AlohaCare’s Agents and Brokers Training and Testing
CY 2019
Table of Contents

• Purpose of this Training
• Company Overview  
  - Check your knowledge
• Licensure Requirements  
  - Check your knowledge
• Medicare Basics
• Enrollment and Disenrollment (Part C and Part D)  
  - Check your knowledge
• Marketing Requirements and other Regulations (Part C and Part D)-Do’s and Don’ts
• Beneficiary Right and Protections  
  - Check your knowledge
• AlohaCare Advantage 2019 Benefit
• Important Compliance Information – Fraud/Waste/Abuse  
  - Check your knowledge
• Take Scored Test
Purpose of this Training

• To meet Medicare regulatory requirements, appointed agents and brokers are required to successfully complete all required training before marketing or selling AlohaCare’s Medicare products.
• This training is to ensure AlohaCare is compliant with applicable State licensure and/or appointment laws when engaging marketing representatives to sell Medicare products.
• Ensure that all agents/brokers selling Medicare products, including employees, subcontractors, downstream entities, and/or delegated entities are trained and tested annually on Medicare rules, regulations, and details specifics to the plan products that they sell.
COMPANY OVERVIEW
Who is AlohaCare?

- Non-profit health plan, founded in 1994
- Hawaii’s 3rd largest health plan
- Medicare Advantage plans offered since 2006
- Proud to be a part of the Hawaii Quest Integration Program since 2015

Mission
Our mission is to serve individuals and communities in the true spirit of aloha by ensuring and advocating access to quality health care for all. This is accomplished with emphasis on prevention and primary care through community health centers that founded us and continue to guide us as well as with others that share our commitment.
Our Service Area

Kauai
5,872

Molokai
2,337

Oahu

Maui
6,679

East Hawaii
6,666

West Hawaii
6,604

Medicare and Medicaid Members

Confidential and Proprietary
Check Your Knowledge

• What is the name of AlohaCare’s CEO?
  A. Francoise Culley-Trotman
  B. Paula Arcena
  C. Bruce Lane
  D. Laura Esslinger

• What is the name of AlohaCare’s Chief Compliance Officer?
  A. Francoise Culley-Trotman
  B. Paula Arcena
  C. Bruce Lane
  D. Laura Esslinger
Check Your Knowledge

• AlohaCare was founded in?
  A. 1982
  B. 1994
  C. 1993
  D. 1980

• AlohaCare provide services in the following areas?
  A. Kauai
  B. Oahu
  C. Molokai
  D. All of the above
Licensure Requirements
Licensure Requirements

How to be “ready to sell” for 2019

To become “ready to sell” our Medicare products and receive commissions, you’ll need to complete several requirements prior to marketing or selling:

Certification:
- You must successfully complete all AlohaCare required training and testing (Medicare training)
- Successful completion of AHIP requirements
- You must complete all required certifications
- You must complete all required re-certifications

Other Requirements:
- Annual re-training and testing is required.
- Adhere to AlohaCare’s policies and procedure
- Understanding of fraud, waste and abuse
Licensure Requirements

How to be “ready to sell” for 2019

To become “ready to sell” our Medicare products and receive commissions, you’ll need to complete several requirements prior to marketing or selling:

Contracting:

New Agents: Agents/Brokers who haven’t contracted to sell our individual Medicare products before must complete and submit all required documents including a signed contract.

Existing Agents/Employees: Agents/employees who are currently selling our Medicare products are required to complete all training and testing and submit all certification before the annual October 1, 2018 deadline.

Licensing and Appointment: You’ll need to be properly licensed in the State of Hawaii and properly appointed by AlohaCare for all products you intend to sell. New agents will also need to pass a background check.
Check Your Knowledge

• How to be “ready to sell” for 2019?
  A. Complete all requirements prior to marketing or selling
  B. Complete few requirements prior to marketing or selling
  C. Complete HMSA requirements prior to marketing or selling
  D. Complete an interview with the CEO prior to marketing or selling

• AlohaCare Agents/employees who are currently selling our Medicare products are required to complete all training and testing and submit all certification before the October 1, 2018 deadline
  A. True
  B. False
Medicare Basics
Medicare basics

Overview of Medicare:

• Who is eligible for original Medicare (Parts A and B)?
  – People age 65 or older
  – People under age 65 with certain disabilities
  – People of any age with End-Stage Renal Disease (ESRD), permanent kidney failure requiring dialysis or a kidney transplant
  – People of any age with Amyotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig’s Disease
Medicare Choices

Original Medicare Coverage

**Part A: Hospital Insurance**
- inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery, home health care.

**Part B: Medical Insurance**
- doctor and other health care providers’ services and outpatient care. Part B also covers durable medical equipment, home health care, and some preventive services.

Stand Alone Plan

**Part D: Prescription Drug Coverage**
- Helps cover the cost of prescription drugs

**Solution**
- Part C- Medicare Advantage (AlohaCare DSNP)+ Medicare A&B+ D and additional benefits
Medicare Choices

What Part A & B Doesn’t Cover
Some of the items and services that Medicare doesn’t cover include:

- Long Term Care (also called custodial care)
- Most dental care
- Eye exams related to prescribing glasses
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting them
- Routine foot care
**Medicare Choices**

**Beneficiary Options**

Remain on **Original Medicare** Parts A & B, and

- Elect to enroll in a stand-alone Part D Rx plan (and pay a monthly premium), and/or
- Elect to enroll in a Medicare Supplement plan (and pay a monthly premium)

OR

Elect to enroll in a **Medicare Advantage** Plan

- Choose a Medical-only Plan, or
- Choose a Medical and Prescription Drug Plan

(Enrollment in a Medicare Advantage plan requires that beneficiaries enroll in Medicare Part B and pay their Part B premium. Plan choices may include a monthly premium.)
Medicare Supplement Plans

• These are supplemental insurance plans designed to help cover Medicare cost share amounts:
  –Deductibles, Copayments and Coinsurance

• Also referred to as “Medigap” Plans

• These are health insurance policies sold by private insurance companies

• Enrollees pay a monthly premium to the private insurance company

• AlohaCare does not have Medicare Supplement Plans
Medicare Prescription Plan (PART D)

• Insurance to cover your prescription drug costs

• You must choose a plan and pay a premium

• Your Choices:
  – Remain with Original Medicare and enroll in a stand-alone Prescription Drug Plan (PDP) from a private company,

  or

  – Enroll in a Medicare Advantage Plan that includes prescription drug coverage

• If you have low income, you may be eligible for assistance to help pay your drug premium and cost sharing. We’ll address Medicare’s “Extra Help” program later in the presentation.
Important member benefit information

Rx Drug Benefit for 2019

As a member of AlohaCare Advantage Plus (HMO SNP), you are automatically qualified for "Extra Help" to pay for your prescription drug costs. This is also called "Low Income Subsidy" or LIS.

