



External Distribution Channel (EDC) Agent Guide

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This Guide is intended for agent use only.

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Section 1: Introduction

Welcome to UnitedHealthcare Medicare Solutions

Using this Guide

UnitedHealth Group Overview

UnitedHealthcare Medicare Solutions Overview

Welcome to UnitedHealthcare Medicare Solutions

We rely on exceptional agents to help us achieve our mission of providing innovative health and well-being solutions that help Medicare consumers achieve healthier and more secure lives.

We are committed to providing you with tools that help you succeed. One such tool is this *Agent Guide* – a comprehensive resource providing information you need to conduct business with UnitedHealthcare Medicare Solutions (“UnitedHealthcare”) efficiently and compliantly.

We expect our agents to share our commitment to compliance and to act with integrity by putting the best interest of consumers first in everything they do on behalf of the company. To help, compliance guidelines are integrated into each section of this guide.

An electronic version of this guide is available on *Jarvis* and is updated regularly. Your comments, suggestions and recommendations for additional content are encouraged. Please submit feedback to your UnitedHealthcare Agent Manager.

Please use this guide as a resource as you work with consumers. Your success ultimately helps UnitedHealthcare achieve our shared mission of providing healthier and more secure lives for our consumers and members.

Sincerely,



Tim Harris
Senior Vice President, External Distribution Channel
UnitedHealthcare Medicare & Retirement

Using this Guide

The *Agent Guide* has been developed for use by all National Marketing Alliance (NMA) /Field Marketing Organization (FMO) agents and solicitors. Throughout the guide the word “agent” is used to refer to any NMA/FMO agent or solicitor. In instances where information relates specifically to an agent, but not a solicitor or vice versa, it will be clearly noted.

- Agent – a licensed, certified, and appointed (if applicable) representative who is contracted with UnitedHealthcare through an NMA/FMO.
- Solicitor – an appropriately licensed captive agent employed by or independently contracted with an External Distribution Channel (EDC) agent, appointed (if applicable) by the Company, and is free to exercise his or her own judgment as to the time and manner of performing services pursuant to a direct or indirect agreement between the Solicitor Agent and the EDC agent.

This guide consists of answers to agents’ most frequently asked questions when it comes to doing business with UnitedHealthcare Medicare Solutions. It provides the business procedures to guide you through getting started with the company, to finding the materials needed to market products in your area, enrolling a consumer, and much more.

UnitedHealth Group Overview

Our Mission

Our mission is to help people live healthier lives and help make the health system work better for everyone.

- We seek to enhance the performance of the health system and improve the overall health and well-being of the people we serve and their communities.
- We work with health care professionals and other key partners to expand access to quality health care so people get the care they need at an affordable price.
- We support the physician/patient relationship and empower people with the information, guidance and tools they need to make personal health choices and decisions.

UnitedHealth Group is a highly diversified health and well-being company headquartered in the United States, serving the markets for health benefits through UnitedHealthcare and the growing markets for health services through Optum. These two platforms share and build upon three core competencies: Clinical Insight (knowledge and experience in organizing health care resources to best serve specific local market needs.), Technology (enabling a variety of interactions at enormous scale and complexity, helping connect all participants in health care.), Data & Information (unique skills collecting, managing, and analyzing data; and the capability to translate data into actionable information.). The breadth and scope of our diversified enterprise help consistently improve health care quality, access and affordability. Our ability to analyze complex data and apply deep health care expertise and insights allows us to serve care providers, individuals, vulnerable populations, businesses, communities, and governments with more innovative products and complete, end-to-end offerings for many of the biggest challenges facing health care today.

UnitedHealthcare is dedicated to helping people live healthier lives by simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers. The company offers the full spectrum of health benefit programs for individuals, employers, military service members, retirees and their families, and Medicare and Medicaid beneficiaries.

Optum is a leading information and technology-enabled health services business dedicated to modernizing the system and improving the health of people and communities. Optum builds innovative partnerships, provides technology and tools that enable unprecedented collaboration and efficiency and taps into valuable health care data to uncover insights that lead to better care at lower cost.

With a total workforce of nearly 260,000 people worldwide, UnitedHealth Group serves people residing in all 50 states in the United States and more than 125 other countries. UnitedHealth Group's workforce includes 30,000 physicians and nurses focused on helping people live healthier lives. UnitedHealth Group invests nearly \$2.9 billion annually in technology and innovation and processes more the 600 billion digital transactions annually.

Source: <http://www.unitedhealthgroup.com/~media/UHG/PDF/About/UNH-Fact-Book.ashx>

For more information: www.UnitedHealthGroup.com, www.UnitedHealthcare.com, www.Optum.com

UnitedHealthcare Medicare Solutions Overview

UnitedHealthcare Medicare & Retirement, an operating unit of UnitedHealth Group (NYSE: UNH), is dedicated to providing innovative health and well-being solutions that help Medicare beneficiaries live healthier and more secure lives.

Serving one in five Medicare beneficiaries, UnitedHealthcare Medicare & Retirement is the largest business dedicated to the health and well-being needs of seniors and other Medicare beneficiaries. For more than three decades, UnitedHealthcare has served the health care coverage needs of Medicare beneficiaries, navigating through multiple evolutions of the Medicare program and growing to become the preferred choice of more beneficiaries than any other company. Today we remain committed to providing people with a choice of innovative health and well-being solutions that help them access the quality care they need and enjoy the superior experience they deserve.

Choice - Medicare is not one size fits all, which is why we offer a variety of smart, affordable plan options that feature enhanced benefits, broad networks and predictable out-of-pocket costs so people can find the plan that's right for them.

Care - Regardless of our members' health status or unique health needs, we're committed to helping them live happier, healthier lives and design our Medicare plans, clinical programs and networks to support that goal.

Experience - Medicare can be complex and confusing. We work to make it as easy as possible for people to navigate the options to find the plan that works best for them and then support them throughout their health care journey with plan benefits, features and resources that can help them live more and worry less.

Our products, services and programs are designed to meet the individual needs of our members as well as their families, physicians and communities. The portfolio of UnitedHealthcare Medicare & Retirement products includes:

Medicare Advantage Plans – More than 4.3 million members in 45 states and the District of Columbia

Part D Prescription Drug Plans – Nearly 5.0 million members in all 50 states, the District of Columbia and five U.S. territories

Medicare Supplement Plans – Nearly 4.4 million members in all 50 states, the District of Columbia and four U.S. territories

UnitedHealthcare Retiree Solutions – Provides employers with high-quality, affordable health care solutions for more than 1.8 million retirees

Source: UnitedHealthcare Medicare & Retirement Fact Sheet

For more information: www.uhc.com/news-room

Section 2: How do I Get Started?

Contracting

Agent Licensing

Appointment

Certification and Training

UnitedHealth Group Learning Management System Access Guide

UnitedHealth Group Learning Management System Website Tips

Contracting

Overview

You receive a writing number (Agent ID) as part of your on-boarding process. An active writing number allows you to access marketing and sales materials on **Jarvis**. The writing number must be indicated on each enrollment application written by you and is used to accurately credit you with the sale of a policy.

You must be contracted, licensed, appointed (if applicable), and certified (fully credentialed) in order to market and sell the UnitedHealthcare Medicare Solutions portfolio of products. If you are not licensed in the state in which the consumer resides at the time of sale you will be terminated.

You must align under a National Marketing Alliance (NMA) organization/ Field Marketing Organization (FMO) or eAlliance organization approved and contracted with UnitedHealthcare. The NMA/FMO or eAlliance organization initiates the contract submission process by providing the contracting paperwork via hard copy, electronic copies, or a link to either an internal or external on-line contracting system to obtain necessary on-boarding information and documentation. The NMA/FMO or eAlliance organization is responsible for verifying the accuracy and completeness of the contracting packet contents. A complete contracting packet contains:

- Agreement (not applicable to solicitor) – At a minimum, the First and signature pages must be submitted. The signature date must be within 30 days of the date received by AOB.
- Appointment Application – The signature date must be within 30 days of the date received by AOB.
- Errors and Omissions Attestation of Coverage – The signature date must be within 30 days of the date received by AOB.
- NMA/FMO Relationship Hierarchy Addendum

- W-9 Form (not applicable to solicitor) – The signature date must be within 30 days of the date received by AOB.

Welcome Letter

Agent On-Boarding emails a Welcome Letter to you and your management. Your writing number and the executed copy of your agent agreement is secure delivered via email to you.

You are required to provide and maintain a current, valid email address.

You can update your contact information by updating your user profile on **Jarvis** or by sending a written request to Agent On-Boarding via fax to (888) 205-7375 or via email to uhpcred@uhc.com.

Errors and Omissions (E&O) Coverage

You must carry and maintain continuous E&O/Professional Liability insurance coverage and provide proof. Failure to carry and maintain proof of E&O/Professional Liability coverage is grounds for termination.

The following guidelines apply:

- The policy must specifically state “Errors and Omissions” or Insurance Agent/Broker Professional Liability.
- The declaration page or certificate of insurance must state the policy number, policy limits, policy period (issue and expiration dates), and carrier.
- Minimum insurance required: E&O/Professional Liability insurance is required at a minimum of \$1,000,000 per claim and/or \$1,000,000 aggregate.
- E&O/Professional Liability for a corporation should state who is covered by the policy (e.g., the corporation, principal, and/or its employees or subcontractors.)

Section 2: How do I Get Started?

- Blanket E&O coverage must explicitly state who the policy covers:
 - ~ Entities that have blanket E&O coverage for their down-line agents may provide a non-carrier produced listing of those covered, as long the down-line is classified as an agent or solicitor level. The listing must be on the entity's letterhead, provide the agent or solicitor's full legal name, and be signed by the entity's principal. Agents or solicitors can be added by providing either an update to the original listing or a separate letter.
 - ~ General Agent (GA) level and above producers must have their own E&O coverage or their name must appear as the certificate holder (or similar) on the confirmation of insurance of a blanket policy.
 - ~ Contracted entities may provide E&O/Professional Liability coverage by submitting a non-carrier produced listing of covered individuals. The listing must be on carrier or business entity's letterhead, provide covered individual's full legal name and signed by the entity's principal or by the carrier. EDC entities may provide coverage for their down-line employees, affiliated producers, agents, and/or subcontractors who are contracted at the individual agent level.
- E&O/Professional Liability for a principal will cover the corporation, but not specifically the employees or subcontractors of the corporation.
- If an agent is not insured by a corporate policy, they may have individual E&O/Professional Liability insurance. The policy should be in their name.
- Submission of E&O/Profession Liability coverage documentation is not required unless specifically requested and may be sent to uhpred@uhc.com.

Agent Licensing

Producer License(s)

You must be licensed in your state of residence and in all states you wish to market and sell. You are responsible for maintaining an active license(s), including all educational requirements. Agent On-Boarding will verify license status using the National Insurance Producers Registry (NIPR). Failure to maintain valid licensing or loss of licensing is grounds for termination of your agent agreement.

You will be terminated if you were not appropriately licensed at the time of the sale. The termination will be not-for-cause and you will not be able to re-contract for a minimum of 12 months following the date of the unqualified sale.

Continuing Education (CE)

UnitedHealthcare has partnered with Kaplan to offer deeply discounted CE courses.

How do I access the CE courses?

You can access online continuing education courses through the Kaplan website or [via Jarvis > Knowledge Center > Continuing Education link](#).

Accessing the UnitedHealthcare Kaplan Portal

- **Go**
to <https://www.kfeducation.com/portallogin>
- **New Users**
 - ~ Create an account under "New Users"
 - ~ Use the portal code "EDC"
 - ~ Select "Create Account"
 - ~ Click "Submit"
- **Current Users**
 - ~ Use the portal code "EDC"
 - ~ Enter your "Identifier"
 - ~ Click "Log In"

Section 2: How do I Get Started?

What courses can I take?

You can get great discounts on both online and live CE sessions. Total access to the CE courses is only \$29.25. The total access selection will give you unlimited access to all credit hours.

Contact PHD@uhc.com for any questions.

Party Identification (Party ID) Notification

You are assigned only one Party ID in your lifetime with UnitedHealthcare Medicare Solutions. The Party ID links all subsequently issued writing numbers to you.

An issuance of a Party ID is not a guarantee of an issuance of a writing number. A writing number will be issued upon successful completion of the contracting process.

Unqualified Sale Termination

You will be terminated if you are not licensed at the time of a sale (see “Termination Due to an Unqualified Sale” in this guide).

Access to Certification Modules

You must complete certification requirements in order for Agent On-Boarding to process the appointment request. (Refer to Agent On-Boarding: Certification and Training for details on the certification process and agent requirements.)

The Party ID Notification Letter includes instructions for accessing the UnitedHealth Group Learning Management System within *Jarvis*. You must complete and successfully pass all required tests and at least one product test, within ninety days of the date of the Party ID Notification Letter, in order to move forward in the contracting process.

If you do not complete certification within ninety days of receiving the Learning Management System login information, the contracting packet is closed. A new contract packet may be submitted without a waiting period.

Background Investigation

You must pass a background investigation in order for Agent On-Boarding to process the appointment request. The investigation is ordered at the time the Party ID is issued or a new contract packet is received.

A background investigation collects information regarding an agent’s criminal, credit, and insurance licensing history, as well as, Office of Inspector General records, and General Service Administration excluded party records. Results are examined against predefined criteria. A Pass-Fail scoring methodology is employed.

Upon receipt of a positive (pass) result, the contracting process continues. If a negative (fail) result is returned, a senior Agent On-Boarding analyst reviews the investigation results. If the review supports the initial determination, the contracting process will terminate and you will receive notification of the decline to appoint due to background investigation. The notification letter will include appeal submission instructions. (Refer to your sales leadership for addition details regarding Denial Due to Background Investigation.)

In the event you have adverse information on your background investigation, the background vendor will send a pre-notification letter to you making you aware that there is information contained in your background investigation which may cause you to fail the background review.

On a periodic basis, a background investigation is ordered for all non-employee agents (all levels), solicitors, and principals who have an active Party ID. A notification letter is sent to you, solicitor, or principal informing them of the upcoming background investigation. The notification letter provides instruction on how to notify Agent On-Boarding if the individual does not authorize the investigation. Agents, solicitors, and principals who do not authorize the background investigation are immediately terminated upon such notification to Agent On-Boarding. If the principal does not authorize the background investigation, this

Section 2: How do I Get Started?

termination includes agencies of these principals. The periodic background investigation review follows the same process outlined above.

If you fail the periodic background process, you will receive a 30-day termination notice, regardless of channel or level (solicitors included).

On a monthly basis, Agent On-Boarding accesses the Office of Inspector General (OIG) –U.S. Department of State Health & Human Services website (www.oig.hhs.gov/exclusions) and downloads the list of excluded individuals/entities. The list is analyzed against the active agent population to ensure active agents have not appeared on the list since the previous month. Any agent or agency appearing on the list is terminated in accordance with their agreement.

On a monthly basis, Agent On-Boarding access the US General Services Administration (GSA) housed in System for Aware Management (SAM) website to download a list of excluded individuals/entities. The list is analyzed against the active agent population to ensure active agents have not appeared on the list since the previous month. Any agent or agency appearing on the list is terminated in accordance with their agreement.

Appeal of Denial Due to Background Investigation

A two-tier appeal process is offered to EDC agents who are declined due to background investigation results.

Appeals must be in writing, include the agent's name and address, and provide detailed information explaining the mitigating circumstances regarding the findings of the background investigation, including correction of errors or explanation of extenuating circumstances. An optional Background Appeal Form is available on *Jarvis*, may be used to submit the appeal documentation.

All appeal documentation is uploaded to the agent's file in the document management system. Appeals may be faxed, mailed, or emailed to the Agent On-Boarding Department:

UnitedHealthcare Medicare Solutions
Attention: Agent On-Boarding
MN006-700E
9800 Health Care Lane
Minnetonka, MN 55343
Fax: 1-888-205-7375 (preferred method)
Email: UHPCred@uhc.com

First-Level Appeal – Tier I

Initial, Tier I, appeals are reviewed and determinations made by designated Agent On-Boarding staff trained specifically to review background investigation results. Tier I appeal reviews will not be conducted by the individual who made the original decision to decline the agent based on background investigation results.

- The Agent On-Boarding specialist will review the background investigation results, appeal letter and attachments, and other pertinent documents and make a determination to approve or deny the appeal.
- If the appeal is approved, the contracting process will resume. New documents may be required if they no longer meet signature date requirements as noted in the Contract Packet Submission section.
- If the appeal is denied, a denial notification letter will be sent via email and postal mail to the agent that describes their right to a second appeal and the process. The NMA/FMO or eAlliance office will receive a copy of the notification letter.

Second-Level Appeal – Tier II

An appeal submitted following a Tier I denial is considered by the Background Tier II Committee.

- The Tier II appeal must contain new or additional information explaining what was not considered in the initial reviews and/or errors regarding the background investigation not revealed previously.
- The Background Tier II Appeal Committee will review the appeal and pertinent documents and render a decision.
- The decision will be sent to the Agent On-Boarding Department which will facilitate processing and documenting the appeal,

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including the communication of the final decision to the agent and applicable NMA/FMO or eAlliance office.

- If the appeal is approved, the contracting process will resume. New documents may be required if they no longer meet signature date requirements as noted in the Contract Packet Submission section.
- If the appeal is denied, a denial notification letter is sent via email and postal mail to the agent. The NMA/FMO or eAlliance office will receive a copy of the notification letter.
- The decision of the Background Tier II Committee is final and may not be appealed.

