

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

CMS New Sales

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

- A "Like Plan" refers to a "like plan type" as described by CMS in the applicable Medicare Communication and Marketing Guidelines (42 CFR §§ 422.2274, 423.2274)

- An "Unlike Plan" refers to an "unlike plan type" as described by CMS in the applicable Medicare Communication and Marketing Guidelines (42 CFR §§ 422.2274, 423.2274)

Understand how you are compensated for new business (true-up)
The first payment is always made at the Initial FYC (Not New) rate. Then, if CMS confirms to us the beneficiary is new to Medicare, meaning not in the Medicare system before the current policy, the first payment is reversed, and the CMS New rate is paid. You're paid the full year amount on new business, regardless of the effective date.

Understand how you are compensated for unlike plan changes (true-up)
The first payment is always made at the Initial FYC (Not New) rate and prorated based on the policy's effective date. If it is determined the beneficiary is making an unlike plan change such as switching from PDP to MA/MAPD or vice-versa, the first payment is reversed, and the CMS New rate is paid. Your CMS New true-up for unlike plan changes is paid a prorated amount based on the new effective date, when the effective date is February 1st or later. Proration applies to all payments, including administrative fees.

The compensation year is January 1 through December 31.

- You'll be paid the full CMS New rate for a beneficiary deemed by CMS as "New to Medicare," regardless of the effective date.
- If the effective date falls after January 1 and a disenrollment occurs prior to the end of that same year, then Aetna shall recoup a prorated amount of the commission for the month(s) in which the beneficiary was not enrolled in that Individual Medicare product.
- You'll be paid the full CMS New rate for a beneficiary making an "Unlike Plan" change when the effective date is January 1st.
- You'll be paid a prorated CMS New rate (or administrative fee) for a beneficiary making an "Unlike Plan" change when the effective date is February 1st or later.

Replacement Sales (New to Aetna)

Definition

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

Overview

➢Replacements are payable only while your contract is in effect. For replacements, we will advance the "replacement rate" set forth on the Schedule 1 of your contract.

- ➢ Unless otherwise indicated in the Schedule 1 of your contract, the "replacement rate" is the same amount as the "renewal rate"

Understand how you are compensated for business that is new to Aetna
The first payment is always made at the Initial FYC (Not New) rate. Depending upon your hierarchy level, after a member is identified as new to Aetna, your rate indicator may be updated to Replacement. If CMS later deems the member is new to Medicare, the CMS New rate will pay.

➢If the replacement has an effective date other than January 1, a prorated amount of the replacement rate will be paid, based upon the number of months the Medicare beneficiary will be enrolled in such Medicare product within the initial calendar year.

Renewals

- With Aetna, if you meet the requirements to receive renewals, you'll be compensated for your renewing business at current-year CMS rates (Fair Market Value) regardless of the effective date.
- Aetna will pay renewal compensation based on either the upline's or agent's (as applicable) hierarchy level as of the original Aetna application received date. The "renewal rate" amount can be found on the Schedule 1 attached to your Producer Agreement.
- Aetna pays lifetime renewals for as long as the member remains continuously enrolled in his/her original Aetna MA/MAPD product. To receive continuous renewal payments, you must remain as the Agent of Record on the policy, and you must meet Aetna's annual commission eligibility requirements.
- For LOA's, renewal compensation payments will continue to be paid to the upline even if the LOA is no longer associated with the upline, if the upline meets our requirements.
- Aetna MA/MAPD renewals are paid monthly, at 1/12th the Renewal rate.
  - MA/MAPD renewals are processed around mid-month.
  - Renewal payments are based on the original hierarchy as of the application signature date.
- SilverScript PDP renewals are paid as follows:
  - For effective dates prior to 1/1/2020, renewals are annualized and paid to the writing agent's top of hierarchy.
  - For effective dates 1/1/2020 and later, renewals follow the Aetna process.

Chargebacks for Rapid Disenrollments

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

- Voluntary rapid disenrollments result in a chargeback of the full commission paid. (These include Open Enrollment Period (OEP) plan changes.) Involuntary rapid disenrollments result in prorated commissions based on the number of months the beneficiary was active.

- For both voluntary and involuntary disenrollments outside of the three (3) month rapid disenrollment period, you retain the commission earned for the length of time the policy was active. Aetna will charge back the unearned commission and it will be reflected on the commission statement.

- If Aetna pays compensation for a sale and a rapid disenrollment occurs thereafter for which CMS requires compensation recovery, you’re required to refund the payment to Aetna. Aetna may deduct the refund amount for a rapid disenrollment from amounts otherwise owed to you.