<table>
<thead>
<tr>
<th>Full Amount</th>
<th>With Extra Help from Medicare, depending upon your income and institutional status, you pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible:</td>
<td>$0</td>
</tr>
<tr>
<td>Generic:</td>
<td>$0 or $1.25 or $3.40*</td>
</tr>
<tr>
<td>For all other drugs:</td>
<td>$0 or $3.80 or $8.50*</td>
</tr>
</tbody>
</table>
Medicare Advantage Plans

- Plan types include: HMOs, POSs, PPOs, SNPs and PFFS

- Generally, you see providers who are contracted and participate directly with the MA Plan

- Some plans provide coverage for services from out-of-network providers; higher cost share may apply
  - Some plans may require a Referral to see out-of-network providers
  - Plans may require certain services to be pre-authorized

- AlohaCare’s Plan
  - HMOs, D-SNP
**Medicare Special Needs Plans (SNPs)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you get your health care from any doctor or hospital?</td>
<td>You generally must get your care and services from doctors, other health care providers, or hospitals in the plan’s network (except emergency care, out-of-area urgent care, or out-of-area dialysis).</td>
</tr>
<tr>
<td>Are prescription drugs covered?</td>
<td>Yes. All SNPs must provide Medicare prescription drug coverage (Part D).</td>
</tr>
<tr>
<td>Do you need to choose a primary care doctor?</td>
<td>Generally, yes.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>In most cases, yes. Certain services, like yearly screening mammograms, don’t require a referral.</td>
</tr>
</tbody>
</table>
What else do you need to know about this type of plan?

- SNPs must limit plan membership to people in one of the following groups:
  1. Institutional SNP (I-SNP): Those living in certain institutions (like a nursing home), or who require nursing facility-level of care at home
  2. Dual Eligible SNP (D-SNP): Those eligible for both Medicare and Medicaid
  3. Chronic Condition SNP (C-SNP): Those with specific chronic or disabling conditions
- Plans may further limit enrollment based on rules for the specific type of SNP
- Plans should coordinate your needed services and providers
- Plans should make sure that providers you use accept Medicaid if you have Medicare and Medicaid
- Plans should make sure that the plan’s providers serve people where you live, if you live in an institution
Check Your Knowledge

• Who is eligible for original Medicare (Part A and C)?
  A. People age 65 or older
  B. People age 56
  C. People under age 65 with certain disabilities
  D. People age 35

• Medicare supplemental plan is also referred to as Medigap plan.
  A. True
  B. False
Check Your Knowledge

• Medicare Advantage Plans types includes?
  A. HMOs
  B. SNPs
  C. POPs
  D. A & B

• Enrollees are NOT allow to see providers that are not contracted or participate directly with the MA plan.
  A. True
  B. False
Enrollment and Disenrollment
Enrollment and Disenrollment

Eligibility for Enrollment in an MA Plan:
In general, an individual is eligible to elect an MA plan when each of the following requirements are met:

- The individual is entitled to Medicare Part A and enrolled in Part B, provided that he or she will be entitled to receive services under Medicare Part A and Part B as of the effective date of coverage under the plan.
- The individual has not been medically determined to have ESRD prior to completing the enrollment request.
- The individual permanently resides in the service area of the MA plan.
- The individual is a U.S. citizen or lawfully present in the United States.
- The individual or his/her legal representative completes an enrollment request and includes all the information required to process the enrollment or meets alternative conditions for enrollment specified by CMS.
- The individual is fully informed of and agrees to abide by the rules of the MA organization.
- The individual makes a valid enrollment request that is received by the plan during an election period.
- For a Special Needs Plan (SNP) additional requirements apply.
Medicare Advantage (MA) Plans and End-Stage Renal Disease (ESRD)

- Individuals can’t enroll if they have ESRD
- There are limited exceptions
  - Transition from one plan to another within the same parent organization
  - No break between coverage
  - Must meet all other enrollment requirements
  - If enrollee joined the plan without ESRD, but developed ESRD while in the plan, may stay in the plan
- If enrollee had a successful kidney transplant or no longer require a regular course of dialysis
  - Beneficiary is considered to have ESRD for MA eligibility purposes
Enrollment and Disenrollment

• Annual (Open) Enrollment Period (AEP)
  – For Only 2018: October 15th through December 31st
  – One-time “like Plan” change between
    (MAPD-MAPD, MAPD-Original Medicare, Part D, MA only Plan-MA only Plan)
    – Medicare Advantage Open Enrollment Period (NEW)
      January 1st-March 31

• Initial Eligibility Period
  – The 3 months before prospective member’s 65th birthday
  - The 3 months after prospective member’s 65th birthday

• Special Enrollment Periods for qualifying events
  – Loss of other group coverage (up to 8 mos after loss)
  – Medi-gap plan ends (63 days)
  – Move out of Medicare Advantage service area (60 days)
  – Move out of Part D service area or plan ends (60 days)
  – If beneficiary is institutionalized
Enrollment and Disenrollment