An agent who is declined due to background investigation results must wait one year from the date of their notification letter to submit a new contract packet. If the agent appeals the decline, they must exhaust both appeal level options and wait one year from the date of the original background decline date to submit a new contract packet.

Appointment

Appointment

Appointment is an official declaration by an insurance company that the requested agent is authorized to represent the company by selling its products. Appointment methods and timeframes vary by state, as each state uses their own rules and allows for submission of paperwork separately. Department of Insurance interface software is used to perform the appointment based upon each state's requirements.

When all contracting requirements are met and you have taken and passed all mandatory certification tests and at least one product certification test, Agent On-Boarding will submit state appointment requests to each state requested (some exceptions apply). Note: The agent's up-line must also be licensed and appointed (if applicable) in the requested state(s).

Effective April 19, 2013, appointment fees are processed as follows:

- UnitedHealthcare pays all appointment fees upon submission to each state.
- All resident state appointment fees are the responsibility of UnitedHealthcare.
- Non-resident state appointment fees on any new or renewal appointments as of January 2013 are the responsibility of the entity requesting appointment (i.e. agent, solicitor, and applicable up-line levels). Note: For a solicitor, the up-line that receives commissions on the solicitor's sales is responsible for the solicitor's non-resident appointment fees.
- Fees for which the entity requesting appointment is responsible are collected by UnitedHealthcare via a debit against the respective entity's commissions or override as applicable.
- Non-resident state appointment fees in states where appointment fee collection from an agent is prohibited are exempt from this requirement.

Writing Number (Agent ID) Notification

Once the appointment request is submitted, you are set to active status in the contracting system, a writing number issued, and the Agreement is executed with the Vice President of External Distribution's signature. A Welcome Letter, which contains your writing number and an executed copy of your Agreement (where applicable), is emailed to you and your management. The Welcome Letter indicates in which states agent appointments have been submitted. All agents are expected to confirm state appointment approval via *Jarvis* prior to marketing/selling any products.

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Intent to Service Termination Process

If you are terminated not-for-cause, the option of becoming a Renewal Eligible Agent by entering a Servicing Status may be available.

If you enter a Servicing Status you must not market or sell UnitedHealthcare Medicare Solutions products.

By entering a Servicing Status, you agree to continue to meet the needs of members in a way that supports the member's healthcare and continue serving as a trusted advisor when needed.

The following process is followed when a Servicing Status is requested.

- Depending on the reason the termination is processed, you will either receive an evite that offers you the opportunity to enter into a "Servicing Status" with UnitedHealthcare or you will receive a standard letter stating your termination will be processed and effective on the given date. The evite needs to be accessed and completed, including e-signature of the "Intent to Service" form.
- If you do not select the "Servicing Status, you will be terminated and notification will be sent to you and your management and uploaded in your agent record.
- If you select "Servicing Status" and complete the "Intent to Service" form, you must maintain the following criteria to remain in "Servicing Status"
 - ~ Maintain an active resident state license (depending on state requirements.)
 - ~ Be appointed to the appropriate UHIC entity for their resident state.
 - ~ Annually complete required certification with a minimum of 85% in 3 attempts or less. For the current list of required certifications, contact the PHD phd@uhc.com (the subject line should contain the agent's Writing ID number,) available 24 hours.
- If you are in a Servicing Status, you are not active and are not eligible to sell UnitedHealthcare Medicare Solutions products or acquire new business.
- Renewal Commissions
 - ~ Servicing Status must be maintained as a condition of receiving renewal commissions with enrollment effective dates of 1/1/2014 and forward for all Medicare Advantage (MA) and Prescription Drug Plan (PDP) business and plan types. Note: Does not include Medicare Supplement Insurance products.
 - ~ If Servicing Status is not maintained, renewal commissions for 2014 and forward will end.
 - ~ Renewals commissions for sales prior to 1/1/2014 will not be impacted. The contract requirements during the time prior to 2014 would continue to apply.
 - ~ Commissions for Medicare Supplement Insurance products are not impacted by this change.
- If you select Servicing Status, your licensing, appointment and certification status is verified. If action is needed to meet the required criteria, you are notified and given a timeframe to complete these actions.
- If an appeal process is applicable you will be notified.
- You may return to Active Status from a Servicing Status by re-contracting and meeting all active agent requirements, including certification.
- If you are the principal of a corporation, you must decide whether to elect Servicing Status for the corporation. **Note:** an Intent to Service form would need to be completed for both yourself and the corporation.
- The Servicing Status effective date will be noted on the Intent to Service form and will continue until your termination by agent or agency request or failure to meet the Servicing Status requirements.

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Failure to meet the requirements for Servicing Status will cause a 2014 renewal commissions to end permanently.

Additional questions regarding Servicing Status may be sent to the Producer Help Desk (PHD) at phd@uhc.com (the subject line should contain the agent's Writing ID number,) available 24 hours.

Non-Active Renewable Eligible Agent – Servicing Status (effective January 1, 2014)

Non-employee agents terminated not-for-cause must enter servicing status in order to receive renewal commission for Medicare Advantage (MA) and Prescription Drug Plans (PDP) with an effective date on or after January 1, 2014. You may receive an invitation from UnitedHealthcare to enter a Servicing Status agreement with your not-for-cause termination notification letter.

- To enter servicing status, you must, (prior to their not-for-cause termination effective date,):
 - ~ Sign and return the Intent to Service form.
 - ~ Hold and maintain thereafter an active resident state license.
 - ~ Have and maintain thereafter an active resident state UHIC appointment.
 - ~ Complete and pass the Medicare Basics and Ethics and Compliance certification tests with a score of 85% or better within six attempts. You must, thereafter, certify on an annual basis prior to January 1.
- Servicing status agents are not required to carry/maintain E&O/Professional Liability insurance coverage and are not subject to periodic background investigations.
- Servicing status agents are not active and must not market UnitedHealthcare Medicare Solutions products or write new business. You may return to active status by re-contracting and meeting all active agent requirements, including certification.
- While in servicing status, you are expected to continue providing service to the member.

- Servicing status will terminate effective the date the agent fails to meet servicing status requirements (e.g., no longer has an active license or fails to meet certification requirements). Renewal commissions for Medicare Advantage and Prescription Drug Plans with an effective date on or after January 1, 2014, will permanently cease as of the servicing status termination date.

Successor Agent Program – Renewal Eligible Non-Employee (effective August 1, 2016)

When all eligibility requirements are met, contracted non-employee agents may request UnitedHealthcare transfer their entire UnitedHealthcare book of business to a successor agent, who agrees to accept and service the original agent's book of business and oversee down-line agent, where applicable.

Eligible products include all UnitedHealthcare Medicare Solutions products and states except for SecureHorizons Medicare Supplement Insurance Plans and Golden Rule plans.

Original Agent Eligibility and Terms of Agreement

- Original Agent must be a renewal eligible agent with UnitedHealthcare as defined below:
 - ~ For MA and PDP enrollments with effective dates prior to 1-1-2014, Original Agent must be in any status other than termed for cause or death;
 - ~ For MA and PDP enrollments with effective dates on or after 1-1-2014, Original Agent must be active (and appropriately licensed, appointed, and certified) or in servicing status (and appropriately licensed, appointed, and certified);
 - ~ For Medicare Supplement Insurance enrollments made in any year, Original Agent must be in any status other than termed for cause or death.
- Original Agent must not be the subject of an open complaint investigation. Open

Section 2: How do I Get Started?

complaint investigations must be closed (refer to the Agent Complaint Process section for details) prior to requesting a successor agent agreement.

- Original Agent must be in the EDC (solicitors are ineligible) or ICA channel.
- Original Agent must have current annual renewal payments of \$2,000 or more for transfer-eligible products.
- Original Agent must sign the “UnitedHealthcare Successor Agent Agreement” including without limitation the following terms:
 - ~ Original Agent’s current Agent Agreement and Writing ID(s) will be terminated.
 - ~ Original Agent acknowledges that the transfer of his/her book of business is contingent on his/her down-line hierarchy, if any, also being transferred to Successor Agent.
 - ~ Original Agent’s rights related to his/her entire, current UnitedHealthcare business, including renewal commissions and up-line payments, if any, will cease upon the effective date of the transfer.
 - ~ Original Agent’s liabilities and obligations related to his/her business that is not eligible to be transferred will continue and survive the termination of his/her Agent Agreement.
 - ~ Original Agent’s current debt related to the transferred business is to be paid in full or transferred to Successor Agent upon transfer of the book of business. Debt repayment plans are not allowed.
 - ~ If Original Agent is the assignee of another agent’s commission, the assignment of commissions agreement will be terminated.

Minimum Successor Agent Eligibility and Terms of Agreement

- Successor Agent must have an active contract (i.e. Successor Agent must not be in servicing status at the time he/she enters the successor agent agreement) with UnitedHealthcare in the same channel as Original Agent (e.g. EDC and EDC, ICA

and ICA). Standard release rules apply, but EDC agents are not required to be in the same NMA or FMO hierarchy.

- Successor Agent must be licensed and appointed (if applicable) in each state in which a currently enrolled MA Plan or PDP member resides and certified in the product type(s) (e.g. MA, PDP, DSNP, CSNP) in which the members are enrolled.
- Successor Agent must not be the subject of an open complaint investigation. Open complaint investigations must be closed (refer to the Agent Complaint Process section for details) prior to requesting a successor agent agreement.
- Successor Agent must sign the “UnitedHealthcare Successor Agent Agreement” and agree to the following terms:
 - ~ Successor Agent agrees to accept and service Original Agent’s entire eligible book of business and oversee, where applicable, down-line agents transferred to Successor Agent’s hierarchy to receive renewal commission/up-line payments.
 - ~ Successor Agent will take on any future charge back debt related to the transferred book of business.
 - ~ Successor Agent is not eligible to transfer Original Agent’s book of business to another successor agent.
 - ~ Successor Agent’s 2016 AARP Medicare Supplement Insurance Persistency Incentive threshold calculation, if applicable, will not incorporate business acquired through a successor agent agreement. Final 2016 persistency incentive payment will be paid according to any successor agreement rules, if applicable.
- Upon transfer, Successor Agent’s Agent Agreement (contract) with UnitedHealthcare will govern the book of business.

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Approval Process

All requests to transfer an original agent's UnitedHealthcare book of business to a successor agent are subject to prior review and approval by UnitedHealthcare.

- UnitedHealthcare will try to approve or disapprove of the request to transfer within approximately 30 days of receipt of the signed interest form. If approved, a "UnitedHealthcare Successor Agent Agreement" between Original Agent and Successor Agent may be executed.
- Successor agent agreements are effective immediately upon full execution (i.e. the date UnitedHealthcare signs the agreement).
- UnitedHealthcare reserves sole discretion to deny any agreement up until it is a fully executed contract.
- UnitedHealthcare reserves sole discretion to remove Successor Agent as Agent of Record (AOR) and to discontinue paying the agent if it determines that Successor Agent is not servicing the members or overseeing down-line agents, if any, as required by the Agent Agreement.

UnitedHealthcare, at its sole discretion, reserves the right to rescind the Successor Agent Program at any time without notice.

Deceased Agent Successor Program – Renewal Eligible Non-Employee (effective August 1, 2016)

The PHD Successor program hotline can be reached at 888-240-9165.

When all eligibility requirements are met, UnitedHealthcare will work with a deceased contracted non-employee agent's next of kin, estate, and/or up-line to establish a successor agent, who agrees to accept and service the members within the deceased agent's book of business and oversee down-line agents, as applicable. In all cases, transfer of a deceased agent's book of business is subject to UnitedHealthcare's prior review and approval.

Eligible products include all UnitedHealthcare Medicare Solutions products and states except for SecureHorizons Medicare Supplement Insurance Plans and Golden Rule plans.

Deceased Agent Successor Program

Qualifications and General Considerations

- Deceased Agent must have been a renewal eligible agent with UnitedHealthcare, as defined below, at the time of death (solicitors are ineligible):
 - ~ For MA and PDP enrollments with effective dates prior to 1-1-2014, Deceased Agent must have been in any status other than termed for cause or death;
 - ~ For MA and PDP enrollments with effective dates on or after 1-1-2014, Deceased Agent must have been active (and appropriately licensed, appointed, and certified) or in servicing status (and appropriately licensed, appointed, and certified);
 - ~ For Medicare Supplement Insurance enrollments made in any year, Deceased Agent must have been in any status other than termed for cause or death.
- Deceased Agent must have been in the EDC channel at the time of death.
- Deceased Agent must have had current annual renewal payments of \$2,000 or more for transfer-eligible products at the time of death.
- Under normal operations, the following occurs upon notification of an agent death:
 - ~ Deceased Agent's Writing ID(s) will be termed for death.
 - ~ If Deceased Agent's book is the assignee of another agent's commission, the assignment of commissions agreement will be terminated.

Successor Agent Eligibility and Terms of Agreement

- Successor Agent must have an active contract (i.e. Successor Agent must not be in servicing status at the time he/she enters the successor agent agreement) with UnitedHealthcare in the same channel as Deceased Agent (e.g. EDC and EDC, ICA

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and ICA). Standard release rules apply, but EDC agents are not required to be in the same NMA or FMO hierarchy.

- Successor Agent must be licensed and appointed (if applicable) in each state in which a currently enrolled MA Plan or PDP member resides and certified in the product type(s) (e.g. MA, PDP, DSNP, CSNP) in which the members are enrolled.
- Successor Agent must not be the subject of an open complaint investigation. Open complaint investigations must be closed (refer to Agent Complaint Process section for details) prior to proceeding with a successor agent agreement.
- Successor Agent must sign the “UnitedHealthcare Successor Agent Agreement” and agree to the following terms:
 - ~ Successor Agent agrees to accept and service Deceased Agent’s entire eligible book of business and accept and oversee, where applicable, down-line agents transferred to Successor Agent’s hierarchy to receive a renewal commission/up-line payments. UnitedHealthcare reserves sole discretion to remove Successor Agent as Agent of Record (AOR) and to discontinue paying Successor Agent if it is determined that Successor Agent is not servicing the member.
 - ~ Successor Agent agrees that outstanding debt related to the transferred business will also be transferred to Successor Agent. He/she also will take on any future charge back debt related to the transferred book of business.
 - ~ Successor Agent is not eligible to transfer Deceased Agent’s book of business to another successor agent.
 - ~ Successor Agent’s 2016 AARP Medicare Supplement Insurance Persistency Incentive threshold calculation, if applicable, will not incorporate business acquired through a successor agent agreement. Final 2016 persistency incentive payment will be

paid according to any successor agreement rules, if applicable.

- Upon transfer, Successor Agent’s Agent Agreement (contract) with UnitedHealthcare will govern the book of business.

Approval Process

UnitedHealthcare must approve all requests to transfer a deceased agent’s UnitedHealthcare book of business to a successor agent.

- UnitedHealthcare must receive notification, including a death certificate and/or obituary, within 30 days of Deceased Agent’s death. If UnitedHealthcare is not properly notified within 30 days of Deceased Agent’s death, UnitedHealthcare may take on the role of servicing Deceased Agent’s book of business or find a successor agent.
- Upon notification of death, next of kin/estate/up-line has 90 days from the date of death to identify a potential successor agent who agrees to the terms of the “UnitedHealthcare Successor Agent Agreement.”
 - ~ UnitedHealthcare will work first with Deceased Agent’s next of kin/estate to identify a successor agent.
 - ~ If next of kin/estate does not wish to help identify a successor agent, UnitedHealthcare will next work with Deceased Agent’s up-line to identify a successor agent.
 - ~ If no successor agent is established and/or no successor agent agreement is signed within 90 days from the date of death, UnitedHealthcare may take on the role of servicing Deceased Agent’s book of business or find an alternate successor agent.
- UnitedHealthcare will try to approve or disapprove the request to transfer within approximately 30 days of receipt of the signed interest form. If approved, a “UnitedHealthcare Successor Agent Agreement” may be executed with Successor Agent.
- Successor agent agreements are fully executed as of the date UnitedHealthcare

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signs the agreement and effective the date noted on the agreement. UnitedHealthcare, at its sole discretion, reserves the right to deny any agreement up until it is a fully executed contract.

UnitedHealthcare, at its sole discretion, reserves the right to rescind the Deceased Agent Successor Program at any time without notice.

Successor Agent Program Appeal Process

An appeal process is offered to agents who are declined for the Successor Agent program.

- Appeals must be in writing, include the agent's name and address, and provide detailed information explaining the rationale for appeal, including information on how the members will be serviced by engaging in the Successor Agent program. Appeals may be mailed, faxed, or emailed to Commissions:

UnitedHealthcare

Attention: Commissions - Successor Agent
MN006-E800

9800 Health Care Lane

Minnetonka, MN 55343

Fax: 1-866-761-9162

Email: sh_commissions_administration@uhc.com

- Appeals are forwarded for consideration to the Successor Agent Approval Board (SAAB)
 - ~ The SAAB reviews the appeal and pertinent documents, renders a decision, and forwards the appeal documentation with noted decision to Commissions.
 - ~ Commissions facilitates processing and documenting the appeal, including the communication of the final decision to the applicable agent(s).
 - ~ If the appeal is approved, the Successor Agent process resumes. New documents may be required if they no longer meet signature date requirements per the Successor Agent process.

- ~ If the appeal is denied, a denial notification letter is sent via email to the agent(s).
- ~ The decision of the SAAB is final and may not be appealed again.