- In order to not be subject to rapid disenrollment compensation recovery, the Medicare beneficiary must remain enrolled with us into the fourth month (e.g., if the individual enrolled in a policy with Aetna on January 1, the individual must still be enrolled in that same policy on April 1 of the same calendar year). An enrollment that occurs during the fourth quarter of a calendar year and terminates 12/31 of the same calendar year is considered a rapid disenrollment unless the termination reason indicates a plan change.

- No recoupment, chargeback, refund, or deduction shall be made if CMS guidance permits payment of commission for the rapid disenrollment with respect to the period that the Medicare product beneficiary was actually enrolled.

Compliance & Agent Oversight

Compliance Overview

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

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

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

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

How to Stay Compliant

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

1.Remember to always refer to and follow the complete and current Medicare Communications and Marketing Guidelines (MCMG), which you can find at https://www.cms.gov/medicare/health-plans/managedcaremarketing/finalpartcmarketingguidelines.html

2.Every time you meet with a beneficiary to discuss Aetna Medicare MA/MAPD or Aetna Medicare PDP products (this includes formal and individual one-on-one appointments), you must:

1. Use our CMS-approved sales presentation from beginning to end (For information events, use sales presentations as a reference tool)
2. Read the sales presentation notes or talking points as part of the script (NOTE: These are for your use only and are not to be shared with beneficiaries)
3. Using the sales video is optional. If you choose to use the video, you must use it in addition to the sales presentation deck

3.Review Aetna's Compliance 101 Training presentation. It contains high-level compliance information you need to know before selling Aetna Medicare products.

1. Use our CMS-approved sales presentation from beginning to end
2. Read the sales presentation notes or talking points as part of the script
3. Using the sales video is optional. If you choose to use the video, you must use it in addition to the sales presentation deck

Fraud, Waste, and Abuse (FWA)

Medicare Marketing Code of Conduct

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

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

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

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

➢Call Ethics Line ® at 1-877-287-2040, which is available 7 days a week, 24 hours a day; or

➢Visit Ethics Line ® on the web at www.CVSHealth.com/EthicsLine, which is available 7 days a week, 24 hours a day; or

➢Confidentially report your concerns in writing to:

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

Agent Oversight

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

Our Agent Oversight team has a responsibility to:

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

Agent Oversight

Agent Monitoring

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

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

Agent Oversight

Disciplinary Action

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

Disciplinary or corrective action may include:

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

Complaints Against Agents & Marketing Incidents

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

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

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

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

Complaints Against Agents & Marketing Incidents

Complaint and Marketing Incident Process

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

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

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

Marketing/Sales Events

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

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

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

Marketing/Sales Events

Key Requirements

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

Marketing/Sales Events

Prohibited Activities:

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

Scope of Appointment (SOA) Requirements

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

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

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

Scope of Appointment (SOA) Requirements

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

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

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

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

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

Scope of Appointment (SOA) Requirements

You may NOT:

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

Permission to Contact Form

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

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

Prohibited Actions

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

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

Contact with Medicare Beneficiaries

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

- MA organizations may make unsolicited direct contact by conventional mail and other print media (for example, advertisements and direct mail) or email (provided every email contains an opt-out option)
- Referred beneficiaries **must** contact the plan, agent, broker, or producer directly
- Beneficiaries can be contacted by permission only and it must be event-specific not open-ended.

Outbound Calls

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

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

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

Contact with Medicare Beneficiaries

Electronic Communication

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

Direct Marketing

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

Telephone

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

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

Marketing Materials

Marketing Policy Overview

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

- You're required to follow all Aetna and CMS marketing requirements. You can find and review the CMS Medicare Communication and Marketing Guidelines on *Aetna Producer World* and www.cms.gov.
- You may only use CMS and Aetna-approved marketing materials when discussing Aetna Medicare plans. To be clear, you may only use materials that have been created by Aetna's marketing team, approved by Aetna, and, as necessary, filed with CMS by Aetna. Note that this includes Multi-plan Materials (as described in the Medicare Marketing Guidelines).
- You may not alter CMS-approved materials in any way, other than to add personal information like agent name, phone number, email, or even date, when permitted, on an approved piece.
- Materials must be used as intended. For example, you can't copy a newspaper ad and mail it to beneficiaries. This is due to specific filing guidelines with CMS based on material type.
- Under CMS guidelines, the official marketing period for AEP for the upcoming benefit year begins October 1. You must **not** market or advertise Aetna products for the upcoming benefit year prior to October 1, even if you have marketing/sales events scheduled in early October. Furthermore, once you begin marketing 2023 products, you must cease marketing 2022 products. Prior-year materials may be provided upon request and enrollment applications may be processed.