**Important Changes for DSNP plans 2019**

- The Medicare Advantage Disenrollment Period (January 1 – February 14 every year) will be replaced with a different arrangement. This will be effective starting in 2019, according to the Centers for Medicare & Medicaid Services (CMS).
- In 2019, a new Medicare Advantage Open Enrollment Period will run from January 1 – March 31 every year. If members are enrolled in a Medicare Advantage plan, they have a one-time opportunity to:
  A. Switch to a different Medicare Advantage plan
  B. Drop their Medicare Advantage plan and return to Original Medicare, Part A and Part B
  C. Sign up for a stand-alone Medicare Part D Prescription Drug Plan (if they return to Original Medicare).
- As of January 1, 2019, people with both Medicare and Medicaid coverage and the Extra Help will lose this continuous SEP and only be able to switch plans once a quarter for the first three quarters of the year, and then once during Medicare’s annual open enrollment period, also referred to as annual election period.
- Prospective members enrolled in other Medicare Advantage plan have a one-time opportunity during each quarterly period to:
  Switch to AlohaCare’s Medicare Advantage plan
  OR
  Drop their Medicare Advantage plan, return to Original Medicare (Parts A and Part B), and enroll in a stand-alone Medicare Part D Prescription Drug Plan
Check Your Knowledge

• Currently people who have both Medicare and Medicaid coverage and others who have the Extra Help are NOT allowed to change their Medicare Advantage (MA) and/or Part D prescription drug plan (PDP) during any month of the year.
  A. True
  B. False

• As of January 1, 2019, people with both Medicare and Medicaid and the Extra Help will lose this continuous SEP and only be able to switch plans once a quarter for the first two quarters of the year, and then once during Medicare’s annual open enrollment period, also referred to as annual election period.
  A. True
  B. False
## Enrollment Effective Dates

### Initial Enrollment Period-turning age 65:

<table>
<thead>
<tr>
<th>If you sign up for Part A/B in this month</th>
<th>Your coverage starts:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three months prior to your 65(^{th}) birthday</td>
<td>The first day of your birthday month (or the 1(^{st}) of the month prior if your birthday)</td>
</tr>
<tr>
<td>The month you turn 65</td>
<td>1(^{st}) month after you sign up</td>
</tr>
<tr>
<td>1 month after you turn 65</td>
<td>2 months after you sign up</td>
</tr>
<tr>
<td>2 months after you turn 65</td>
<td>3 months after you sign up</td>
</tr>
<tr>
<td>3 months after you turn 65</td>
<td>3 months after you sign up</td>
</tr>
<tr>
<td>During the Jan 1-Mar 31 General Enrollment Period</td>
<td></td>
</tr>
<tr>
<td><strong>SEP, Part D, MA:</strong> Always the 1(^{st}) of the month following application</td>
<td></td>
</tr>
</tbody>
</table>
How Members Enroll in our Plan:

Via an appointment:
Schedule a private meeting with one of our licensed benefit consultants. We will walk you through our plan benefits and answer all of your questions to make sure that AlohaCare is the right choice for you.

By paper application:
Fill out the Enrollment Form in the packet. Make sure you fill out all of the information and select your choice for a Primary Care Provider (PCP). Sign the Enrollment Form and mail it back to us using the postage-paid envelope.
Enrollment and Disenrollment Formats

How Members Enroll in our Plan:

Enroll online:
Enroll online at www.AlohaCare.org/MedicareEnrollment. You may also enroll in AlohaCare Advantage Plus through the CMS Medicare Online Enrollment Center located at www.medicare.gov.

By phone:
Enroll over the phone by calling 973-6395 or Toll-Free at 1-866-973-6395. TTY/TDD users call 1-877-447-5990. From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Hawaii Time. From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Hawaii Time.
Enrollment Anti-Discrimination

• Plans may not discriminate based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability or geographic location.

• Only SNPs may limit enrollment to dual-eligible, institutionalized individuals, or individuals with severe or disabling chronic conditions.

• Basic services and information must be made available to individuals with disabilities, upon request.
Disenrollment

**Voluntary Disenrollment**
- All members are provided the disenrollment process in the Evidence of Coverage and are given an opportunity to address any issues in question prior to disenrollment.

**Involuntary Disenrollment**
- Premiums are not paid timely (subject to grace period/good cause)
- Individual engages in disruptive behavior
- Individual provides fraudulent information on enrollment form or permits abuse of enrollment card
- Individual moves outside the plan service area
- Individual loses entitlement to Medicare parts A or B
- Loss of dual eligibility
- Death
- Individual no longer meets plan eligibility requirements (e.g., Special Needs Plan)
Check Your Knowledge

• What are the requirements to enroll in Medicare Advantage Plans?
  A. Must have Medicare Part B and Part C
  B. Must have Medicare Part A and Part B and live in the service area
  C. Must have Medicare supplemental insurance “Medigap”
  D. All of the above

• Annual (Open) enrollment Period (AEP) for only 2018 is .
  A. October 15th –December 31th
  B. October 15th –December 7th
  C. October 1st –December 7th
  D. October 5th –December 31th
Check Your Knowledge

• Enrollees can enroll via
  A. Appointment with an agent
  B. Paper application
  C. Phone
  D. All of the above

• What is the initial eligibility period?
  A. The 3 months before prospective member’s 65th birthday
  B. The 3 months before prospective member’s 65th birthday
  C. The 3 months before prospective member’s 65th birthday
  D. The 3 months after prospective member’s 65th birthday
Check Your Knowledge

• AlohaCare may not discriminate based on race. Ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability or geographic location
  A. True
  B. False

• Voluntary disenrollment is the only means of disenrollment for enrollees.
  A. True
  B. False
Marketing Requirements
Marketing Requirements and other Regulation

Medicare Marketing Guidelines:

- Marketing and disclosure
- Gifts
- Promotional educational activities
- Agents/brokers
- Rewards and incentives
- Do’s and Don’ts
- Understanding the New Medicare Marketing Guidelines
Disclosure of Plan Information for New and Renewing Members

• MA and PDPs must disclose plan information
  • At time of enrollment and at least annually
    • Required ANOC
    • Low Income Subsidy (LIS) rider
    • Member ID card at the time of enrollment/as needed
    • Summary of Benefits
  
  ▪ Explanation of Coverage (EOC), Comprehensive Formulary, and Pharmacy and Provider Directory - Must provide the hard copy or a notice describing where they can be found online together with how to request a hardcopy
  
  ▪ Documents for new enrollees must be provided no later than 10 calendar days or the last day of the month before the effective date, whichever is later
Unsolicited Beneficiary Contact

• Prohibited unsolicited marketing activities
  – Electronic communications
    • Unless express permission is given
  – Door-to-door solicitation
  – Calls/visits after attending sales event
    • Unless permission is given
  – Common areas (e.g., parking lots, hallways, sidewalks, etc.)