Requests to Change NMA/FMO or Independent Career Agent (ICA) Channel

All contracted EDC agents who are appointed (if applicable) to sell for UnitedHealthcare must align under a NMA/FMO approved by and contracted with UnitedHealthcare. An agent may only be aligned with one NMA/FMO.

When an agent changes NMA/FMOs or moves to the ICA channel, residual override commissions are retained by the hierarchy structure in place at the time of the original sale.

Please contact your up-line for additional details regarding aligning under a new NMA/FMO or moving to the ICA channel.

Request a Change in Hierarchy within the same NMA/FMO

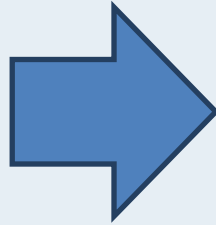
All contracted EDC agents who are appointed (if applicable) to sell for UnitedHealthcare must align under an NMA/FMO approved by and contracted with UnitedHealthcare. The NMA/FMO has discretion to move and change the level of agents and solicitors within their hierarchy structure. You must agree to the changes and required paperwork must be submitted by the NMA/FMO to Agent On-Boarding. Residual override commissions are retained by the hierarchy structure in place at the time of the original sales.

Please contact your up-line for additional details regarding changing a hierarchy within the same NMA/FMO.

Certification and Training Process



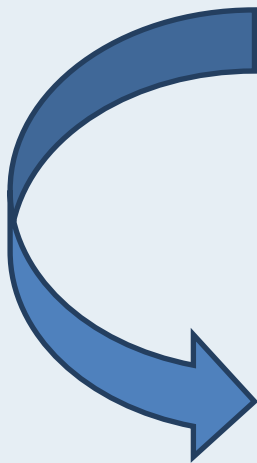
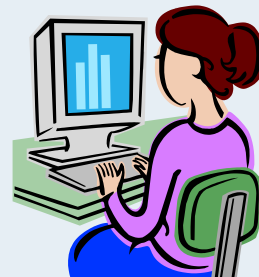
Agent is recruited



Agent must be Licensed, Contracted, Certified, and Appointed (if applicable)



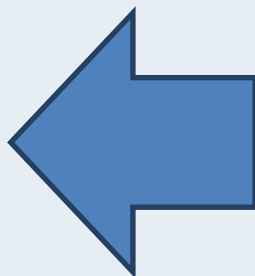
Agent must complete and pass all applicable certification tests



Agent must pass each certification test within 6 attempts with a minimum score of 85%



Agent is qualified to sell applicable products



Agent is certified



Certification and Training

General Overview

Sales training is a business process that begins during the on-boarding of an agent and is repeated annually, prior to the start of a new selling season, to ensure that plan benefit and regulatory changes are appropriately communicated to you in a consistent manner.

To be considered certified for the current year, you must be certified for the current plan year or the subsequent plan year. For example, an agent on-boards August 1, 2016, and passes the 2017 Dual Special Needs Plans (DSNP) certification test the same day. This agent can sell both 2016 and 2017 DSNPs, if they have taken and passed either the 2016 or the 2017 DSNP certification test. However, an agent who has only taken and passed the 2016 DSNP certification test is not certified to sell 2017 plans.

To ensure you have a fundamental understanding of the Medicare program, Medicare insurance products, and the Centers for Medicare & Medicaid Services (CMS) and state regulations, and UnitedHealthcare rules, policies, and procedures, an annual certification process is required of all agents.

Ongoing training and development is required on an annual basis, upon significant benefit or regulatory changes, or as the need is identified for individual agents.

You must become certified as part of your initial on-boarding process and remain certified on an on-going basis in order to market and sell UnitedHealthcare Medicare Solutions products.

Under no circumstance may you market or sell UnitedHealthcare Medicare Solutions portfolio of products until you are fully certified in the products you are authorized to sell.

You must be certified for the plan year for which an Enrollment application is written. For example, if in December 2016, you write an Enrollment application with a January 1, 2017 effective date, you must have completed your 2017 product certification.

No commission will be paid on any Enrollment application written by an agent who was not fully credentialed at the time the Enrollment application was written.

Sales Training and Certification Program

An online certification program, developed by UnitedHealthcare Medicare Solutions Sales Development personnel in collaboration with subject matter experts, consists of a series of in-depth product training modules and certification tests. Topics include Medicare Marketing Guidelines (MMG), compliance regulations, federal and state regulations, ethics, fraud, waste, and abuse, and Medicare Advantage (MA), Prescription Drug Plan (PDP), Special Needs Plans, and Medicare Supplement product lines. Content is revised annually or as new regulations are released.

Prerequisite Modules include:

- Medicare Basics – Includes a review of Original Medicare, eligibility, premiums, and benefits.
- Ethics and Compliance - Includes the Pledge of Compliance, Code of Conduct, privacy and security content, Medicare Marketing Guidelines, Fraud, Waste, and Abuse, and General Compliance training
- AARP Course

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Mandatory Test for any agent listed as the presenting agent for an educational event, marketing/sales event, UnitedHealthcare MedicareStore event, and/or an agent or sales leader conducting virtual (online) marketing/sales events.

- Events Basics – Includes compliance regulations and rules, policies, and procedures regarding event reporting, conducting educational and/or marketing/sales activities at an event, provider-based activities, and event cancellation procedures. Note: Events Basics is located in the Electives section of the learning management system.

The product line modules featured in this section are illustrative only and may not reflect the Company's current plan, product, and module offerings.

Product Line Modules/Tests include:

- Medicare Advantage (MA) Plans, including Health Maintenance Organization (HMO), Point of Service (POS), Preferred Provider Organization (PPO), Regional Preferred Provider Organizations (RPPO), Private Fee-for-Service (PFFS) Plans.
- Chronic Condition and Dual Special Needs Plan
- Institutional and Institutional-Equivalent Special Needs Plan
- Prescription Drug Plan (PDP).
- UnitedHealthcare Senior Care Options (invitation only)
- AARP Medicare Supplement Insurance Plans

An agent is portfolio certified upon successful completion of all of the following product tests for the applicable plan year: MA, PDP, Chronic and Dual SNP, and AARP Medicare Supplement Plans.

You must access the certification modules and associated assessments using their assigned log in IDs and passwords. You are required to take and pass the certification tests on your own behalf for the plans you wish to sell.

In the completion of any module and/or associated test, you are not to use any aid or assistance not contained within the module, including, but not limited to sharing or comparing answers, taking the test as part of a group, or using answer keys.

If you are found to have used any aid or assistance not contained within the module, in completing any module and/or associated test, you will be subject to discipline up to and including termination with cause.

If you are not literate in English, you may complete certification tests in a UnitedHealthcare office with an interpreter and proctor present. The proctor should be a UnitedHealthcare employee or a UnitedHealthcare contracted vendor proctor. The use and name of a proctor must be documented. Neither the interpreter nor proctor may provide any assistance in the completing of the exam.

For each test, you have six attempts to successfully complete the test and score a minimum of 85% on the test.

2017	2016	2015	2014	2013	2012	2011	2010	2009	2008
2017 Prerequisites									
2017 Medicare Basics									
2017 Medicare Basics Test									
2017 Ethics and Compliance									
2017 Ethics and Compliance Test									
2017 AARP Course									
2017 AHIP (EDC Only)									
2017 AHIP (EDC Only)									
EDC Agents choosing to certify via AHIP, click link above FIRST!									
2017 AARP Medicare Supplement Plans Certification									
2017 AARP Medicare Supplement Plans									
2017 AARP Medicare Supplement Plans Test									
2017 AARP Medicare Advantage Certification									
2017 Medicare Advantage Plans (HMO, PPO, POS, PFFS)									
2017 Medicare Advantage Plans (HMO, PPO, POS, PFFS) Test									
2017 AARP PDP Certification									
2017 Medicare Prescription Drug Plans									
2017 Medicare Prescription Drug Plans Test									

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AHIP Certification

You may receive partial credit if you elect to certify by America's Health Insurance Plan (AHIP). You are still responsible for completing remaining prerequisites: Ethics and Compliance, including the Pledge of Compliance, AARP Course and any other product courses as required. Once the prerequisites are complete, the agent will be certified in Medicare Advantage (MA) Plans – HMO, PPO, POS, and Medicare Prescription Drug Plans product courses.

UnitedHealthcare Medicare Solution accepts (with limitation) America's Health Insurance Plans (AHIP) certification and recertification in place of 2017 Medicare Basics, 2017 Medicare Advantage Plans, and 2017 Medicare Part D Plans (PDP). Please note: UnitedHealthcare Medicare Solutions only accepts AHIP Certification for EDC agents.

The minimum passing score for an AHIP module is 85%. While AHIP allows an unlimited number of attempts to achieve the minimum score, UnitedHealthcare will only accept the AHIP certification if the passing score was achieved **within six attempts**. If you transmit AHIP certification data to UnitedHealthcare and your passing score was not achieved within six attempts, you will not receive credit for the AHIP module **and** will not be allowed to take UnitedHealthcare Medicare Solution equivalent module.

If you are a returning AHIP user, your AHIP account will direct you to the appropriate recertification tests. To be fully certified using the AHIP path, you must log onto www.UnitedHealthProducers.com and pass the tests for each of the following:

- 2017 AHIP
- 2017 Ethics and Compliance
- 2017 AARP Course

If you choose to certify through AHIP, you must complete the 2017 AHIP Certification before any other 2017 certification tests. Failure to do so will result in AHIP score rejection.

Agent Certification Requirements

Prior to appointment, you must complete the initial registration on **Jarvis** to access the UnitedHealth Group learning management system and successfully complete a set of tests and at least one product test.

- Upon receipt of your Welcome Letter, you will need to re-register on **Jarvis** using the writing number included in your letter.

You must complete certification requirements, including the Pledge of Compliance and UnitedHealth Group Code of Conduct, on an annual basis.

As part of the contracting and on-boarding process, and on an annual basis (prior to a selling season) thereafter, you must complete and pass a set of prerequisite exams (including the Pledge of Compliance) and at least one product exam.

You are required to:

- Review and electronically sign the Pledge of Compliance (Statement details available in the 2017 Pledge of Compliance Statement section) on an annual basis.
 - ~ The Pledge is part of the Ethics and Compliance test and must be signed (i.e. electronic agreement).
 - ~ The Pledge constitutes an agreement by the agent to make a “personal commitment to fair and honest marketing practices and to comply with CMS and state regulations regarding the sale of Medicare products.”
 - ~ If you do not indicate acceptance of the terms and conditions of the Pledge of Compliance, you cannot continue with the certification process or market UnitedHealthcare Medicare Solutions products.
 - ~ If you request credit for AHIP courses, signing the Pledge of Compliance is required and a prerequisite to the electronic credit request process

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- Complete all mandatory (prerequisite) tests, and at least one product test, and attain a minimum passing score of 85% within six attempts for each test.
 - ~ For each module, you have six attempts to successfully complete the test and score a minimum of 85% on the module.
 - ~ After six unsuccessful attempts to score the minimum of 85% on the Medicare Basics, Ethics and Compliance, and/or AARP 101 tests, you are not allowed to market, sell, write an enrollment application, or be paid a commission for **any** UnitedHealthcare Medicare Solutions product for the remainder of the applicable selling year. Example: if an agent fails 2017 Medicare Basics, you will be ineligible to sell for the 2017 selling year.
 - ~ After six unsuccessful attempts to score the minimum of 85% on a specific product module, you are not allowed to sell the product which was the subject matter of the failed module for the remainder of the applicable selling year.
 - ~ You are prohibited from marketing or selling a specific product, will not be able to order member materials for a specific product, and will not be eligible to receive commission for an enrollment application written unless they have completed and passed the related product module.
 - ~ If you are prohibited from marketing or selling a specific product, you will be unable to access and order materials related to the specific product.

No commission will be paid on any enrollment application unless you have passed the mandatory tests in the related product.

- ~ Prior to reporting and conducting an educational or marketing/sales event, you must pass the test for the applicable plan year with a minimum score of 85% within six attempts.

- ~ After six unsuccessful attempts to score the minimum of 85% on the Event Basics test, you will be prohibited from being listed as the presenting agent and/or presenting at an educational event, marketing/sales event, UnitedHealthcare MedicareStore and/or virtual marketing/sales event for the remainder of the applicable selling year.

The 2017 Pledge of Compliance Statements:

- I will act in an ethical manner and with integrity; treating consumers, members, and colleagues with courtesy, respect, and dignity at all times and will never intentionally put the consumer/member or UnitedHealthcare at risk.
- I will comply with all federal and state regulations and guidelines, federal and state laws, and company rules, policies, and procedures that govern the marketing and sale of UnitedHealthcare products.
- I will adhere to all contracting, licensing, appointment, and certification requirements and will not present any UnitedHealthcare plan for which I am not properly contracted, licensed, appointed, and certified at the time of marketing or sale whether through formal or informal presentation, consumer appointment, or other marketing efforts.
- If I am a contracted agent, I will adhere to all the terms and conditions of my agent contract, including the Branded Products Addendum.
- I will not misrepresent my relationship with UnitedHealthcare, any federal or state agency including the Centers for Medicare & Medicaid Services, or any third party affiliation such as AARP.
- I will not imply to consumers or members that their enrollment is in any way sponsored, endorsed, or shared by any

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particular federal or state agency or third party such as AARP.

- I will not disparage UnitedHealthcare or its products, any competitor or competitor's products, or any government entity or program, including Original Medicare.
- I will treat all UnitedHealthcare-provided resources and property, including leads, with respect and for the use intended or provided. Additionally, I will not share my personal log on information or use another agent's log on information nor will I sell a lead provided by UnitedHealthcare.
- I will comply with all regulations, guidelines, rules, policies, and procedures related to the use of marketing materials; logos; websites; and brand, product, and entity names.
- I will adhere to and comply with all anti-discrimination regulations and guidelines, specifically I will not engage in practices that discriminate against Medicare-eligible consumers except as provided by federal rules of access to Medicare.
- I will not engage in unsolicited contact, selective marketing or health screening (except as provided for specific enrollment criteria for Special Needs Plans), or any marketing activities that disguise the true intent of the solicitation or outreach.
- I will adhere to UnitedHealthcare event reporting requirements when hosting a marketing/sales or educational event. I will comply with all regulations, guidelines, rules, policies, and procedures related to events including reporting, advertising, hosting, attending, or conducting educational or marketing/sales events.
- I will adhere to and comply with all regulations related to protecting the privacy of consumers and members, including their health and personally identifiable information, including the appropriate reporting of suspected or real disclosures. This includes the appropriate use and safeguarding of documentation including Scope of Appointment forms, Enrollment Applications, lead and business reply cards, sign-in sheets, and any other document containing a consumer or member's health and/or personally identifiable information.
- I will comply with all regulations, guidelines, rules, policies, and procedures related to the Enrollment process including obtaining Scope of Appointment, confirming consumer eligibility, service area and election period requirements, and agent-assisted enrollment guidelines. This includes adhering to the appropriate use of all enrollment mechanisms including paper, telephonic, electronic, and internet-based and the timely submission of the Enrollment Application.
- I will only use the agent identification number issued to me by UnitedHealthcare on Enrollment Applications for which I assisted the consumer in the enrollment process. Specifically, I will not use the identification number of another agent on an Enrollment Application solicited by me nor will I place my identification number and/or signature on an Enrollment Application that I did not solicit and complete. UnitedHealthcare will not share or split commission payments between agents.
- I will not:
 - ~ Lead a consumer to believe their signature on an Enrollment Application is for any purpose other than to enroll in a Medicare Advantage, Prescription Drug, or Medicare Supplement Plan;
 - ~ Enroll a consumer into a plan that they or their authorized legal representative did not authorize; or
 - ~ Fraudulently alter, complete, and/or sign an Enrollment Application or any other business document using a consumer's identifying information such name

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and/or Medicare or Social Security number.

- I will work with the consumer's Power of Attorney or Authorized Representative if the consumer has mental or physical limitation issues that prevent the consumer from fully understanding the plan.
- If I collect a first month's premium check from a consumer for a Medicare Supplement Plan, I will remit the check to UnitedHealthcare in a timely manner,
- I will not engage in any form of inducement, including the giving or accepting of gifts or financial incentives, coercion, deception, or abuse of fiduciary trust in conducting business on behalf of UnitedHealthcare. This includes any arrangements to share or split any payment or commission with the consumer or member.
- I attest that I have read, understand and will abide by UnitedHealthcare / [UnitedHealth Group's Code of Conduct: Our Principles of Ethics and Integrity](#), which includes UnitedHealth Group's Conflict of Interest policy on page seven. I understand that it is my obligation to comply with the law, this Code and all applicable UnitedHealthcare policies and contractual obligations.

I further understand that I have an affirmative duty to report all suspected illegal or unethical conduct, including violations of law, this Code, Company policies and contractual obligations, or any concerns about accounting, internal controls, auditing matters, or suspected fraud and abuse. UnitedHealthcare maintains a strict non-retaliation policy for good faith reporting of actual or potential illegal or unethical conduct.

- Effective January 1, 2016: I attest that I have read, understand and will abide by the Fraud, Waste, and Abuse training provided by the Centers for Medicare & Medicaid Services

available at CMS.gov or as may have been provided by my up-line (External Distribution Channel only). I will complete, retain and make available upon request the certificate of completion.