Marketing Policy Overview (continued)

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

Sales Presentations

Keep in mind:

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

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

Enrollment

How to Order Sales Kits

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

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

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

Requirements

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

Kit Personalization

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

How to Order Sales Kits (continued)

Kit Limits

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

Order Confirmation

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

Delivery

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

Enrollment Process

Election Periods Overview

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

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

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

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

Open Enrollment Period (OEP)

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

Election Periods Overview (continued)

Special Election Period (SEP)

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

Annual Election Period (AEP)

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

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

Enrollment Application Turnaround Time

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

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

- For Aetna MA/MAPD, DSNP and Allina: Upload images, fax, or email.
- For SilverScript PDP: First, enter the application into the Agent Portal within 24 hours of receiving the application from the beneficiary. Second, send all pages of the signed, completed application and the Scope of Appointment within 24 hours of portal entry. Agents can upload, email, fax or mail the application

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

Duplicate Enrollment Applications

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

Aetna MA/MAPD, DSNP and Allina Enrollment Options

Paper Applications			
Online			**Think Agent** Once you're ready to sell, you can download the Think Agent app from the Apple and Google Play store. The app is compatible with Android 5 or greater, version 11; or IOS 11.0 or greater, version 14.5; or on your desktop at https://app.thinkagent.com After downloading, click "Sign Up" to submit your request for a new user account. You will be asked to provide your name, National Producer Number and email address. It is also available through Producer World by clicking the *Enroll* tab.
ATN	FAX	Mail	Upload
NG JV IS	1-866-756-5514	P.O. Box 7405 London, KY 40742	Go to Aetna Producer World Click on: • Individual Medicare • Enroll • Upload an Enrollment Application • Upload a MA/MAPD app
US QS	1-844-984-0393	P.O. Box 7083 London, KY 40742	N/A

Aetna MA/MAPD, DSNP and Allina Enrollment Options (Continued)

Paper Applications	
Email	**MedicareEnrollmentTransactions@aetna.com** Scan and save the paper application, Scope of Appointment (SOA), and any required paperwork as a single document in an approved file format. The Image should be sent in PDF format. Attach the file to an email message and send it to the above address. We recommend one applicant (and one attachment) per email. However, for greater efficiency, up to five (5) applicants/attachments per email are allowed. Email attachments cannot exceed seven (7) pages each. Write the name of each applicant in the subject link so that the names appear on your email confirmation. Note: The subject line cannot contain numbers and the email body cannot contain embedded images, graphics, or logos. Note: Please see additional email requirements on the next page.
Phone	You can assist a beneficiary with contacting us by phone, but telephonic enrollment requests must be initiated entirely by the beneficiary or his/her authorized representative. All telephonic sales calls must be recorded in their entirety, including the enrollment process.

Aetna MA/MAPD, DSNP and Allina Enrollment Options (Continued)

Enrollment Application Email Requirements:

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

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

Aetna Medicare Part D Enrollment Options

- **Step 1: You must enter the enrollment application into the Agent Portal within 24 hours of receiving the application from the beneficiary. Instructions on how to enter enrollments are located in the Reference Materials section of the Agent Portal. Failure to complete the step can result in your enrollment not being processed.**

- **Step 2: Please send all pages of the signed, completed application and the Scope of Appointment to Aetna Medicare Part D Insurance Company within 24 hours of portal entry. Choose one of the following options:**
- Upload: Upload a scanned copy of the documents via the Agent Portal secure mailroom
- Email: enrollmentverification@CVScaremark.com
- Fax: 1-866-552-6205
- Mail: SilverScript Insurance Company

  Attn: Agent Processing

  PO Box 30002

  Pittsburgh, PA 15222-0330

The Enrollment Process: What You Need to Know

Before Completing an Enrollment Application with a Beneficiary:

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

The Enrollment Process: What You Need to Know

- PCP Information
  - All provider data can be found in the provider directory.
  - Fill in the PCP name on the application.
  - Fill in the Provider ID. This is a 7-digit code.
  - Fill in the Primary Care ID. This is a 6-digit code.
  - Important: We need both PCP codes populated on the application to identify the requested PCP. If either code is missing and we are not able to identify the PCP, we will automatically assign your client an alternative PCP.
  - Check the Existing Patient checkbox if your client is an existing patient of the provider.
    - If this box is not checked, and the provider is only taking existing patients, your client will be assigned a different in-network PCP.

The Enrollment Process: What You Need to Know

Confirming Eligibility:

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

Referral-Only Sales

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

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

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

Referral-Only Sales (continued)

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

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

Member Experience

After Submitting the Application

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

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

After Submitting the Application (continued)

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

After Submitting the Application (continued)

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

Enrollment Applications: Cancellation, Withdrawal, or Disenrollment

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

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

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

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

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

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

Producers must be Ready to Sell – which means licensed in the applicable state, appointed by Aetna, certified, and contracted – prior to engaging in the sale of Aetna products. This communication is intended for use by producers only and is not intended for distribution to Medicare beneficiaries. Any publication or distribution of this communication to unauthorized recipients without Aetna's approval is prohibited.