NOTE: Prohibited activities don’t include conventional mail or other print media
Sales Events

Promotional Activity Reminders

- Prospective enrollees may not
  - Be provided meals
  - Have meals subsidized
- At any event or meeting where
  - Plan benefits are being discussed, or
  - Plan materials are being distributed

Educational Event Reminders

- Educational events for prospective members
- No marketing activities at educational events
- Plans may distribute
  - Medicare and/or health educational materials
  - Agent/broker business cards
  - Distributed material must not contain marketing information
Marketing in Health Care Settings

• Marketing allowed in health care common areas
  – Hospital or nursing home cafeterias
  – Community or recreational rooms
  – Conference rooms

• No marketing in health care settings where patients get care
  – Waiting rooms
  – Exam rooms and hospital patient rooms
  – Dialysis centers and pharmacy counter areas
Nominal Gift Requirement

• Organizations can offer gifts to potential enrollees
  • Must be of nominal value
    □ Defined in Medicare Communications and Marketing Guidelines
    □ Currently $15 or less per individual gift based on retail value
    □ There’s a maximum aggregate of all gifts of $75 per person, per year
  • Given regardless of beneficiary enrollment and without discrimination
  • May not be in the form of cash or other monetary rebates, even if worth is $15 or less
Rewards and Incentives

- CFR 422.134 expands rewards and incentive programs
- Applies to MA organizations only
- Focus on encouraging participation in activities that promote
  - Improved health
  - Prevention of injuries and illness
  - Efficient use of health care resources
Marketing Material Requirements

• The Centers for Medicare and Medicaid Services (CMS) requires review and approval of certain materials
  – Plans must maintain materials and make them available at CMS’s request
• CMS creates standardized and model marketing materials
• Marketing for upcoming plan year
  - May not occur before October 1
Marketing Material Requirements

- Marketing star ratings in materials must get equal or greater prominence
  - Individual measures may be marketed/communicated with overall performance rating
  - Low-performing star rating status
    - Low Performance Icon
  - Plans may not try to discredit their low performing status by showcasing a separate higher rating
Agent/Broker Requirements

Licensure and Appointment of Agents

• MA and PDP organization agents/brokers or other marketing representatives
  – Must comply with state-licensure laws
    • Applies to all agents/brokers
    – Must be appointed by the plan, if required by the state

Reporting of Terminated Agents

• Organizations must report termination of agents/brokers to
  – State(s), per state law
  – CMS Account Manager (for-cause terminations)
Agent/Broker Training and Testing

- All agents/brokers must be trained and tested annually
  - Medicare rules and regulations
  - Plan details specific to plan products sold
  - Applies to all agents/brokers

- Completed prior to marketing the product
  - Must pass test with 85%
Scope of Appointment Reminders

• Must specify product type
  – MA, Medicare Prescription Drug, and Cost Plans
• 48 hours before personal/individual marketing and/or in-home appointment
• Additional products can only be discussed
  – With person with Medicare’s request
  – At separate appointment
• Must protect member information at all times e.g. completed application forms (see Compliance training slides for information on HIPAA)
Cross-Selling Prohibition

- Prohibited during any MA or Part D sales activity or presentation
- Can’t market non-health related products
  - Annuities
  - Life insurance
  - Other products
- Allowed on inbound calls per the request of the person with Medicare
Agent/Broker Compensation Rules

- CMS’s compensation rules
  - CMS sets limits on how much independent agents/brokers can be paid for enrollments
  - Designed to eliminate inappropriate enrollment moves from plan to plan
    - Also called “churning”
- Two types of compensation
  - Initial—for people new to Medicare or who make an “unlike plan” change (e.g., MA-PD to Original Medicare with a PDP)
  - Renewal—begins second year in a plan and for like plan changes (MA-PD to a different MA-PD)
- Agents can only be paid for the number of months an enrollee is in the plan
Check Your Knowledge

• Agents or brokers are permitted to set up individual marketing appointments at educational events.
  A. True
  B. False

• Who’s responsible for training and testing agent/brokers about the Medicare Program and proper marketing of Medicare products?
  A. Department of insurance
  B. The Centers for Medicare and Medicaid Services
  C. Medicare health plan
  D. You do not have to take a training or testing
### Compensation Type

<table>
<thead>
<tr>
<th>Compensation Type</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Year</td>
<td>$455</td>
<td>$482</td>
</tr>
<tr>
<td>Renewal Year</td>
<td>$228</td>
<td>$241</td>
</tr>
</tbody>
</table>

- Compensation year is Jan 1 through Dec 31, regardless of beneficiary enrollment date
- Renewal Year is Jan 1 following initial enrollment
- AlohaCare pays initial commission in full in the month of initial enrollment; renewal commissions are paid on a monthly basis
- Recoupment must occur for months a member is not in the plan
Referrals

- Referral/Finder’s fees paid to independent, captive or employed agents/brokers may not exceed the amount that CMS determines could reasonably be expected to provide financial incentive for an agent or broker to recommend or enroll a beneficiary into a plan that is not the most appropriate to meet his or her needs.