- I will respond as directed to any inquiry received from UnitedHealthcare related to my sales activities and actions to support investigation of any complaints or concerns and will produce all related documentation within the timeframe requested.
- I will complete any assigned corrective and/or disciplinary action within the indicated timeframe.
- I will accept and read all notices from UnitedHealthcare, regardless of communication method, including newsletters and email notifications, that may contain contractual and/or compliance information and updates related to marketing/sales activities. I will ensure a valid email address is on file (in my agent profile) at all times.
- I will comply with HIPAA Privacy and Security Rules and any UnitedHealthcare specific requirements related to the protection of Protected Health Information (PHI). I understand that it is my responsibility to ensure all electronic PHI is secured through a valid encryption process, whether that information is stored or transmitted (e.g., if PHI is sent over the internet by email, it is only sent via secure, encrypted email), and that such encryption requirements apply to desktop and laptop computers as well as portable electronic devices that store or transmit PHI.

I understand that any breach of this Pledge could result in the immediate termination of my contract and appointment, if applicable, with UnitedHealthcare and that, at UnitedHealthcare's discretion such a breach may result in the immediate suspension of my ability to market or promote UnitedHealthcare's products.

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UnitedHealthcare may report breach of this Pledge to any regulatory agency as appropriate.

New Product Training Modules

- You will receive notification through standard agent communications of the availability of new training modules.
- For new product related modules, you must pass the test with a minimum score of 85% within six attempts to be allowed to order materials, submit enrollment applications, and receive commission for the specific product covered in the completed module.

First Tier, Downstream, and Related Entities (FDR)

NMA/FMO working on UnitedHealthcare Medicare Advantage (MA) or Part D programs must provide **either their own Standards of Conduct or the UnitedHealth Group Code of Conduct** to employees (including temporary workers and volunteers), the CEO, senior administrators or managers, governing body members and subcontracted delegates who are involved in the administration or delivery of our MA or Part D benefits or services within 90 days of hire and annually thereafter.

Please contact your up-line for additional details regarding FDR requirements.

Elective and Supplemental Learning and Development

Opportunities are generally available to all agents for ongoing learning and development. This is supplemented with dedicated sales training and development resources that may conduct needs assessments, design training, and develop training programs and tools.

Agent Remedial Training

Remedial education and/or training may be provided to or required of specific agents.

Certification Status Verification

UnitedHealth Group learning management system allows you to verify the status of your certification status and history. Product certifications are displayed in your development plan in the product certification window for each year and can be printed to demonstrate certification status.

Requests for Certification Related Information

Requests for certification related information including the certification process, module, and/or test content, certification status, or to submit an appeal should be directed to the PHD at phd@uhc.com (the subject line should contain your Writing ID number), available 24 hours. Requests that cannot be resolved by the PHD are documented and escalated to the certification team.

UnitedHealth Group Learning Management System Access Guide

Upon receipt of a complete contracting packet, you will receive a Party ID Notification Letter. The Party ID notification letter includes your permanent Party ID number and information regarding access to online certification training. The Party ID links all your subsequent Writing IDs to you (where applicable). You will receive only one Party ID with UnitedHealthcare.

You can access the online certification system through *Jarvis*.

See the *Jarvis* section in this guide for *Jarvis* registration instructions.

Once you register on *Jarvis*, you are able to take courses to obtain product certification. Registering on *Jarvis* with your Party ID limits your website access to certification modules.

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Upon successfully completing the contracting, licensing, and appointment process, you will receive your Welcome Letter. The Welcome Letter provides you with your writing number and information regarding re-registering on **Jarvis**. Re-registering with the agent writing number allows you access to additional features and functionality of **Jarvis**.

For additional certification system and guidance details, refer to **Jarvis > Knowledge Center Tab > Certifications**.

From the “Resources” tab within each course, content of the certification module can be printed or saved as a PDF. You are encouraged to print or save the course content as it may be used for review purposes.

Submit questions regarding certification and access to **Jarvis** to the PHD at phd@uhc.com (include your Agent ID in the subject line).

UnitedHealth Group Learning Management System Website Tips

- The UnitedHealth Group Learning Management System is compatible with the following browsers:
 - Internet Explorer 11
 - Safari
 - Mozilla/Firefox
 - Google Chrome
- Compatibility view may need to be activated to view the course/test content properly. Do this by clicking Tools, then selecting Compatibility View. Make sure "unitedhealthgroup.com" is added to the Compatibility View Settings popup box.
- Set screen resolution to 1024 x 768.
- Have Acrobat reader version 6 or higher.
- Have Macromedia Flash Player 9 or higher.
- Turn off pop-up blockers.

Section 3: What Tools and Resources are Available to Help Me?

Jarvis

Producer Help Desk

Quick Resource Tip Sheet

Agent Communications

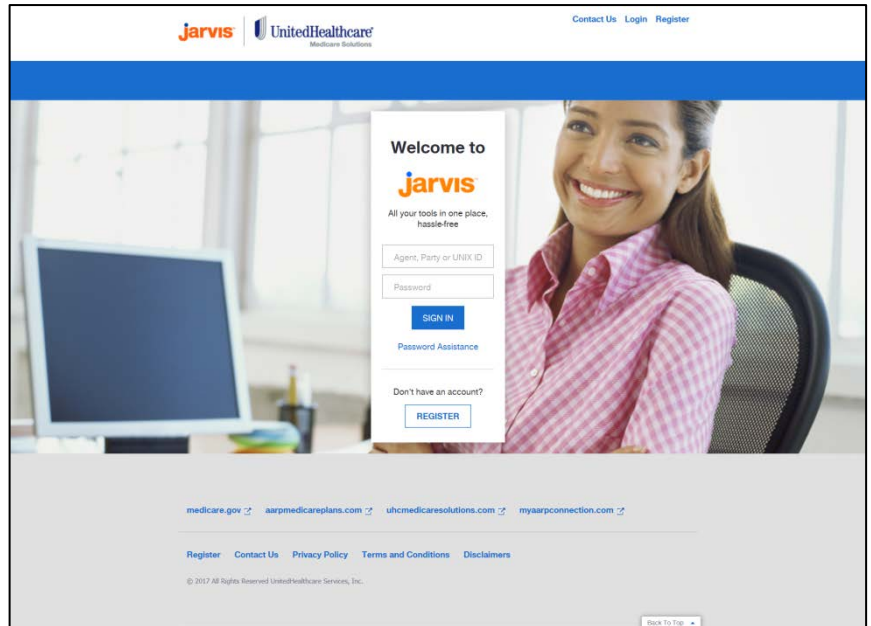
Section 3: What Tools and Resources are Available to Help Me?

Jarvis

Note: The images are only representative of what may appear on *Jarvis* and may vary based upon channel and access rights. *Jarvis* appearance and available resources may change periodically.

Jarvis provides a secure one-stop-shop with access to the tools and information needed to conduct business with UnitedHealthcare. By accessing *Jarvis* you can access certifications, obtain product information and sales materials, access the LEAN enrollment tool, view enrollment application status, view commission statements and status, acquire sales and compliance information, and much more.

Jarvis is designed to be intuitive and easily navigated for a hassle free experience. The navigation bar boldly displays commonly used sections and a robust search feature. The **Sales & Marketing Tools**, **Enrollment**, **Commissions**, and **Knowledge Center** sections on the navigation bar also include a drop-down function that offers a direct route to common sub-sections within each of the sections.



You can access *Jarvis* through the following link www.uhcjarvis.com

System Requirements

Desktop

- Internet Explorer version 11.x or higher
- Other allowable browsers: Google Chrome, Mozilla/Firefox, Safari
- Screen resolution of 1024 x 768
- Acrobat reader version 6 or higher

Mobile/Tablet

- Apple iPhones
- iPhone6 on IOS8
- iPhone5s on IOS7

Apple iPads

- iPad on IOS7.1 or higher

Android Phones

- OS Lollipop 5.0 or higher
- OS Marshmallow 6.0 or higher
- OS KitKat/Jelly Bean 4.4 or higher

Section 3: What Tools and Resources are Available to Help Me?

Already Registered on the Distribution Portal

If you are already registered on the Distribution Portal, you will not need to re-register on *Jarvis*. You can login to *Jarvis* using your current username and password used on the Distribution Portal.

New Agent Initial Party ID Registration

New agents must register upon first time use of *Jarvis*. You can begin your registration by clicking “Register” on the welcome page on *Jarvis*. You will need the following information in order to register for account activation:

- Party ID (communicated in the Party ID Notification Letter)
- Last 4 digits of your Social Security number or Tax identification number
- ZIP code

Registering with your Party ID limits your access to the “UnitedHealthcare Knowledge Center – Training Page”, but enables you to start the certification process while the contracting process is being completed. When the contracting process is complete, you will need to re-register using your Agent ID/Writing Number provided in your Welcome Letter.

The screenshot shows the Jarvis 'Register your Account Here' Step 1 registration form. The header includes the Jarvis and UnitedHealthcare logos, with links for 'Contact Us', 'Login', and 'Register'. The main heading is 'Register your Account Here' with a sub-heading: 'New to Jarvis? Use your Party ID to create an account and start taking certifications. Once you receive your Agent ID, create a new account and access all the features in Jarvis. If you are a Non-Agent user, please visit the UnitedHealthcare Secure website to request access to Jarvis.' The form is divided into 'Step 1' and 'Need Help?' sections. Under 'Step 1', there is a 'Personal Information' section with the question 'Which ID do you want to register?' and two radio button options: 'Party ID' (selected) and 'Agent ID'. Below this are input fields for 'Enter Agent or Party ID', 'Last four digits of your Tax Identification Number or Social Security Number', 'Last four digits TIN or SSN', and 'ZIP Code' with a sub-field 'Enter 5-digit ZIP Code'. A 'CONTINUE' button is at the bottom. The 'Need Help?' section provides contact information for the Producer Help Desk (PHD), including a 'Call Us' button and hours: 'Monday - Friday 7 am - 8 pm CST' and 'Call UnitedHealthcare: 888-381-8581'.

The screenshot shows the Jarvis 'Register your Account Here' Step 2 registration form. The header includes the Jarvis and UnitedHealthcare logos, with links for 'Contact Us', 'Login', and 'Register'. The main heading is 'Register your Account Here' with a sub-heading: 'New to Jarvis? Use your Party ID to create an account and start taking certifications. Once you receive your Agent ID, create a new account and access all the features in Jarvis. If you are a Non-Agent user, please visit the UnitedHealthcare Secure website to request access to Jarvis.' The form is divided into 'Step 2' and 'Need Help?' sections. Under 'Step 2', there are input fields for 'Agent or Party ID', 'Email', 'Enter Password', and 'Re-enter New Password'. Below these is a checkbox for 'I accept the Terms and Condition and Privacy Policy.' and a 'CONTINUE' button. The 'Need Help?' section provides contact information for the Producer Help Desk (PHD), including a 'Call Us' button and hours: 'Monday - Friday 7 am - 8 pm CST' and 'Call UnitedHealthcare: 888-381-8581'. A 'Back To Top' link is at the bottom right.

The screenshot shows the Jarvis 'You are ready to use Jarvis!' sign-in screen. The header includes the Jarvis and UnitedHealthcare logos, with links for 'Contact Us', 'Login', and 'Register'. The main heading is 'You are ready to use Jarvis!' with a sub-heading: 'Sign in with your ID and password'. Below this is a 'SIGN IN' button.

The screenshot shows the Jarvis 'Training' page. The header includes the Jarvis and UnitedHealthcare logos, with links for 'Home', 'Sales & Marketing Tools', 'Enrollment', 'Commissions', and 'Knowledge Center'. A search bar is present. The main heading is 'Training'. Below this is a section for 'Certifications' with a sub-heading: 'Certifications'. The text reads: 'Certification modules, taken during your onboarding and annually after that, provide you with an overview of the Medicare program, an understanding of the various Medicare insurance options, and the rules and regulations that guide your marketing and sales activities. For more details on the certification process, technical requirements and user guides, visit the Certifications page.' Below this is a 'LAUNCH CERTIFICATIONS' button.

Section 3: What Tools and Resources are Available to Help Me?

Agent ID Complete Access Registration

Once you have completed the product certification process and are appointed with UnitedHealthcare, you will receive a formal welcome letter and Agent ID/Writing Number. Once you received your Agent ID welcome letter, you may re-register on *Jarvis* using your Agent ID to obtain complete access. You can begin your re-registration by clicking on “Register” on the welcome page of *Jarvis*. In order to register for complete access, you must be active, licensed, contracted, appointed (if applicable), and certified. You will need the following information in order to re-register for complete access

- Agent ID (communicated in the Party ID Notification Letter)
- Last 4 digits of your Social Security number or Tax identification number
- ZIP code

Access *Jarvis* using your Agent ID provides you with complete access to *Jarvis* based on the products and states in which you are contracted and certified to sell. If you are having difficulties with your registration or accessing *Jarvis*, you can contact the Producers Help Desk (PHD) at phd@uhc.com or 888-381-8581.

The screenshot shows the Jarvis registration page at Step 1. The header includes the Jarvis and UnitedHealthcare Medicare Solutions logos, with links for Contact Us, Login, and Register. The main heading is "Register your Account Here" with a sub-heading "Step 1". Below this, it asks "Which ID do you want to register?" with radio buttons for "Party ID" and "Agent ID". There are input fields for "Enter Agent or Party ID", "Last four digits of your Tax Identification Number or Social Security Number" (with a sub-field for TIN or SSN), and "ZIP Code" (with a sub-field for 5-digit ZIP Code). A "CONTINUE" button is at the bottom. A "Need Help?" sidebar on the right provides contact information for the Producer Help Desk (PHD), including a "Call Us" button and hours: Monday - Friday, 7 am - 8 pm CST, and the phone number 888-381-8581.

The screenshot shows the Jarvis registration page at Step 2. The header is the same as Step 1. The main heading is "Register your Account Here" with a sub-heading "Step 2". It asks for "Agent or Party ID" and "Email" with input fields. Below that are "Enter Password" and "Re-enter New Password" fields. A checkbox for "I accept the Terms and Condition and Privacy Policy." is present. A "CONTINUE" button is at the bottom. The "Need Help?" sidebar on the right is identical to the one in Step 1.

The screenshot shows the Jarvis sign-in page. The header includes the Jarvis and UnitedHealthcare Medicare Solutions logos, with links for Contact Us, Login, and Register. The main heading is "You are ready to use Jarvis!" with the instruction "Sign in with your ID and password". A "SIGN IN" button is centered at the bottom.

Section 3: What Tools and Resources are Available to Help Me?

Jarvis Password Resets

Jarvis allows you to reset your password by following these steps:

- Access the Jarvis welcome page at www.uhcjarvis.com
- Click on “Password Assistance”
- Complete the fields under Step 1
 - ~ Select the applicable ID
 - ~ Enter the applicable ID number
 - ~ Enter the last four digits of your Tax Identification or Social Security Number
 - ~ Enter your 5 digit ZIP code
- Click “Continue”
- Complete the fields under Step 2
 - ~ Enter the applicable ID
 - ~ Enter New Password*
 - ~ Re-enter New Password
 - ~ Check the “Terms and Conditions” box
- Select “Continue”

The screenshot shows the Jarvis Password Assistance Step 1 form. At the top, there are logos for Jarvis and UnitedHealthcare, along with links for Contact Us, Login, and Register. The main heading is "Password Assistance". Below this, a blue bar indicates "Step 1". The form is titled "Personal Information" and asks "Which ID do you currently use?". There are two radio buttons: "Party ID" (selected) and "Agent ID". Below this is a text input field labeled "Enter Agent or Party ID". The next section asks for the "Last four digits of your Tax Identification Number or Social Security Number:" with a corresponding text input field labeled "Last 4 digits TIN or SSN". The final section is "ZIP Code:" with a text input field labeled "Enter 5 digit ZIP Code". A blue "CONTINUE" button is at the bottom. On the right side, there is a "Need Help?" section with a "Call Us" button and contact information: "Monday - Friday 7 am - 8 pm CST" and "Call UnitedHealthcare: 888-381-8581".


Password Guideline

- Must be between 8 and 50 characters
- Must contain:
 - ~ A number
 - ~ An uppercase letter
 - ~ A lowercase letter
 - ~ A special character, for example: @ _ - , #
- Cannot contain:
 - ~ ? ' ; / "
- Cannot be the same as your username, first or last name.
- Cannot contain four or more repeating numbers, letters or characters.
- Cannot contain three or more sequential numbers or letters (for example: 123, ABC).
- Cannot contain any spaces.
- Should be changed once every 365 days.

The screenshot shows the Jarvis Password Assistance Step 2 form. At the top, there are logos for Jarvis and UnitedHealthcare, along with links for Contact Us, Login, and Register. The main heading is "Password Assistance". Below this, a blue bar indicates "Step 2". The form has three text input fields: "Agent ID or Party ID", "Enter Password" (with a strength indicator), and "Re-enter Password". Below these is a checkbox labeled "I accept the Terms of Conditions and Privacy Policy". A blue "CONTINUE" button is at the bottom. On the right side, there is a "Need Help?" section with a "Call Us" button and contact information: "Monday - Friday 7 am - 8 pm CST" and "Call UnitedHealthcare: 888-381-8581".


Section 3: What Tools and Resources are Available to Help Me?

Home Page



Welcome, [Agent Search](#) [Contact Us](#) [Sign Out](#)


Home | Sales & Marketing Tools | Enrollment | Commissions | Knowledge Center |



Welcome to Jarvis!

It's all right here - the [tools](#) and resources you need to sell UnitedHealthcare Medicare products including training, communication, compliance, and so much more! You'll find commonly used sections located at the top of the page on the blue navigation bar. It's a simple, intuitive site, but take a few minutes to go through our training for more details.


[JARVIS TRAINING](#)



Top 10 Things to Know About Jarvis

The inside scoop on some of the new things you will find on **Jarvis** and how to navigate successfully.


[LEARN MORE](#)



Simpler Consumer Insight

Jarvis combines your consumer's application status and recent activity into one. This efficiency runs across all plans and helps you better track progress so you can react sooner to changes in status.

[APPLICATION STATUS](#)



Still Warming Up to Jarvis?

Thanks for logging in! We hope you have spent some time getting to know **Jarvis**. If you need to access the UnitedHealthcare Distribution Portal, you can access it for the next few weeks using your same user name and password.

[ACCESS HERE](#)


FEATURED

[VIEW FULL STORY](#)

MARCH 8, 2017 • SALES

Health Care Fraud Affects Everyone

Health care fraud affects everyone. As a UnitedHealthcare sales representative, it is your responsibility to report any and all suspicions of fraud, waste and abuse; violations of UnitedHealth Group policies or procedures and federal or state laws; and illegal or unethical conduct.



- Sales & Marketing Tools
 - [Plan Search](#)
 - [Sales Materials](#)
 - [Authorized to Offer](#)
- Enrollment
 - [Provider and Rx Search](#)
 - [Enrollment Tool](#)
 - [Application Status](#)
- Commissions
 - [Commission Search](#)
 - [Commission Statements](#)
 - [Production Summary](#)
- Knowledge Center
 - [Training](#)
 - [Product Overview](#)
 - [Agent Guide and Handbooks](#)
 - [Agent Communications](#)
 - [Compliance Information](#)
 - [Member Communications](#)
 - [Account Info](#)
 - [Jarvis FAQ](#)

[medicare.gov](#) [aarpmedicareplans.com](#) [uhcmedicaresolutions.com](#) [myaarpconnection.com](#)

[Contact Us](#) [Privacy Policy](#) [Terms and Conditions](#) [Disclaimers](#) [Sign Out](#)

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EDC Agent Guide

Version 3.7

June 22, 2017

Agent Use Only

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Section 3: What Tools and Resources are Available to Help Me?

Sales & Marketing Tools

The Sales & Marketing Tools section offers access to the Plan Search, Sales Materials, and Authorized to Offer features on *Jarvis*.

Plan Search

The Plan Search section allows you to search all UnitedHealthcare Medicare Solutions plans in a particular ZIP code.

Sales Materials

The Sales Materials section provides sales materials, marketing and promotional items. You can access the UnitedHealthcare Toolkit from the Sales Materials section. The UnitedHealthcare Toolkit is where you can order Enrollment Guides and marketing materials.

Authorized to Offer

The Authorized to Offer section provides information regarding the Authorized to Offer AARP Medicare plans program. Information includes an overview of the Authorized to Offer AARP Medicare Plans program and the A2Oh! Rewards program and available resources.

The screenshot displays the Jarvis website interface. At the top left, the Jarvis logo and UnitedHealthcare Medicare Solutions logo are visible. On the top right, a user is greeted with "Welcome," and there are links for "Agent Search," "Contact Us," and "Sign Out." Below this is a blue navigation bar with menu items: "Home," "Sales & Marketing Tools" (which is expanded), "Enrollment," "Commissions," and "Knowledge Center." A search bar labeled "Search Jarvis" is also present. The main content area features three cards: "Plan Search" (with a right-pointing arrow), "Sales Materials" (with a right-pointing arrow), and "Authorized to Offer" (with a right-pointing arrow). Each card contains a brief description and links to related resources. At the bottom, there is a "JARVIS TRAINING" button next to an image of hands holding a document.

Section 3: What Tools and Resources are Available to Help Me?

Enrollment

The Enrollment section offers access to the Provider and Rx Search, Enrollment Tool, and the Application Status features.

Provider and Rx Search

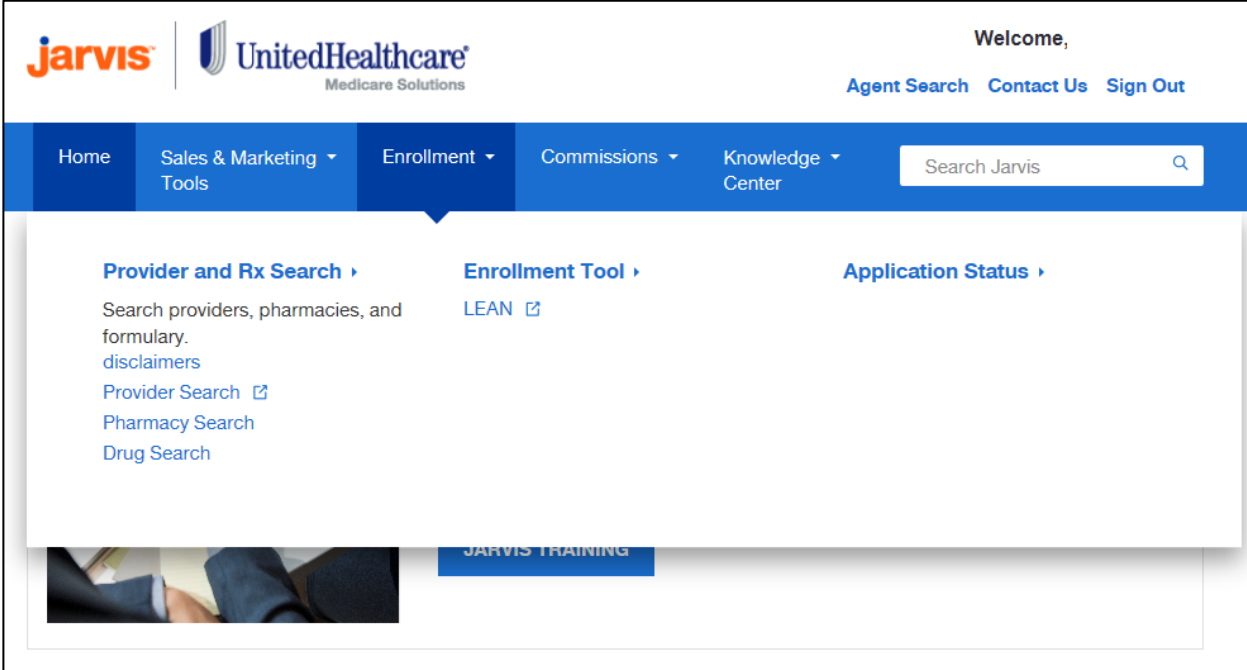
The Provider and Rx Search section offers a redirect link to the Provider Search program. You can also access the Pharmacy Search and the Drug Search feature on *Jarvis*.

Enrollment Tool

The Enrollment Tool section offers an overview of the Landmark Electronic Application Navigator™ (LEAN) and a redirect to the LEAN tool.

Application Status

The Application Status section provides a table and search function for your recent application activity.



The screenshot displays the Jarvis website interface. At the top left, the Jarvis logo is next to the UnitedHealthcare Medicare Solutions logo. On the top right, there is a 'Welcome,' message and links for 'Agent Search', 'Contact Us', and 'Sign Out'. Below this is a navigation bar with 'Home', 'Sales & Marketing Tools', 'Enrollment', 'Commissions', and 'Knowledge Center'. A search bar labeled 'Search Jarvis' is on the right. The 'Enrollment' menu is expanded, showing three main options: 'Provider and Rx Search', 'Enrollment Tool', and 'Application Status'. Under 'Provider and Rx Search', there are links for 'Search providers, pharmacies, and formulary. disclaimers', 'Provider Search', 'Pharmacy Search', and 'Drug Search'. Under 'Enrollment Tool', there is a link for 'LEAN'. Below the menu is a 'JARVIS TRAINING' banner with an image of a person in a suit.

Section 3: What Tools and Resources are Available to Help Me?

Commissions

The Commissions section offers access to the Commission Search, Commission Statements, and Production Summary features.

Commission Search

The Commission Search section allows you to search and display specific commission details. You can search using one or more search criteria in the fields provided.

Commission Statements

The Commission Statement section allows you to view and download your commission statements.

Production Summary

The Production Summary section allows you to view your production summary for a specific date range.

The screenshot shows the Jarvis UnitedHealthcare Medicare Solutions website. At the top left are the Jarvis and UnitedHealthcare Medicare Solutions logos. On the top right, it says "Welcome," followed by links for "Agent Search", "Contact Us", and "Sign Out". Below this is a blue navigation bar with menu items: "Home", "Sales & Marketing Tools", "Enrollment", "Commissions", and "Knowledge Center". A search box labeled "Search Jarvis" is on the right. Below the navigation bar, three main sections are highlighted: "Commission Search", "Commission Statements", and "Production Summary". Below these sections is a promotional banner for "JARVIS TRAINING". The banner includes an image of a person working at a desk with a laptop and a notebook, and text that reads: "It's all right here - the tools and resources you need to sell UnitedHealthcare Medicare products including training, communication, compliance, and so much more! You'll find commonly used sections located at the top of the page on the blue navigation bar. It's a simple, intuitive site, but take a few minutes to go through our training for more details." A blue button labeled "JARVIS TRAINING" is positioned to the right of the text.

Section 3: What Tools and Resources are Available to Help Me?

Knowledge Center

The Knowledge Center section offers access to a variety of supporting resources and features. The Knowledge Center section may include access to:

- Training
- Product Overview
- Agent Guides and Handbooks
- Agent Communications
- Compliance Information
- Member Communications
- Account Info
- *Jarvis* FAQ

The screenshot shows the Jarvis Knowledge Center website interface. At the top left, the Jarvis logo is displayed next to the UnitedHealthcare Medicare Solutions logo. On the top right, there is a "Welcome," message and links for "Agent Search", "Contact Us", and "Sign Out". Below this is a navigation bar with tabs for "Home", "Sales & Marketing Tools", "Enrollment", "Commissions", and "Knowledge Center". A search bar labeled "Search Jarvis" is located to the right of the navigation bar. The "Knowledge Center" dropdown menu is open, showing a grid of categories: Training (with sub-items: Certifications, Foundational, Systems & Technology, Products, Programs, Compliance, Business/Sales Skills, Continuing Education), Product Overview (with sub-items: Medicare Advantage, Medicare Supplement, Part D), Compliance Information, Member Communications, Account Info, and Jarvis FAQ. Below these are Agent Guide and Handbooks and Agent Communications.

Section 3: What Tools and Resources are Available to Help Me?

Producer Help Desk

Jarvis is available 24 hours a day, seven days a week, providing you access to Enrollment applications and commission status, plan information, marketing materials, and much more. (See previous section for details.) If, however, you are unable to locate what you need on **Jarvis**, need assistance with a pending enrollment application, or have a commission inquiry, the Producer Help Desk (PHD) is available.

Email: phd@uhc.com (include your Agent ID in the subject line) or icssupport@uhc.com (enrollment application status and updates only)

Telephone: 1-888-381-8581 (Available Monday-Friday 7 a.m. to 8 p.m. CT).

The PHD is a contact center that strives to maximize the effectiveness of the agent community while enhancing agent knowledge and effective use of company tools and resources by:

- Helping you use self-service tools and access resources including providing first-level technical support of the tools.
- Providing you with information on the certification and commission process as well as, resolving certification and/or commission questions and disputes.
- Supporting the UnitedHealthcare Medicare Solutions product portfolio including answering product support inquiries.
- Educating you on the company's material fulfillment process.
- Assisting you with contracting or commission inquiries.

The PHD email address is for agent use only and is not to be shared or distributed to members or consumers.

Inquiries Made on Behalf of an Existing Member

Email inquiries must be sent via secure email. **All** of the following information must be available when you call or included within your email:

- Your full name
- Your Agent ID
- Name of the agency for which you work
- Member or consumer's full name
- 2 of the following:
 - Member or consumer's date of birth, Member ID number, last 4 digits of the Medicare ID (Health Insurance Claim Number - HICN) number or address
- Member's AARP member number (if call is regarding AARP Medicare Supplement Insurance)

]

Section 3: What Tools and Resources are Available to Help Me?

Quick Resource Tip Sheet

Throughout this guide there are references made to websites, email addresses, and telephone numbers. You will find all of those resources listed below for quick reference.

General Agent Support

Producer Help Desk

Telephone: 1-888-381-8581
7 a.m. to 8 p.m. Central Time (CT) Monday through Friday

Email: PHD@uhc.com (enter your Agent ID in the subject line)

Marketing and Advertising Material

Agent Marketing

Agent_Marketing_Requests@uhc.com

Scope of Appointment

Fax: 1-866-994-9659

Medicare Marketing Guidelines

The Centers for Medicare & Medicaid Services

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

Compliance Questions - Contact for questions regarding marketing or for access to Medicare marketing guidelines

Compliance_Questions@uhc.com

Customer Service Resources

Customer Service – PFFS

Telephone: 1-866-579-8774 TTY: 711
8 a.m. to 8 p.m. Central Time (CT) 7 days a week

Customer Service – HMO/PPO/RPPO/POS

Telephone: Find plan-specific numbers in the plan's Summary of Benefits or the back of the member's ID card. 8 a.m. to 8 p.m. CT, 7 days a week

Customer Service – AARP Medicare

Supplement Insurance Plan

Telephone: 1-800-523-5800
TTY: 1-800-232-7773
7 a.m. to 11 p.m. Eastern Time (ET) Monday – Friday 9 a.m. to 5 p.m. ET Saturday

Agent On-Boarding (Contracting, Appointment, Licensing)

UHPCred@uhc.com

Compliance Support

Contact

For answers to questions about UnitedHealthcare Sales Distribution policies and procedures, Medicare Marketing Guidelines, or privacy, security or ethics issues, send an email to Compliance_Questions@uhc.com.

Report violations

Non-employees should email issues regarding illegal or unethical conduct, including violations of law, contractual obligations and company policies (including the Principles of Ethics and Integrity); privacy issues; or suspected fraud, waste and abuse that impacts UnitedHealthcare to Compliance_Questions@uhc.com.

Section 3: What Tools and Resources are Available to Help Me?

Websites

There are many websites that provide tools and content for you and your consumer audience.

Jarvis

www.uhcjarvis.com . For compliance and product information, sales materials, conduct online enrollment, view enrollment application and commission status, and take your certification modules.

For additional information on UnitedHealth Group, go to www.UnitedHealthGroup.com

Websites by Product Brand

For additional information on UnitedHealth Group, go to www.UnitedHealthGroup.com

- Medicare Advantage

www.aarpmedicareplans.com
www.uhcmedicareolutions.com

- Medicare Supplement Insurance Plans

www.AARPMedicarePlans.com

- Prescription Drug Plans

www.AARPMedicarePlans.com
www.uhcmedicareolutions.com

- UnitedHealthcare Nursing Home Plan

Medicaid: www.myevercare.com
Medicare: www.uhccommunityplans.com
Nursing Home: www.myevercare.com
Hospice: www.evercarehospice.com
Caregivers: www.whatissolutionsforcaregivers.com

Websites for Medicare Information

www.cms.gov
www.medicare.gov
[Medicare and You \(2016\)](#)

Agent Communications

UnitedHealthcare is committed to providing you with ongoing communications about its product portfolio, policies and procedures, applicable federal and state regulations, and company rules and business requirements.

Routinely communicated topics include:

- Updates to applicable federal and state regulations that affect the agent.
- Operational policies and procedures, especially those around commissions and certification.
- Event reporting requirements.
- Updates to product rates, sales materials, and **Jarvis**.
- Updates to the Private Fee-for-Service non-deemed provider listing.
- Information to inform and drive change in agent behavior as identified through noncompliant behavior and trends.

Communication Method

Email is the primary method of communication.

As such, you:

- Must provide and maintain a valid email address available to UnitedHealthcare.
- Must receive and read all communications emailed from UnitedHealthcare.
- Refrain from opting out or unsubscribing in any way from receiving email sent from UnitedHealthcare.

Other Communications Methods

Communications may also be disseminated through the following methods:

- Mailings
- Manager meetings
- Outbound calls
- **Jarvis**

Update your contact information in your user profile on **Jarvis** or by contacting the PHD.

Focus News

Focus News is an agent newsletter distributed via email by UnitedHealthcare Medicare Solutions, includes articles on compliance, compensation, marketing, customer service, operations, processes and procedures, products, regulatory issues, and sales.

Disclosing Proprietary Information, Media Requests, and Public Relations Materials

- UnitedHealthcare proprietary data must not be released to anyone outside the company without the required approval from the Chief Distribution Officer, Compliance, or Legal.
- All media request inquiries, including informational interviews, must be directed to the Director of Corporate Communications. Agents are prohibited from speaking to the press regarding plan information without prior written permission from the Director of Corporate Communications.
- All press releases and other public communications must be submitted for approval to the Vice President of Corporate Communications.

Section 4: Product Portfolio

Product Portfolio Overview

Medicare Advantage Health Plans

Medicare Advantage Special Needs Plans

Medicare Supplement Insurance Plans

Prescription Drug Plans

Medicare Star Rating Overview

Product Portfolio Overview

The information contained within this section regarding plans and plan benefits is illustrative only and cannot be relied upon as a reflection of UnitedHealthcare's current product offering. Please contact the PHD at phd@uhc.com (enter your Agent ID in the subject line) for information on current plans and plan benefits.