- Referral fees must be included in the total compensation not to exceed the fair market value for that calendar year. For 2019, the amount is $100 for MA plans and $25 for PDPs.
Marketing Do’s and Don’ts

DO:
• Distribute educational materials free of plan-specific information
• Distribute educational health-care materials
• Give out your business card and contact info for beneficiaries to use to initiate contact
• Collect Scopes of Appointment
• Hold the event in a public venue (optional, but under no circumstance should events be held in-home or in one-on-one settings)
• Schedule future marketing appointments

DON’T:
• Distribute plan-specific materials or enrollment packets
• Conduct sales presentations, even after the main educational presentation
• Discuss any carrier-specific plans or benefits or distribute marketing plan materials
• Require attendees to sign in (sign-in sheets MUST be optional)
Marketing Do’s and Don’ts

Sales events, on the other hand, are designed to steer, or attempt to steer potential enrollees towards a limited set of plans. During a sales event:

**DO:**
- Follow the specific carriers filing and reporting procedures prior to the event
- Follow the specific carrier’s cancellation procedures
- Make sure to use only carrier-approved materials
- Collect applications
- Call attendees from a sales event if they gave permission for a follow-up call (you must have documented permission to contact)

**DON’T:**
- Offer meals
- Make absolute statements
- Use pressure to sign someone up
- Cross-sell or promote non-health-related products
- Require attendees to sign in (sign-in sheets **MUST** be optional)

Individual appointments fall under the same category as sales events and the same CMS regulations apply. Don’t forget, whether you’re meeting face-to-face, or discussing plans one-on-one over the phone, you must have a Scope of Appointment.
Disciplinary Actions for Non-Compliance

- Agents/Brokers are responsible for ensuring compliance with CMS’ regulations and guidance.

- Agents/Brokers may be subject to compliance actions if they violate any regulatory guidance and/or AlohaCare’s policies and procedures.

- AlohaCare takes appropriate corrective action when potential noncompliance or fraud and abuse is substantiated through investigation. Corrective action related to reporting fraud and abuse to the government is described in section B of the compliance plan. In other circumstances, AlohaCare takes appropriate corrective action intended to correct the underlying root cause of the issue that caused or allowed the issue to occur and prevent future noncompliance or fraud and abuse.
Communication vs. Marketing

• Formally known as the Medicare Marketing Guidelines (MMG), CMS’ regulations are now named the Medicare Communications and Marketing Guidelines (MCMG). One of the biggest changes in the new guidelines is how marketing materials are categorized. In the past, all marketing materials were subject to review by CMS. This year, there’s a little more leeway.

• Materials will now be classified into two sections: communications and marketing. The new MCMG defines communications as “activities and use of materials to provide information to current and prospective enrollees,” making it the more general of the two. Materials that fall under this category are not subject to review by CMS.
Communication vs. Marketing

• Marketing, however, is a subset of communications. These materials are often more specific and provide detailed information. The purpose of these materials is to draw a beneficiary’s attention to a certain plan and influence their decision. These pieces could potentially include information on the plan’s benefit structure, cost sharing, and measuring or ranking standards. Marketing materials are subject to CMS review.

• CMS determines the category that the material falls into by reviewing both the content and the intent of the piece.
2019 Changes: New Medicare Marketing Guidelines

Contact Via Email

• According to the guidance, agents are permitted to make unsolicited direct contact with potential enrollees through conventional mail and other print media, such as advertisements or direct mail.
• Additionally, agents can make unsolicited direct contact with beneficiaries via email. However, in order to remain compliant, your email must contain an “opt out” function.
• Agents would need to utilize an email marketing platform that allows you to include these opt outs, such as Constant Contact or MailChimp. While you are permitted to do this, Ritter Insurance Marketing does not recommend mass emailing unless you completely understand how to use your email marketing application.
2019 Changes: Medicare Marketing Guidelines

Reinstatement of the Open Enrollment Period

- The Medicare Advantage Disenrollment Period (MADP) which would normally take place from January 1 through February 14 is being replaced with the Medicare Advantage Open Enrollment Period (OEP). The new OEP will occur between January 1 and March 31 annually beginning in 2019.

- During this time, clients who are enrolled in a Medicare Advantage plan (and those who are newly eligible for MA plans) will be permitted to choose a different MA plan or return to Original Medicare, with or without a prescription drug plan. The OEP is an expansion in both length and choice from the old MADP, but the MCMG puts clear guidelines into place for how agents can communicate with plan members through this period.
2019 Changes: Medicare Marketing Guidelines

Reinstatement of the Open Enrollment Period

With this change, agents must be mindful of “knowingly targeting.” The MCMG states Plans/Part D Sponsors may not do the following (so as an agent, you should follow suit):

- Send unsolicited materials advertising the ability/opportunity to make an additional enrollment change or referencing the OEP
- Specifically target beneficiaries who are in the OEP because they made a choice during Annual Enrollment Period (AEP) by purchase of mailing lists or other means of identification
- Engage in or promote agent/broker activities that intend to target the OEP as an opportunity to make further sales
- Call or otherwise contact former enrollees or clients who have selected a new plan during the AEP through another agent

You are allowed to send marketing materials and hold one-on-one meetings, but only at the request of the beneficiary.
Check Your Knowledge

• Referral fees must be included in the total compensation not to exceed the fair market value for that calendar year. For 2019, the amount is $100 for MA plans and $25 for PDPs.

A. True
B. False
Beneficiary Right and Protections
Who does this apply to?
Protection applies to both Original Medicare and Medicare Advantage plans (Medical & Prescription Drug Coverage)

- See any doctor or specialist (including women's health specialists), or go to any Medicare-certified hospital, that participates in Medicare.
- Get certain information, notices, and appeal rights. These help you resolve issues when Medicare may not or doesn't pay for health care.
- Request an appeal of health coverage or payment decisions.
- Buy a Medicare Supplement Insurance (Medigap policy)
- Being treated with dignity and respect at all times
- Being protected from discrimination
- Getting information about Medicare that is easy to understand and helps them make health care decisions
- Getting answers to questions about Medicare
- Receiving culturally competent services
Getting Needed Care

• Getting emergency care when needed
• Learning about all treatment choices in clear language
• Making complaints about payment, services, or other problems, including quality of care
• Having personal health information kept private
• Choice of health care providers
• Access to health care providers
  - Receiving a treatment plan, which allows an enrollee to see a specialist within the plan as many times as needed
  - Women may go directly to a woman’s health care specialist within the plan for routine and preventive services
• Knowing how the plan pays their doctors
• Fair, efficient, and timely appeals process
• Filing grievances about other concerns or problems
**Beneficiary Complaints**

- Enrollees have the right to ask the plan to address complaints about payment, services received, nondiscrimination practices and other concerns or problems they may have about getting health care, or the quality of the health care received under any Medicare plan.
- Grievances, coverage decisions, and appeals are three ways that Medicare has set up to solve problems with a health plan. Written explanations of the process are included in the enrollment packets.