UnitedHealthcare Medicare Solutions

The portfolio of UnitedHealthcare Medicare Solutions plans includes Medicare Advantage Plans, Medicare supplement insurance plans, and Part D Prescription Drug Plans. These plans provide a portfolio of services to the rapidly growing Medicare population. Plans are insured or covered by an affiliate of UnitedHealthcare, a Medicare Advantage organization and a Prescription Drug Plan sponsor with a Medicare contract.

The Medicare Advantage products include network (Health Maintenance Organization (HMO), Point-of-Service (POS), Preferred Provider Organization (PPO), and Regional Preferred Provider Organization (RPPO)) and non-network-based Private Fee-for-Service (PFFS) plans. In addition, Special Needs Plans (SNPs) are specific types of Medicare Advantage plans.

AARP® Brand and UnitedHealthcare Relationship

UnitedHealthcare has a long-standing relationship with AARP. UnitedHealthcare and AARP are aligned in caring about individuals over the age of 50 and their access to affordable, quality healthcare.

UnitedHealthcare offers Medicare Advantage, Prescription Drug Plans, and Medicare supplement insurance plans with the AARP name and trademark as part of its portfolio. UnitedHealthcare pays a royalty fee to AARP for use of the AARP name and trademark. AARP uses this fee to fund advocacy efforts and various programs and services.

AARP is not an insurance provider and makes informed decisions about what products and services include their name. AARP has a choice on what plans carry its name and UnitedHealthcare feels privileged to be one of those selected.

Before you can be authorized to offer AARP branded Medicare plans, you must go through special training that helps you to better understand the issues faced by people as they age and which product may be best suited for their needs.

Section 4: Product Portfolio

Authorized to Offer (A2O) AARP® Medicare Plans Program

The Authorized to Offer (A2O) AARP Medicare Plans program recognizes agents who have met and continue to meet all certification standards, demonstrate competency on AARP Medicare Plans insured by UnitedHealthcare Insurance Company, and continue to serve AARP member's best interests. AARP Medicare Plans includes AARP Medicare Supplement Plans, insured by UnitedHealthcare, and AARP MedicareComplete®, insured by UnitedHealthcare, and AARP MedicareRx Plans, insured by UnitedHealthcare.

There are two levels in the A2O program.

A2O Level 1 Benefits

- Ability to offer AARP branded products
- Access to marketing and enrollment materials for the product(s) they are authorized to offer.

A2O Level 2 Benefits

- Ability to offer AARP branded products
- Access to Level 1 marketing materials
- Exclusive access to additional sales and marketing pieces and AARP branded promotional items
- The opportunity to earn cash rewards and trips through the A2Oh! Rewards Program

A2O Level 1

In order to obtain A2O Level 1 agent status, the agent must:

- Complete one AARP branded certification requirement
- Produce a minimum of five AARP Medicare Supplement active and paid sales during the program measurement period that runs annually from January through December.

Agents who fail to attain the quality production minimum will be de-authorized from selling AARP Medicare Supplement plans for 60 days. The agent will be sent a communication if the agent has not attained the quality production minimum. Agents that fail to meet the quality production minimum for two consecutive years will be permanently de-authorized from selling the AARP Medicare Supplement plans.

Active Level 1 agents with 100 or more AARP Medicare Supplement **active** members in their book of business at the end of the measurement period will not be de-authorized.

Agents de-authorized from selling AARP Medicare Supplement Plans can continue to sell AARP MedicareComplete and AARP MedicareRx Plans during the de-authorization period.

Section 4: Product Portfolio

A2O Level 2

In order to obtain A2O Level 2 agent status, the agent must:

- Complete all three AARP branded certification requirement
 - ~ AARP Medicare Complete
 - ~ AARP Medicare Rx
 - ~ AARP Medicare Supplement Insurance Plans
- Produce 30 or more AARP Medicare Supplement active and paid sales during the program measurement period that runs annually from January through December.
- Successfully complete the Mature Markets (AARP 231) course

Note: Invitations to take the Mature Markets (AARP 231) course to become an A2O Level 2 agent are distributed by UnitedHealthcare to qualified agents on a monthly basis.

A2O Level 2 agents have access to all Level 1 materials as well as exclusive Level 2 marketing materials. AARP-branded Level 2 marketing materials include a business card with the AARP name or logo on it, web banner, a brochure, fact sheet, table runners, a letter of introduction, greeting cards, tent cards, personalized promotional items and window cling/signage. Level 2 materials also include AARP Medicare Supplement marketing materials that promote the product as well as the agent as the local go-to resource for the product. Solicitor agents are not permitted to join Level 2 status.

A2O Level 2 agents can now earn points towards cash rewards on commission-eligible, accepted and paid sales of AARP Medicare Supplement Insurance plan and Select Plan applications for consumers over age 65, during the measurement period of January 1 through December 31 (this excludes under age 65 applications, riders and plan changes). The program will provide points on an application basis as well as when certain milestones are reached by A2O Level 2 agents. Agents must be contracted, licensed, appointed, and authorized to offer AARP Medicare Supplement plans in the state that the consumer resides for each application submitted. Agents will start to accumulate points if they are a current, active, A2O Level 2 agent or as soon as they have completed the Mature Markets 231 course. The quality production minimum of 30 applications for A2O Level 2 status must be met. Point accrual begins with the 31st application.

A2O Level 2 agents must maintain the Level 2 quality production minimum and certification requirements during the measurement period of January 1 and December 31 each year to continue using Level 2 materials.

Active Level 2 agents with 200 or more AARP Medicare Supplement active members in their book of business at the end of the measurement period will retain Level 2 status and will continue to have access to Level 2 A2O program materials.

For additional information about the A2O program the Program Guidelines are available on [Jarvis](#). Agents may also email the PHD.

Agents can view their A2O status on [Jarvis](#) under “[Account Info](#)”.

Medicare Advantage Health Plans

UnitedHealthcare Medicare Solutions may offer Medicare Advantage health plans that cover benefits in addition to those covered under Original Medicare. Residents in some counties have several plans from which to choose. The plans often include an integrated Part D drug benefit with medical coverage.

- **MedicareComplete[®] Plans** are Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and Point of Service (POS) plans that offer benefits in addition to those covered under Original Medicare. Most MedicareComplete plans carry the AARP name - “AARP MedicareComplete insured through UnitedHealthcare.” The remaining MedicareComplete plans are UnitedHealthcare branded. Following are details on the three types of MedicareComplete plans:
 - ~ **MedicareComplete HMO Plans** enable members to receive care through a network of contracted local doctors and hospitals that coordinate their care. Out-of-pocket costs are typically lower for these plans than for other MedicareComplete plans. Some plans do not require referrals for specialty care.
 - ~ **MedicareComplete Plus POS Plans** are HMO plans that offer a Point-of-Service (POS) option. These plans include all of the features of MedicareComplete HMO plans plus the ability to go outside the contracted network for certain health care services, typically at a higher cost. Some POS plans offer open access to providers with no referrals needed.
 - ~ **MedicareComplete Choice PPO Plans** give members access to a network of contracted local doctors and hospitals, but also allow them the flexibility to seek covered services from physicians or hospitals outside of the contracted network, usually at a higher cost. Members do not need a referral for specialty care.
- **Care Improvement Plus Medicare Advantage Plans** offer benefits in addition to those covered under Original Medicare and comprehensive care management. Local PPO and Regional PPO plan options are available. Members do not need a referral for specialty care.

UnitedHealthcare[®] MedicareDirect[™] Plans are Private Fee-for-Service (PFFS) plans, offering the freedom to receive care from any Medicare eligible provider that agrees to accept the plan’s terms and conditions of payment. PFFS plans may or may not use networks, referrals, or prior authorization for care. This depends on whether the PFFS plan is a network or non-network plan. UnitedHealthcare only offers non-network PFFS plans. These plans do not require referrals for care.

In Florida, plans are also marketed under the brands of Preferred Care Partners and Medica HealthCare Plans. In Utah and Nevada, plans are also marketed under the brands of Sierra Spectrum and Senior Dimensions.

Medicare Advantage Special Needs Plans

The UnitedHealthcare Medicare Solutions portfolio of Special Needs Plans (SNP) offer additional benefits, provide enhanced care management, and coordinate care from a variety of health service providers – which Original Medicare and Medicaid alone do not offer. All SNPs include Part D prescription drug coverage. Plans and benefits vary depending on location and plan type.

Special Needs Plan Types

- **Chronic Condition Special Needs Plans** are designed for consumers diagnosed with chronic conditions such as diabetes, chronic heart failure, and/or cardiovascular disorders. These plans offer benefits in addition to those covered under Original Medicare such as routine dental, vision, hearing, transportation, and routine podiatry services. Consumers must have a qualifying chronic condition to enroll. UnitedHealthcare offers Local PPO and Regional PPO Chronic Condition plans through Care Improvement Plus. In addition, the UnitedHealthcare Chronic Complete HMO plan is available in select counties in Texas and the Preferred Special Care Miami-Dade HMO plan is available in Miami-Dade county, Florida.
- **Dual Eligible Special Needs Plans (Dual SNP)** are intended for consumers eligible for Medicare & Medicaid benefits. Dual SNP plans are tailored to low-income consumers who need help to get the most from what is available to them through Medicare and Medicaid. Plans provide benefits in addition to those covered under Original Medicare, such as routine eyewear and transportation to doctor appointments. Members must have Medicaid to enroll. UnitedHealthcare offers Dual SNP plans under the brands of UnitedHealthcare, Care Improvement Plus, Preferred Care Partners, or Medica HealthCare Plans, depending on the service area.
- **UnitedHealthcare Nursing Home Plans – Institutional Special Needs Plans (ISNP)**
UnitedHealthcare Nursing Home Plans provide personalized, closely monitored, and coordinated care to nursing home residents. These plans supplement coverage of nursing facility services with the added support of a nurse practitioner and provide benefits in addition to those covered under Original Medicare. Members must reside in a contracted Skilled Nursing Facility. The Institutional SNP is sold exclusively by contracted, licensed, certified, and appointed (if applicable) OptumCare staff. For additional information, agents may contact their local Optum office, dial 1-877-314-7683 (8 a.m. to 8 p.m., 7 Days a week, Central Time (CT)), or visit www.uhcmedicareolutions.com.
- **UnitedHealthcare Assisted Living Plans – Institutional Equivalent Special Needs Plans (IESNP)** - UnitedHealthcare Assisted Living Plans provide personalized, closely monitored, and coordinated care to individuals who live in a contracted assisted living facility and require the same level of care. The IESNP is sold exclusively by contracted, licensed, certified, and appointed (if applicable) OptumCare staff. For additional information, agents may contact their local Optum office, dial 1-877-314-7683 (8 a.m. to 8 p.m., 7 Days a week, Central Time (CT)), or visit www.uhcmedicareolutions.com.

Medicare Supplement Insurance Plans

A Medicare supplement insurance plan can help protect Medicare consumers against the rising cost of health care by covering some of the out-of-pocket expenses associated with Medicare. Medicare supplement plans are designed to complement Original Medicare and help enhance the member's overall health care coverage. Plans include:

- **AARP Medicare Supplement Insurance Plans** - benefits vary by plan, but all offer hospitalization coverage for Medicare Part A coinsurance, medical expenses coverage for Medicare Part B coinsurance, and portability of benefits, that means the plan goes with the policyholder wherever they are in the United States. AARP Medicare Supplement Insurance plans are supplemental plans available in all states and 5 United States territories. Consumers must be an AARP member or a spouse or partner of an AARP member living in the same household to enroll in an AARP Medicare Supplement Insurance Plan. Consumers can sign up for an AARP membership at the time they enroll in an AARP Medicare Supplement Insurance plan.
- **AARP Medicare Select Plan C and Select Plan F** are available in certain areas in certain states. The AARP Medicare Select Plans provide the same benefit coverage as standardized Medicare Supplement Plans C and F, but insured members pay a lower cost premium because they are required to use a network hospital for coverage of inpatient and outpatient hospital services. In a medical emergency, members do not have to use a network hospital.

Note: Rates, regulatory guidelines, and enrollment materials for AARP Medicare Supplement Insurances plans vary by state.

Prescription Drug Plans

AARP Medicare Rx Preferred (PDP)

- The AARP® MedicareRx Preferred drug list includes most generic and commonly used brand name drugs covered by Medicare Part D. \$0 annual deductible, lower copayments with the Preferred Retail Pharmacy Network and access to more than 65,000 network pharmacies make this our most popular prescription drug plan.

AARP MedicareRx Saver Plus (PDP)

- The AARP® MedicareRx Saver Plus plan includes most generic drugs and many commonly used brand name drugs covered by Medicare Part D. It offers a \$400 annual deductible, lower monthly premiums, lower co-pays with the Preferred Pharmacy Network and access to more than 65,000 network pharmacies. Note: This plan is not available in: America Samoa, Guam, the Northern Mariana Islands, Puerto Rico or the U.S. Virgin Islands.

AARP MedicareRx Walgreens (PDP)

- The AARP MedicareRx Walgreens (PDP) plan is a new 2017 stand-alone Part D plan with an exclusive preferred retail pharmacy benefit with Walgreens pharmacies. This plan offers a low Part D premium, \$0 T1-T2 deductible and low co-pays with a generic-centric formulary. Walgreens is the exclusive preferred retail pharmacy with over 8,000 locations nationwide. Members must use Walgreens pharmacies to get the plan's lowest copays, including \$0 for Tier 1 drugs. There is also a standard network with 30-35 thousand pharmacies.

Section 4: Product Portfolio

Explanation of AARP MedicareRx Tiers

AARP MedicareRx Plans, insured through UnitedHealthcare, are Medicare Part D Plans with five different coverage levels or tiers of copayments/coinsurance for prescription drugs. The amount paid for each prescription depends on the tier assigned to the prescription drug.

Tier 1: Preferred Generic - Lowest Co-pays – Lower-cost, commonly used generic drugs.

Tier 2: Generic - Low Co-pays – Many generic drugs.

Tier 3: Preferred Brand - Medium Co-pays – Many common brand-name drugs, called preferred brands, and some higher-cost generic drugs.

Tier 4: Non-Preferred Brand – Coinsurance – Non-preferred generic and non-preferred brand name drugs.

Tier 5: Specialty Tier - Co-insurance – Unique and/or very high-cost drugs.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and generally not available until after the patent on the brand-name drug has expired.

Generic Drug – Generic drugs are medications that usually cost less and are sold under a generic name for the brand-name drug (usually its chemical name). Because generic drugs are less expensive than their brand-name equivalent, the copayment usually is less as well. Generic drugs are approved by the U.S. Food and Drug Administration (FDA).

Specialty Drugs – Generic and Brand drugs designed to treat special types of medical conditions.

Coverage Gap –The prescription drug coverage stage when a member usually pays more of cost of eligible drugs including the discounted cost of their medications, than the plan. In 2017, the coverage gap begins after the member and the plan together have spent \$3,700 in total yearly drug costs. From this point, the member will pay no more than 51% of the total cost for generic drugs or 40% of the total cost for brand-name drugs until they reach \$4,950 in yearly True Out-of-Pocket (TrOOP) drug costs. Once the member reaches \$4,950 in TrOOP costs, they will enter the catastrophic coverage phase, during which the plan pays nearly all of the member's drug expenses until the end of the year, with no upper limit.

If the member has both Medicare and Medicaid coverage, they will not experience a gap in coverage even if their benefit plan has a coverage gap.

Medicare Star Rating Overview

Overview:

The Centers for Medicare and Medicaid Services (CMS) uses Star Ratings to rate the quality of Medicare Advantage (MA), including Special Needs Plans (SNP), and Prescription Drug Plans (PDP). Star Ratings are also used to determine additional funding from CMS in the form of quality bonus payments and rebates. Star Ratings measure plans across a number of performance categories – including clinical quality, health plan operations and member satisfaction – on a scale of one to five, with five stars being the highest rating. The ratings are published annually in October at www.medicare.gov. The 1-5 stars designation below:

- 5 Stars - "Excellent"
- 4 Stars - "Above Average"
- 3 Stars - "Average"
- 2 Stars - "Below Average"
- 1 Star - "Poor"



Why are Star Ratings important to our members/consumers?

Star Ratings are one of many tools available to help consumers evaluate the quality and value of a Medicare plan. An additional benefit of favorable ratings comes in the form of quality bonus payments and rates, which help UnitedHealthcare continue to offer quality benefits and services to our members, such as lower out-of-pocket costs and more resources to help support their health and well-being needs.

Star Ratings are just one factor that may be part of a member's decision-making process. Premiums, out-of-pocket expenses and whether their doctor is in a plan's network are also important factors when choosing an MA or MAPD plan.

What measures determine a Star Rating?

CMS uses more than 30 measures to determine a plan's Star Rating. The measure performance categories include clinical quality, health plan operations and member satisfaction. Health outcomes and member satisfaction are heavily emphasized in the Star Ratings scores. You may help improve our Star Ratings by simply being accurate when you present a plan and leveraging every opportunity to help members increasingly engage in their health care and effectively use their benefits (such as completing an annual care visit and recommended preventive services).

Star Ratings are assigned by CMS and calculated based on more than 30 measures. Each star measure has a weighted factor between one and five. Although every applicable star measure is factored into a contract's overall rating, the measures with a higher weighted factor have greater influence in the calculation.

In addition, UnitedHealthcare is collaborating closely with care providers to help improve member health through data-sharing, financial incentives and practice-based support.

Section 4: Product Portfolio

Low Performing Plans:

You should always recommend whichever plan is the best fit for the consumer's health care needs. Remember, Star Ratings reflect how the plan performed approximately two years prior, and if the plan has a low rating, those areas of measurement may be greatly improved today. In addition, precisely what is measured by Star Ratings changes from year to year.

How You Can Positively Impact Star Ratings: You are the 'face of our plan' and how you portray our plans and interact with our consumers can positively affect our Star Ratings. Your professionalism and accuracy are very important to some of the performance categories measured by CMS, especially for the member satisfaction category. You can positively impact these measures by encouraging members to use their benefits to complete an annual wellness visit, seek appropriate care, complete preventive screening and tests, and adhere to their medications.

- Know the benefits you are selling, to accurately explain the plan and determine the best fit for the consumer. This supports the consumer with their plan selection, strengthens your relationship, and may also help avoid complaints.
- Encourage consumers and members to use their benefits because Star Ratings are partially based on whether or not our members obtain specific services, such as: annual screenings and preventive care, visit their Primary Care Physician (PCP), and properly using their medications (referred to as "medication adherence").
- Reduce the chance that any type of complaint would be filed, by doing what is required in all sales presentations and appointments and lending proper support to your consumers.

What am I required to say or do, when it relates to Star Ratings: When presenting our plans at a marketing/sales event, individual appointment, or telephonically, you are required to say and do the following:

- **State out loud** what Star Ratings are
- **State out loud** what the Star Rating is for the plan you are presenting (the ratings are found in the enrollment guide for the plan you are presenting)
- **Tell** the audience/consumer the page where the Star Rating is located in the enrollment guide. Tell them they can find more information on www.Medicare.gov
- **Mention** 1-2 measures CMS considers when establishing a Plan's Star Ratings.
Examples you can mention:
 - ~ Member use of preventive care (such as annual screenings)
 - ~ Access to Care
 - ~ Member use of prescribed medications – use as prescribed to improve your health (i.e., adherence)
 - ~ Customer Satisfaction

Questions consumers may have regarding Star Ratings:

Why does this plan not have a Star Rating?

- A plan could be too new or too small with too little data for measurement and calculation. When that necessary information becomes available, the Star Rating will be determined and made available on Medicare.gov and be provided in future enrollment materials. You do not need to be concerned if the Star Rating is not yet published.

Section 4: Product Portfolio

What do the plan ratings specifically measure?

- Currently, CMS calculates a plan's rating based on more than 30 individual quality measures.
- The measures and methodology by which the ratings are calculated is set by CMS and subject to change from year to year.
- Below are a few examples of the quality measures and where they apply:

Star Quality Measures	Medicare Advantage Health Plan (Part C)	Prescription Drug Plan (Part D)
Staying Healthy: How often members got various screenings, tests, vaccines and other check-ups that help them stay healthy.	X	
Managing Chronic (long term) Conditions: How often members with different conditions got certain tests and treatments that help them manage their conditions.	X	
Member Satisfaction: Member feedback about health plan responsiveness and care.	X	X
Member Complaints & Appeals: How often members filed a complaint against the plan; appeal fairness and timeliness; audit findings (Part D).	X	X
Customer Service: How well the plan handles calls from members.	X	X
Drug Pricing & Patient Safety: How well the drug plan prices prescriptions and provides updated information on the Medicare website, and how often members with certain medical conditions get prescription drugs that are considered safer and clinically recommended for their condition.		X

How is UnitedHealthcare improving its Star Ratings?

UnitedHealthcare is driving exceptional performance for health plan operations, raising clinical quality measures, and improving member satisfaction. Our commitment to the quality of care and the experience for our members continues to guide our long-term investments and drive our daily priorities. We remain focused on making steady Star Ratings improvement that benefits those we serve.

Section 5: How do I Get Marketing and Enrollment Materials

UnitedHealthcare Toolkit

Brand and Logo Usage – Marketing and Advertising Materials, Web Links, and Websites

Ordering Marketing and Enrollment Materials and Supplies

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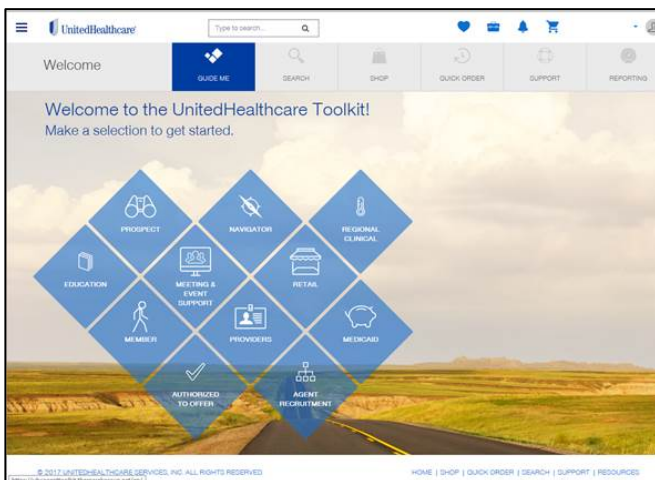
UnitedHealthcare Toolkit

The **UnitedHealthcare Toolkit** allows you to access marketing and advertising materials that can be customized and/or personalized with targeted messages that can be downloaded and used immediately. A variety of materials are available, including ads, flyers, and postcards with an assortment of pre-approved options from which to choose.

When used appropriately, all pre-approved marketing materials are compliant with regulatory, the Centers for Medicare & Medicaid Services, state Department of Insurance offices, and company brand standards.

Note: that any changes to these materials makes them non-compliant. Approved marketing material may not be altered in any way (beyond the personalization or customization options available on the **UnitedHealthcare Toolkit**), including handwritten agent notes (e.g., agent contact information), underlining (e.g., a particular plan benefit), or modifying an item's size or approved purpose.

The **UnitedHealthcare Toolkit** is available to agents that are contracted, licensed, appointed (if applicable), and certified. Your access is limited to those products for which you are certified and states in which you are licensed.



Accessing the UnitedHealthcare Toolkit

To access the **UnitedHealthcare Toolkit**, follow these steps:

- Log on to **Jarvis** and navigate to the “**Sales & Marketing Tools**” tab.
- Click on “**Agent Toolkit**” located on the navigation bar.
- Then click on the “**Agent Toolkit**” hyperlink to access the Agent Toolkit.

Materials are categorized by language and then by product or theme and event. Many approved materials are available in both meeting (formal marketing/sales events) and non-meeting formats.

UnitedHealthcare Toolkit Training

Instructor led trainings may be available to help you in learning how to navigate and use the **UnitedHealthcare Toolkit**. You can view these offerings on **Jarvis**.

- Log on to **Jarvis** and navigate to the “**Sales & Marketing Tools**” tab.
- Click on the “**Sales Materials**” hyperlink.
- In the “**Agent Toolkit**” section details, click the “**Learn More About the Agent Toolkit in the Knowledge Center**” hyperlink.
- Under the “**Instructor Led**” section, select the “**Training Calendar**” hyperlink.

Additional UnitedHealthcare Toolkit Training

Once inside the **UnitedHealthcare Toolkit** you can view additional resources including online video tutorials. These tutorials provide step-by-step instruction on how to use the **UnitedHealthcare Toolkit** and create marketing materials. Simply click on the “**Support**” tab when in the **UnitedHealthcare Toolkit** to access these resources.

Brand and Logo Usage – Marketing and Advertising Materials, Web Links, and Websites

Marketing Materials

Other than the materials and preapproved templates (e.g., logo) provided by UnitedHealthcare, you have no authority to use any brand names, trademarks, service marks, logos, or domain names in any written materials or on any website without the proposed use of such material submitted, reviewed, and approved prior to use in any marketing materials. Additionally, you are not permitted to incorporate in an email address or register or operate internet domain names incorporating the name of any UnitedHealth Group brand or affiliate (e.g., AARP).

Branded Medicare Advantage (MA) and Prescription Drug Plan (PDP) marketing materials require UnitedHealthcare and/or the Centers for Medicare & Medicaid Services (CMS) approval prior to use. Branded Medicare supplement insurance plans marketing materials require approval from UnitedHealthcare and the Department of Insurance (DOI) for the state(s) in which you plan to market.

Marketing materials require CMS approval and include any materials (e.g., flyers, business reply cards (BRC), print, outdoor, direct mail, radio, or television advertising; and presentation slides/charts) targeted to Medicare consumers that:

- Promote UnitedHealthcare or any Medicare Advantage (MA) or Prescription Drug Plan (PDP) offered by UnitedHealthcare
- Inform Medicare consumers that they may enroll in or remain enrolled in a MA or PDP offered by UnitedHealthcare
- Explain benefits of enrollment in a MA or PDP or applicable plan rules

- Explain how services will be covered under a MA or PDP or condition of such coverage

The following materials are examples of marketing materials, which require UnitedHealthcare and CMS approval prior to use, if used for one or more of the purposes identified above. Note: Pre-approved materials of the types listed below are available for agent use through the **UnitedHealthcare Toolkit**.

- General audience materials, such as general circulation brochures, direct mail, newspapers, magazines, television, radio, billboards, yellow pages or the Internet
- Marketing representative materials, such as sales/enrollment scripts, for telemarketing or other presentations
- Presentation materials, such as slides and charts
- Promotional materials, such as brochures, or leaflets, including materials circulated by physicians, other providers, or third-party entities
- Membership communications and communication materials, including membership rules, subscriber agreements, member handbooks and ID card instructions to members (e.g., Evidence of Coverage)
- Communications to members about contractual changes and changes in providers, premiums, benefits, and plan procedures (e.g., Annual Notice of Change, Provider/Pharmacy Directory Formulary)
- Membership activities (e.g., materials on plan policies, procedures, rules involving non-payment of premiums, confirmation of enrollment or disenrollment, or non-claim specific notification information)

UnitedHealthcare is responsible for the submission to CMS of all marketing materials used by agents to represent UnitedHealthcare Medicare Solutions plans.

Marketing materials related to an upcoming plan year must not be distributed prior to October 1 preceding the beginning of the contract year. For example, marketing materials related to the 2018

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plan year must not be distributed prior to October 1, 2017. Once marketing activities begin for the new contract year, current year marketing activities must cease. However, prior year materials may be provided to consumers upon request, including enrollment applications (e.g., An agent markets and enrolls a consumer in a current year UnitedHealthcare Medicare Solutions plan with an effective date of October 1, November 1, or December 1 due to a Special Enrollment Period or a consumer “ages-in” to Medicare due to an Initial Coverage Election Period).

Medicare Supplement Insurance plans marketing materials are filed with and approved by ASI, Inc. and the individual state to:

- Promote AARP Medicare Supplement Insurance plans offered by UnitedHealthcare.

Generic Materials

UnitedHealthcare policy states that you may create generic materials that mention MA and/or PDP products in a general way, but that do not specifically mention, describe, or promote UnitedHealthcare MA and/or PDP plans. A Sales Policy Job Aid – Marketing and Generic Materials resource is available on *Jarvis*.

Although generic materials do not require UnitedHealthcare and/or CMS approval, they must be compliant with any CMS Medicare Marketing Guidelines (MMG). Generic materials are not required to be submitted for prior approval, but may be reviewed retrospectively.

If compliance issues or concerns are identified in a retrospective review, UnitedHealthcare will ask you and/or your agency to resolve the issue or concern, as necessary, including ceasing the use of any such material until it is revised.

In order for material to be considered generic, it must not contain:

- UnitedHealthcare brand, trademark, service mark, logo and/or domain name (Example: UnitedHealthcare, AARP®, etc.)

- Plan Specific Names (Example: Plan A)
- Product Specific Names (Example: Medicare Complete)
- Benefit Information

Generic materials must:

- Include any applicable disclaimers
- Use a font size equivalent to or larger than Times New Roman 12pt
- Clearly identify who the material owner is

Generic Materials must not:

- Use the term “free” to describe benefits or services
- Use the term “entitled” except when referencing Part A
- Use the term “senior” when describing enrollment eligibility.
- Use abbreviated product titles when they first appear in a material
- Use absolute or qualified superlatives unless substantiated.
- Use misleading or inaccurate language
- Use inappropriate agent titles. Your agent title must accurately state your relationship to UnitedHealthcare and provide an accurate title that reflects the intent of the content with the consumer.

Generic Business Reply Cards (BRC) must:

- Identify from whom the material is coming and include an agent or agency name
- Identify the product(s) that the consumer authorizes the agent to discuss when contact is made (e.g., Medicare Advantage, Prescription Drug Plans, Medicare Supplement Insurance)
- Explicitly indicate specific contact method(s) and must include a mechanism, such as a checkbox, so the consumer can indicate the method(s) by which the agent is permitted to contact the consumer
 - ~ The BRC or lead card cannot simply state that by returning the card the agent is permitted to contact the consumer
 - ~ A BRC or lead card may include a “Send me Information” option, but if a

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consumer selects it, the agent is prohibited from contacting the consumer by phone or email

- Must include a statement similar to, “A sales representative may contact you about Medicare Advantage, Prescription Drug Plans, or Medicare Supplement Insurance plans”.

Generic BRCs must not:

- Contain any high-pressure or scare-tactic statements, such as “do not delay,” “reply immediately,” “response time is limited,” “required,” or “needed to ensure delivery”
- Contain any request for the consumer’s date of birth, medical conditions, current medications, etc. Note: Materials may ask if a consumer is Medicare eligible

Generic BRCs may:

- Indicate that a phone number and/or email address is required
- Include two signature lines, so each spouse can provide permission to contact

If you are unsure whether a material is a generic marketing material, you may submit the document for review

to Compliance_Questions@uhc.com.

Please be advised, with this process, Compliance does not prospectively approve language or materials. We advise of any potential issues we may see when questions come in, but do not issue approvals for generic agent items.

We strongly recommend that every effort should be made to use pre-approved materials available within the **UnitedHealthcare Toolkit**.

Marketing and Advertising Materials Featuring UnitedHealthcare Medicare Solutions Brands

UnitedHealthcare provides preapproved materials and templates to ensure consistency of branding and messaging, legal and regulatory compliance, and partner approval. All marketing and promotional materials, advertisements, circulars, brochures, or similar material concerning the products and other materials and information furnished by UnitedHealthcare are copyrighted and shall remain proprietary to UnitedHealthcare.

Pre-Approved Materials

You may at your discretion and without further approval, use marketing materials provided by UnitedHealthcare Medicare solutions so long as the materials are not altered and are used in a manner consistent with all applicable regulations and UnitedHealthcare policy. Any preapproved marketing material template provided by UnitedHealthcare Medicare Solutions that can be customized and/or personalized by agents, may be used at your discretion so long as the materials are not altered beyond the customization and personalization allowed and they are used in a manner consistent with all applicable regulations and UnitedHealthcare policy.

Approved marketing material may not be altered in any way (beyond the personalization or customization options available on the **UnitedHealthcare Toolkit**), including handwritten agent notes (e.g., agent contact information), underlining (e.g., a particular plan benefit), or modifying an item’s size or approved purpose. However, you may encourage the consumer to make notes on the marketing materials.

You must be contracted, appointed (if applicable), and certified in order to access and order pre-approved marketing materials through the **UnitedHealthcare Toolkit**. Your access is limited to the products and/or plans in which you are licensed and certified to sell.

Section 5: How do I Get Marketing and Enrollment Materials?

You may access and download and/or order materials through **Jarvis** using your secure logon. Plan related materials are available through the **Sales Materials Portal** and marketing materials are available through the **UnitedHealthcare Toolkit**, which requires separate logon and password. Only products you are allowed to order are visible. Sharing log on credentials with or providing materials to an agent who is not appropriately contracted, licensed, appointed, and certified is prohibited.

Sales Materials Portal

To access Sales Materials, follow these steps:

- Access Jarvis
- Select “Sales & Marketing Tools” tab
- Select “Sales Materials”
- Select “Order Materials”

UnitedHealthcare Toolkit

To access pre-approved marketing materials, follow these steps:

- Access Jarvis
- Select “Sales & Marketing Tools” tab
- Select “Sales Materials”
- Select “Launch Agent Toolkit”

Materials and options may vary by channel, license, and product certification.

Exception Process for Materials Containing a UnitedHealthcare Brand or Logo and/or Plan Related Information

Every effort must be made to use preapproved materials and templates. Requesting a custom piece should be limited to rare and exceptional circumstances. All custom marketing material that references or uses a UnitedHealthcare brand or logo in any manner must be submitted for approval. Use of agent-created marketing materials featuring a UnitedHealthcare brand or logo without prior written approval by UnitedHealthcare is prohibited.

Requests for approval of agent/agency created marketing materials using any AARP mark or branded product name in marketing or agent recruitment activity **will not** be considered.

Requests for approval of agent/agency created branded material or the development of custom material for Sierra brands must be submitted to UnitedHealthcare Nevada’s Medicare sales office in Las Vegas, Nevada.

All other requests for approval of agent/agency created branded material or the development of custom material are processed as follows:

External Distribution Channel (EDC)

- You must send a written marketing exception request along with the marketing materials to your National Marketing Alliance (NMA)/Field Marketing Organization (FMO) up-line. Upon review and approval, the NMA/FMO must email the request to their UnitedHealthcare Vice President Sales (formerly known as Regional Sales Director (RSD)) for evaluation.
- If the Vice President Sales agrees that no suitable preapproved material or template exists, the Vice President Sales must email the marketing exception request and marketing materials to agent_marketing_requests@uhc.com.