**Step 1:**
- Members should contact the health plan by telephone or in writing.
- From the date the problem occurred, a member has 60-days to file a grievance.
- A member can ask for an expedited grievance review in certain circumstances.

**Step 2:**
- Health plan reviews and responds.
- Plans has 30-days to review and notify member of its decision.
- Plan has 24 hours to respond to an expedited grievance.
Right to Covered Services

MA plan makes a coverage decision when it:

• Makes a decision to provide, cover or pay for services,
• Asks a member to leave the hospital, or
• Ends a member’s Home Health Agency (HHA), Skilled Nursing Facility (SNF), or Comprehensive Outpatient Rehabilitation Facility (CORF) coverage

For Part D, plan coverage decisions are called Formulary exceptions. A member or provider may submit a Formulary exception to request that AlohaCare:

• Cover a Part D drug that a member believes he/she should receive but is not listed on the Formulary
• Pay for a Part D drug that a member already paid for or received
• Change the amount he/she must pay for a prescription drug or
• Make an exception to a UM rule (such as a quantity limit, Step Therapy, PA) for a prescription drug
Right to Appeal

- An appeal is the action a member takes if he or she disagrees with a coverage or payment decision made by his or her plan.
- When members request to appeal the denial of payment, by the Plan, for services rendered.
  - The timeframe for resolution is 60-days.
Benefits:
AlohaCare Advantage Plus (HMO SNP)
2019 Medicare Cost Share

Part A (Hospital)
• Premium: Generally, no cost to beneficiary
• Beneficiary benefit cost share:
  $0 Deductible for days 0-60
  $0 Daily Copayment for 61-90 days
  $0 Daily Copayment for 91-150 days (lifetime reserve days)
• 151 or more days (Patient pays 0%; cost covered by QUEST Integration Plan if medically necessary

Part B (Doctors and other outpatient services)
• Premium: Generally, Beneficiaries pay a Part B premium each month. Most people will pay the standard premium amount. However, if income (based on 2 years prior) is above a certain amount, they may pay more.
• Beneficiary benefit cost share:
  Coinsurance covered by Medicaid for the dually eligible

Note: There is no annual maximum out-of-pocket liability protection with Original Medicare

Note! These cost share amounts may change for 2020
AlohaCare Advantage Plus (HMO SNP)

Medicare Benefit Guide (Effective January 1-December 31, 2019)

Prospective Enrollees Benefit Includes:

$0 monthly premium
No Monthly Premium!
Pay $0 a month for AlohaCare Advantage Plus. You must continue to pay your Medicare Part B premium.

Coordinate Your Care!
When you have your Medicare and Medicaid (QUEST Integration) plans with AlohaCare, it’s easier to get your benefits. One plan means one number to call to get all your questions answered.
Prospective Enrollees Benefit Includes:

$2,000 Preventive and Comprehensive dental Coverage

EVERYONE DESERVES A BEAUTIFUL SMILE!

AlohaCare offers preventive and comprehensive dental coverage for our members. Your Medicaid plan only covers emergency dental services, but as a member of our Medicare plan, you’ll be covered for a wide range of dental services that will keep you smiling!

- Oral Exams
- Routine Cleaning
- X-rays
- Root Canals
- Extractions
- Dentures

You will be covered for up to $2,000 per plan year for preventive and comprehensive dental services.

To find a participating dentist: visit www.AlohaCare.org/MedicareSNP
AlohaCare Advantage Plus (HMO SNP)

Medicare Benefit Guide (Effective January 1-December 31, 2019)
Prospective Enrollees Benefit Includes:

$75 a quarter for Over-the-Counter (OTC) Items. SAVE MONEY ON EVERYDAY ITEMS!

AlohaCare offers our members a pre-paid debit card to pay for OTC eligible items at the pharmacy. You will get a quarterly benefit (every 3 months) of $75 to spend. You can use this card to purchase the following:

- Adult Cough, Cold and Flu Medicine
- Allergy and Sinus medications
- Bandages (Band-Aids)
- Diabetes Care Accessories
- First Aid Kits and Supplies
- Toothbrushes and Toothpaste
- Vitamins, Multi-Vitamins and Minerals
- And much more!

This debit card will be sent to you upon your enrollment into AlohaCare Advantage Plus. It will be automatically replenished every three months. Unused money will not transfer over to the next three months.

OTC delivery services may be available when medically necessary and prior authorized.
Prospective Enrollees Deserve More Aloha!

• **MORE ALOHACARE STAFF THAT TAKES CARE OF YOU!**
  You have a care manager that works with you and your doctors to help you get and stay healthy. Your care manager can help you find the care you need when life gets complicated.

• **MORE CARE IN YOUR NEIGHBORHOOD!**
  We hire staff who know your community. If you are unable to come to us, we’ll come to you!

• **MORE DOCTORS TO CHOOSE FROM!**
  We’ve added doctors statewide to better care for you and your Ohana.

• **MORE WAYS TO STAY HEALTHY!**
  Complete certain services at your doctor’s office, and choose from a selection of gifts. Contact us for more information.
### AlohaCare Advantage Plus (HMO SNP)

Medicare Benefit Guide *(Effective January 1-December 31, 2019)*

#### MONTHLY PREMIUM

| Monthly Premium | $0 premium per month (You must continue to pay Medicare Part B premium) |

#### ADDED VALUE BENEFITS NOT COVERED BY ORIGINAL MEDICARE

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit Details</th>
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<tbody>
<tr>
<td>Dental Services</td>
<td>$2,000 per plan year</td>
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<tr>
<td>Over-the-Counter (OTC) Items</td>
<td>You pay nothing $75 every 3 months (Delivery services may be available when medically necessary and prior authorized)</td>
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<tr>
<td>Emergency &amp; Urgent Care (Worldwide)</td>
<td>Plan covers up to $1,000 per plan year</td>
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<tr>
<td>Podiatry (Routine)</td>
<td>Plan covers up to 8 routine visits per plan year</td>
</tr>
<tr>
<td>Acupuncture*</td>
<td>Plan covers up to 15 treatments or $1,000 per plan year</td>
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<tr>
<td>Nurse Advice Line</td>
<td>Available 24 hours a day, 7 days a week</td>
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Compliance
Compliance Rules

Behold, the mighty Fraud Triangle!
The primary goal of AlohaCare’s Compliance Plan is to ensure that AlohaCare’s health plan operations are conducted in compliance with applicable federal and state laws, regulations, and sub-regulatory guidance. The objectives of AlohaCare’s Compliance Program are to prevent, detect, investigate, and report noncompliance and fraud, waste, and abuse.

The methodology AlohaCare’s Compliance Program uses to meet this objective is described in each of the seven elements of AlohaCare’s Compliance Plan.
What Is HIPAA?

• HIPAA (Health Insurance Portability and Accountability Act of 1996) is United States legislation that provides data privacy and security provisions for safeguarding medical information. The law has emerged into greater prominence in recent years with the proliferation of health data breaches caused by cyberattacks and ransomware attacks on health insurers and providers.

• AlohaCare is committed to protecting the privacy of our members Protected Health Information ("PHI").

• Plans/Part D sponsors are reminded that other laws – such as the HIPAA privacy rules - may limit the use of information gathered from other sources or in connection with other products offered by the Plan/Part D sponsor.
Compliance Fraud, Waste & Abuse (FWA)

Why do I need FWA Training

Every year billions of dollars are improperly spent because of fraud, waste, and abuse. This training will help you detect, correct, and prevent fraud, waste, and abuse. YOU are part of the solution!!!
Compliance, Waste & Abuse (FWA)

Why this is important

The US healthcare system loses between $505 billion and $850 billion every year, due to fraud, waste, and abuse.

**Estimated Waste in US Healthcare**

- Unnecessary Care: 37%
- Fraud & Abuse: 22%
- Administrative Inefficiency: 18%
- Medical Mistakes: 12%
- Preventable Conditions: 11%
Compliance Fraud, Waste & Abuse (FWA)

The AlohaCare FWA Program

- Our FWA program is integrated into the Compliance Plan.
- The FWA program includes elements for detection, prevention, and correction of fraud, waste, and abuse.
Compliance Fraud, Waste & Abuse (FWA)

Detecting FWA

• In order to detect FWA first you need to know who and what to look for!
Compliance Fraud, Waste & Abuse (FWA)

What is Fraud?
• **Fraud** involves a person or organization intentionally submitting false information to receive money or benefits.
• For example, a provider intentionally submitting claims when no patient was seen is an example of **fraud**.

What is Waste?
• **Waste** is the overuse of services that results in unnecessary costs.
• **Waste** usually doesn’t include criminal actions, and can be due to inefficiency
• For example, running many diagnostic tests when one test would provide the information needed is an example of **waste**.
Compliance Fraud, Waste & Abuse (FWA)

What is Abuse?

- **Abuse** includes actions that result in unnecessary costs through improper payment for services that don’t meet recognized standards of care, or are not medically necessary.
- For example, a provider upcoding a visit (by choosing a higher paying visit when the medical records don’t support it) is an example of abuse.

Abuse of a person?

- **Abuse** isn’t always about services and payment. It can be about the physical or mental abuse of a member.
- Reporting this kind of abuse is just as important as reporting any other kind.
- An example member abuse is when a family member is stealing a member’s medications.
Compliance Fraud, Waste & Abuse (FWA)

What does fraud look like?

• Fraud, Waste, and Abuse (FWA) are similar, and the difference between each depends on the facts in a case.
• What you need to know is that any time you find Fraud, Waste OR Abuse you need to report it to the Compliance Department!

Who is likely to commit FWA?

• Most people who work with us, QUEST or Medicare are honest.
• Some are not though!
• Any of the following may be involved in fraud and abuse:
  – Doctors and health care practitioners
  – Suppliers of durable medical equipment (DME)
  – Employees of providers
  – Employees of health plans
  – Members of QUEST and/or Medicare
  – People providing Home and Community Based Services (HCBS) to our members
Compliance Fraud, Waste & Abuse (FWA)

What does fraud look like?

- **FWA** isn’t always obvious, but you can look for signs:
  - Do the documents you’re working with have inconsistencies (signatures or names don’t match)?
  - Does the caller on the phone give incorrect information when they are verifying their identity?
  - Does the member you’re seeing not match the description we have in Guiding Care (such as age, gender, or medical condition)

Preventing FWA

- There are many ways in which AlohaCare works to prevent FWA.
- Some of the methods we use include:
  - Making sure staff, providers and vendors aren’t excluded from accepting healthcare dollars
  - Routine auditing and monitoring
  - Member surveys
  - Data Analysis
  - Training
Compliance Fraud, Waste & Abuse (FWA)

Excluded Parties

• The federal and state government keep lists of people and organizations that are not allowed *(Excluded)* to receive payment for Medicare and QUEST.

• **Civil Monetary Penalties** can be imposed on a company (like AlohaCare) **if they hire or pay someone who is excluded** from participating in these programs.

Checking for Exclusions

• AlohaCare does not pay any individual or entity if they are on the exclusions lists.

• The Compliance Department checks all employees, temporary employees, Board members, consultants, providers, and vendors/agents against the exclusions lists.

• Checks are done prior to hire or contracting and monthly thereafter.

• If a match is found, the relationship with the *excluded* person or organization is terminated.
Compliance Fraud, Waste & Abuse (FWA)

Why would anyone be Excluded?

• A person or entity may be excluded for a number of reasons including:
  – Being convicted of unlawful manufacture, distribution, prescription, or dispensing of controlled substances
  – Submitting false or fraudulent claims to a federal healthcare program
  – Patient abuse or neglect
  – Provision of unnecessary or substandard services
  – Taking kickbacks
  – Defaulting on health education loan or scholarship obligations
Acronyms

- **ANOC** Annual Notice of Changes
- **CMS** Centers for Medicare & Medicaid Services
- **EOC** Evidence of Coverage
- **ESRD** End-Stage Renal Disease
- **HIPAA** Health Insurance Portability and Accountability Act
- **HMO** Health Maintenance Organization
- **LIS** Low Income Subsidy
- **MA** Medicare Advantage
- **MA-PD** Medicare Advantage with Prescription Drug Coverage
- **MAO** Medicare Advantage Organizations
- **MMG** Medicare Marketing Guidelines
- **OEP** Open Enrollment Period
- **PDP** Prescription Drug Plan
- **PPO** Preferred Provider Organization
- **SEP** Special Enrollment Period
- **SHIP** State Health Insurance Assistance Program
- **SNP** Special Needs Plan
- **TTY** Teletypewriter
- **MQD** Med-Quest
Check Your Knowledge

• AlohaCare is committed to protecting the privacy of our members Protected Health Information ("PHI").
  A. True
  B. False

• The Compliance Department checks all employees, temporary employees, Board members, consultants, providers, and vendors/agents against the exclusions lists
  – True
  – False
Check Your Knowledge

• Why would anyone be excluded?
  A. Being convicted of unlawful manufacture, distribution, prescription, or dispensing of controlled substances
  B. Submitting false or fraudulent claims to a federal health care program
  C. Defaulting on health education loan or scholarship obligations
  D. All of the above
## References

<table>
<thead>
<tr>
<th>Content</th>
<th>Reference(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage Basics</td>
<td>42 CFR Part 422</td>
</tr>
<tr>
<td></td>
<td>• Subpart A—General Provisions</td>
</tr>
<tr>
<td></td>
<td>• Subpart B—Eligibility, Election, and Enrollment</td>
</tr>
<tr>
<td></td>
<td>• Subpart C—Benefits and Beneficiary Protections</td>
</tr>
<tr>
<td></td>
<td>Medicare Managed Care Manual (MMCM) Ch. 1 &amp; 2</td>
</tr>
<tr>
<td>Part D Basics</td>
<td>42 CFR Part 423</td>
</tr>
<tr>
<td></td>
<td>• Subpart A—General Provisions</td>
</tr>
<tr>
<td></td>
<td>• Subpart B—Eligibility and Enrollment</td>
</tr>
<tr>
<td></td>
<td>Medicare Prescription Drug Benefit Manual (PDBM) Ch. 1 &amp; 3</td>
</tr>
<tr>
<td></td>
<td>MMCM Ch. 1 &amp; 2; PDBM Ch. 1 &amp; 2</td>
</tr>
<tr>
<td>Extra Help</td>
<td>42 CFR Part 423</td>
</tr>
<tr>
<td></td>
<td>• Subpart P—Premiums and Cost-sharing Subsidies for Low Income Individuals</td>
</tr>
<tr>
<td></td>
<td>• Subpart S—Special Rules for States-Eligibility Determinations for Subsidies and General Payment Provisions</td>
</tr>
<tr>
<td></td>
<td>PDBM Ch. 13</td>
</tr>
</tbody>
</table>
## References

<table>
<thead>
<tr>
<th>Content</th>
<th>Reference(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Election Periods</td>
<td>42 CFR §422.62- Election of coverage under an MA plan</td>
</tr>
<tr>
<td></td>
<td>42 CFR §423.38- Enrollment periods</td>
</tr>
<tr>
<td></td>
<td>MMCM Ch.2 Section 30; PDBM Ch. 3 Section 30</td>
</tr>
<tr>
<td>Enrollment and Disenrollment Process</td>
<td>42 CFR Part 422; Subpart B—Eligibility, Election, and Enrollment</td>
</tr>
<tr>
<td></td>
<td>42 CFR Part 423; Subpart B—Eligibility and Enrollment</td>
</tr>
<tr>
<td></td>
<td>MMCM Ch.2; PDBM Ch. 3</td>
</tr>
<tr>
<td>Beneficiary Protections</td>
<td>42 CFR Part 422; Subpart C—Benefits and Beneficiary Protections</td>
</tr>
<tr>
<td></td>
<td>MMCM Ch. 17f; PDBM Ch. 5</td>
</tr>
<tr>
<td>Part C Organizational Determinations and Appeals, Part D Coverage</td>
<td>42 CFR Part 422; Subpart M—Grievances, Organization Determinations, and Appeals</td>
</tr>
<tr>
<td>Determinations and Redeterminations, and Grievances</td>
<td>42 CFR Part 423; Subpart M—Grievances, Coverage Determinations, Redeterminations, and Reconsiderations</td>
</tr>
<tr>
<td></td>
<td>MMCM Ch. 13; PDBM Ch. 18</td>
</tr>
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<td>Content</td>
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</tr>
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<td>-------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Overview of Marketing</td>
<td>42 CFR Part 422; Subpart V—Medicare Advantage Marketing Requirements 42 CFR Part 423; Subpart V—Marketing Requirements Medicare Marketing Guidelines (MMG)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Overview of Marketing Materials Requirements</td>
<td>42 CFR §422.2260 - 422.2266 42 CFR §423.2260 - 423.2266 MMG</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Agent/Broker Compensation</td>
<td>42 CFR Part 422; Subpart V—Medicare Advantage Marketing Requirements 42 CFR Part 423; Subpart V—Marketing Requirements MMG Section 70.9-70.10</td>
</tr>
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<td>Part C Organizational Determinations and Appeals, Part D</td>
<td>42 CFR Part 422; Subpart M—Grievances, Organization Determinations, and Appeals 42 CFR Part 423; Subpart M—Grievances, Coverage Determinations, Redeterminations, and Reconsiderations MMCM Ch. 13; PDBM Ch. 18</td>
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QUESTIONS?
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