Agent Materials only consider requests if all of the following requirements are met:

- There is strong evidence of business need
- There are no existing materials or templates to fulfill the need,
- There is a substantial business impact (i.e. a significant increase in lead generation, conversion, and new business sales),
- The proposed marketing material may be used by multiple agents,
- Use of the proposed marketing material is consistent with established practices for UnitedHealthcare Medicare Solutions brands, and
- The proposed marketing material does not pose any risk of damage to UnitedHealth Group, UnitedHealthcare Medicare Solutions or any of its brands.

If all of the criteria above are met, Agent Materials will coordinate all requests with

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Compliance, Legal, and other internal reviewers as required. The request will be returned with a decision of Approved, Denied, or Changes/Resubmission. The requestor will be notified if additional time is needed if state or CMS filing is required.

Approvals for logo use will be granted only for the marketing material submitted; they may not be taken generally as blanket approvals. Approval may also be limited to one-time use.

Prior to use, you must send a finalized version of the marketing material to agent_marketing_requests@uhc.com.

Both the requesting and the approving parties must keep a written record of all approvals granted.

Marketing Guidelines for A2O Level 1 and Level 2 AARP-Branded Materials

You are prohibited from creating new or altering existing marketing materials for AARP Medicare Plans. Any material that states the product name or uses a logo for an AARP-branded product in any piece must be approved by UnitedHealthcare and AARP Services, Inc. (ASI), AARP's wholly owned subsidiary, and in some cases, filed with each state and/or the Centers for Medicare and Medicaid Services (CMS) prior to use. Therefore, you must only use approved sales and marketing materials provided by UnitedHealthcare to promote AARP Medicare Plans. You must not create your own pieces with the AARP-branded product name or logo. The availability of sales and marketing materials may vary by state and/or county.

The following guidelines apply when using approved marketing pieces:

For AARP Medicare Supplement pieces, verify that the piece has been approved in the state(s) you would like to market in. If you do not see a state listed in the [UnitedHealthcare Toolkit](#), the piece is not approved for use in that state. Check

back frequently, as states are added when approvals are received.

You may use the provided marketing materials for your own lead-generating purposes. Leads gathered using higher level marketing materials cannot be passed down to lower level agents. For example, a Level 2 agent may not send out Level 2 mailers and pass along leads to a Level 0 or 1 agent. The leads must be used for the Level 2 agent only.

You are prohibited from altering the pieces beyond the editable fields. You must not remove, edit, move or add information to the pieces. You may not make pieces smaller because CMS and each state's Department of Insurance require a minimum font size.

You are prohibited from using approved pieces in an email campaign. Exception: You may use approved pieces for agent recruitment email campaigns. See approved material on the [UnitedHealthcare Toolkit](#).

You are prohibited from making unsolicited contact, such as cold calls. This includes any follow up calls to the mail recipients to see if they received any mailer or flyer.

Please note that you only have access to materials for products in which you are fully certified and authorized to offer. Distribution of materials to agents who are not authorized to offer is strictly prohibited. Agents who do not comply may face disciplinary action, including, but not limited to, termination of contract.

A2O Business Card Guidelines

A2O business cards are available to Level 2 agents. The A2O business card notifies recipients that the agent listed on the card is an Authorized to Offer AARP Medicare Plans agent.

The following are the approved agent title for use on an A2O business card:

- EDC agents may use "Sales Agent"

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The following information is prohibited from use on an A2O business card:

- Blog, Facebook, Twitter and other social media URLs
- Business slogans
- Listing/naming offered products
- Business logo (for EDC agents)

Web Banner Guidelines

The A2O web banners are designed to support the marketing efforts of UnitedHealthcare and our Level 2 agents who are Authorized to Offer AARP Medicare Plans. UnitedHealthcare has developed correlating guidelines to help agents appropriately communicate the offering to the public and leverage the power of the AARP brand to their best advantage. Other than the provided web banner, the use of the product name or logo for an AARP-branded product on any website, social media or URL is prohibited unless approved by UnitedHealthcare and AARP Services, Inc. (ASI) and in some cases, filed with each state and/or CMS prior to use.

In addition to adhering to these web-banner-specific guidelines, you must continue to ensure that all marketing and brand guidelines are being followed.

- Web banners may be placed on the Level 2 agent's or agency's website that is registered with UnitedHealthcare. Placement of the web banners should be below your masthead and navigation. We recommend placing the banners on the home page and your products page. Three banner options, varying in size, are available to allow you to select the size that best fits your web page.
- Agencies must have at least **60% of agents** who are Authorized to Offer Level 2 in order to remain eligible to display the A2O web banner on their website.
- Web banners cannot be re-created, manipulated or changed by you. Web banners must be used exactly as provided.

Provided link must not be broken and/or redirected.

- No other reference to AARP and the AARP-branded products may be listed or displayed other than those in the provided web banners. Rules for displaying and/or listing the UnitedHealthcare brand are available in the *Sales Policy Job Aid – Agent Website Guidelines*.
- Level 2 agents must maintain the quality production minimums and certification requirements each year from January through December to be able to display the web banner on their website. If requirements are not met and you become Level 1, the web banner must be taken down.

Window Clings Guidelines

The A2O window cling can be displayed in your storefront window. The window cling will help your customers recognize your status as an agent Authorized to Offer AARP Medicare Plans, insured by UnitedHealthcare. Window clings are mailed to Level 2 agents.

- Artwork was developed by AARP Services, Inc. (ASI) and cannot be re-created, manipulated or changed by you. The window cling is 6"x9". The window cling must be used exactly as provided, must be shown in its entirety and must adhere to the dimensions established by ASI.
- The window cling may only reside at Authorized to Offer Level 2 agent brick and mortar office locations where you conduct your primary business. It is never permitted to be placed or used on agent vehicles, homes or at non-affiliated third party locations.
- At a given location, at least **60% of agents** must be Authorized to Offer Level 2 to remain eligible to display the window cling.
- The window cling may never be obstructed nor obstruct other non-affiliated third party offers. Please use best practices by refraining from overlapping or layering the cling with other external signage or communication tools.

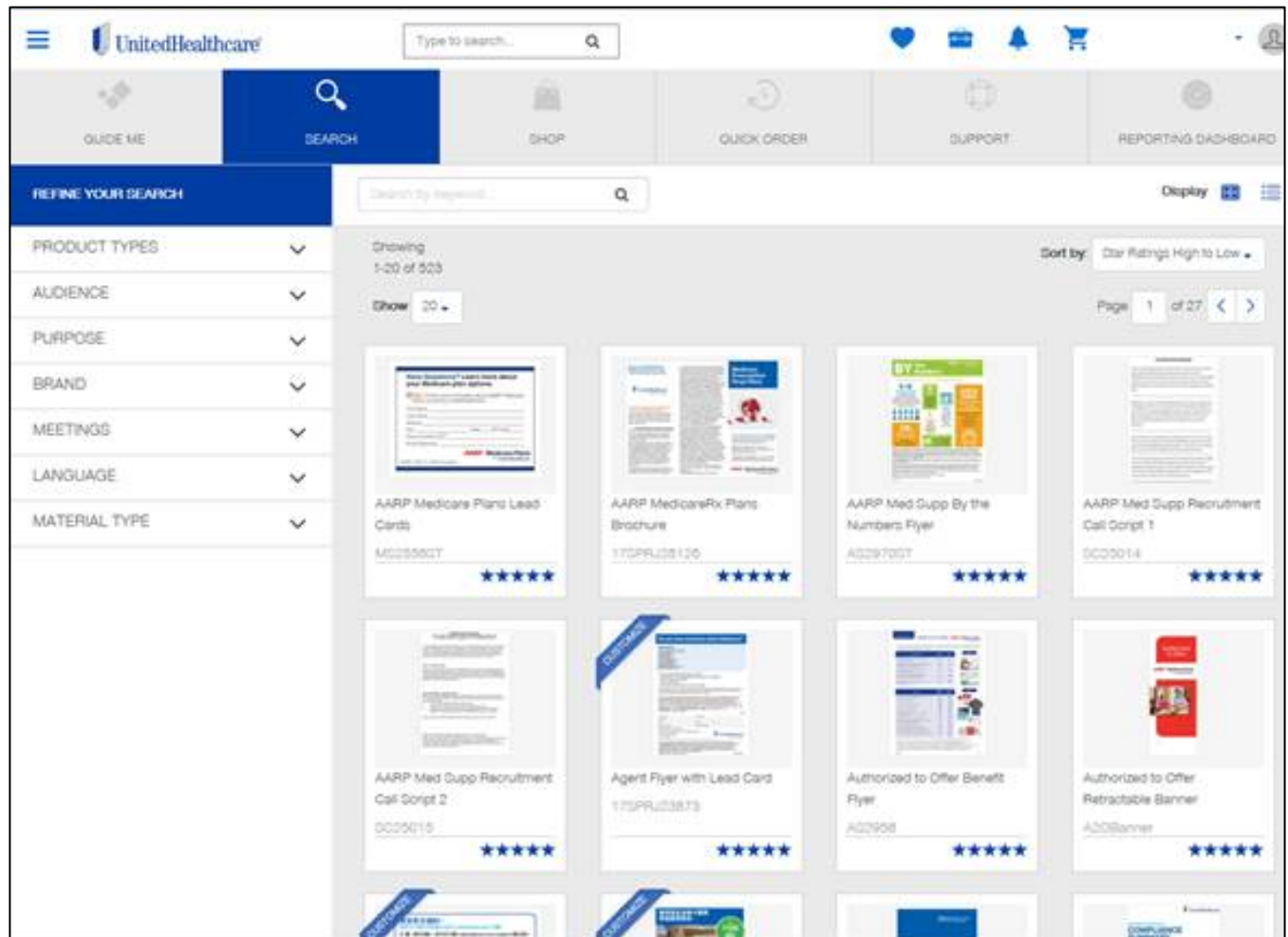
Section 5: How do I Get Marketing and Enrollment Materials?

- The condition of the window cling must be monitored and maintained. For example, if a window cling is scratched, written on, losing adhesiveness and/or color, it needs to be replaced. Replacement requests can be made through the UnitedHealthcare Producer Help Desk at phd@uhc.com or 1-888-381-8581.

E-mail Signature and Letterhead

You are prohibited from using the AARP logo and/or reference to the Authorized to Offer Program and/or their level in any email signature or stationery, which includes any letterhead and/or postcards.

[UnitedHealthcare Toolkit > Search](#)



Section 5: How do I Get Marketing and Enrollment Materials?

Prohibited Terminology

You are prohibited from distributing marketing materials that are inaccurate, misleading, or otherwise create misrepresentations that you are in any way affiliated with or endorsed by Medicare, CMS, the Social Security Administration, or any other regulatory entity. The misrepresentation rules apply to business cards, communications (including email signatures), website domain names, email addresses, a company name, marketing materials or any form of advertisement.

Agent Titles

Your agent title must accurately state your relationship to UnitedHealthcare and provide an accurate title that reflects the intent of the contact with the consumer.

In addition, using the word Medicare and/or any language in a title that implies that you have additional knowledge, skill, or certification above licensing requirements that cannot be verified are prohibited.

Examples of prohibited agent titles:

- Medicare Sales Agent
- Senior Advisor

Examples of approved agent titles:

- Sales Agent
- Sales Representative
- Independent Sales Agent
- Independent Sales Representative
- Licensed Agent
- Licensed Sales Agent
- Licensed Sales Representative

You may add their National Marketing Alliance (NMA)/Field Marketing Organization (FMO) after an approved title.

Branded Agent Business Cards

You can order business cards **through** the **UnitedHealthcare Toolkit**. Follow these steps to order business cards:

- Click on “Shop”
- Click on “Medicare Advantage”
- Click on “Other”
- Click the applicable business card and fill in the personalization/customization fields.

Authorized to Offer Level 2 agents may have additional options; see the program for details.

Generic Agent Business Cards

You may develop your own generic business card. However, you may not use the UnitedHealthcare brand or logo on generic business cards, letterheads, labels, envelopes, or in an e-mail signature.

You may not use symbols, emblems, names (including acronyms), and color schemes on business cards in reference to Medicare, the Social Security Administration, or any other regulatory entity when used in a manner that conveys or may convey the false impression that the business or product mentioned is approved, endorsed, or authorized by Medicare or any other government entity.

You may add professional and educational credentials (e.g. CLU, ChFC, CFP, PhD). However, you must be able to provide documentation to substantiate credentials upon request. Certifications must be current and removed from business cards upon expiration (if applicable).

Agent/Agency Websites (consumer and agent facing)

The promotion of your affiliation with UnitedHealthcare Medicare Solutions, through the use of Web links and logos, must comply with Company and the Centers for Medicare &

Section 5: How do I Get Marketing and Enrollment Materials?

Medicaid Services (CMS) marketing guidelines. Please refer to: *Sales Policy Job Aid - Agent Website Guidelines* available on **Jarvis**.

You may not use UnitedHealthcare Medicare Solutions brands and/or logos on your website(s) that are not included in the Guidelines without written permission from UnitedHealthcare Medicare Solutions.

You should refer to the *Sales Policy Job Aid - Agent Website Guidelines* for instructions related to the creation and content of agent/agency created websites. Agent-created consumer-facing websites are directed to consumers and are used by agents to market their services and announce their affiliation with UnitedHealthcare. However, they must not include plan specific information, such as plan name, benefits, or cost sharing information. Agent-created agent-facing websites are directed for recruitment activities, education, and communication and are not open to the public if a password is required to authenticate access.

The following provisions apply to both agent-created consumer-facing and agent-created agent-facing websites unless noted:

- You must be licensed, contracted, appointed (if applicable), and certified with UnitedHealthcare in order to announce their affiliation, display the UnitedHealthcare Medicare Solutions brand name and/or logo, and/or hyperlink to the UnitedHealthcare website on an agent-created website.
- Prior to webpage “going live”, you must register your website by submitting an email containing the required information noted in the *Sales Policy Job Aid - Agent Website Guidelines* and include a list of each individual webpage (i.e., URL) that contains any mention of UnitedHealthcare or the UnitedHealthcare Medicare Solutions brand or logo to compliance_questions@uhc.com. There is no formal approval provided by UnitedHealthcare after registering the website and is considered “live” after you complete the registration.
- The same sales and marketing rules set by CMS for presentations and materials apply to websites. All agent websites may be subject to review by UnitedHealthcare Agent Oversight to ensure they are consistent with all business and operational policies.
- The UnitedHealthcare Medicare Solutions brand name and logo is the only approved brand name and logo available for use on an agent/agency created website.
- No exception or approval to use the AARP brand or logo is permitted with the exception of limited permission use as granted to A20 agents.
- You must not copy and paste logos from UnitedHealthcare Medicare Solutions websites or other marketing materials. Website-ready graphic file of the approved logo is available by email request to compliance_questions@uhc.com.
- You are prohibited from altering in anyway authorized brand name, logo, product names, or plan descriptions including the Authorized to Offer Web banner for Level 2 agents. Inappropriate brand or logo use, including retired/obsolete logos, and/or without written permission obtained by the agent prior to use may be referred to the Disciplinary Action Committee (DAC) and subject to progressive disciplinary actions up to and including termination.
- You may place the hyperlink www.UnitedHealthcareMedicareSolutions.com on your website if certified to sell UnitedHealthcare Medicare Solutions products and/or AARP Medicare plans. The link connects to the home page of the UnitedHealthcare Medicare Solutions website. You must not place hyperlinks to specific pages within the website. You must not place a hyperlink

Section 5: How do I Get Marketing and Enrollment Materials?

to www.AARPMedicarePlans.com except as it applies to AARP Web banners.

- You may post a generic electronic Business Reply Card (eBRC) on your website, however, a disclaimer must appear if the BRC asks for either phone number or email address, for example: “A sales agent (or other approved title) may call or e-mail as a result of completing the information to discuss Medicare Advantage, Prescription Drug Plans, or Medicare Supplement Insurance”. The same content regulations apply to an electronic BRC as to a paper BRC.
- The first time the UnitedHealthcare brand is used on any individual webpage, it needs to be followed by the appropriate trademark symbol. Refer to the *Sales Policy Job Aid - Agent Website Guidelines* for the required registered trademark symbol and its placement.
- You may post the type of product (e.g., Medicare Advantage, Part D, Medicare Supplement Insurance) you are authorized to offer on behalf of UnitedHealthcare.
- Use of pre-approved verbiage to describe the UnitedHealthcare Medicare Solutions plan benefit descriptions is strictly limited to agent-facing agent websites and expressly prohibited from use on consumer-facing websites. Pre-approved boilerplate language for an agent-facing website is provided in the *Sales Policy Job Aid - Agent Website Guidelines*, may not be modified, and must be used verbatim.
- An agent-facing website must contain this disclaimer, “The information on this website is for agent use only and is not intended for use by the general public.”
- For educational information, you may provide a link to the official website for Medicare and Medicaid <http://medicare.gov/>.
- Agents/agencies are not permitted to display any AARP logo, brand, or product name on any agent/agency created website with the exception that AARP Medicare Plans Level 2 Authorized to Offer (A20) agents may display the AARP Web banner on their consumer-facing website. No other use of the AARP logo or brand is allowed on agent websites.
- Use of product names, descriptions, and/or plan benefits is strictly limited to agent-facing agent websites and expressly prohibited from use on consumer-facing websites. Additionally, use of product names, descriptions, and/or plan benefits is limited to the verbiage provided in the *Sales Policy Job Aid - Agent Website Guidelines*.
- You are not permitted to register or operate internet domain names incorporating the name of any UnitedHealth Group brand or affiliate (e.g. AARP).
- You are discouraged from using the word Medicare in an internet domain name that may give the perception that the website is in anyway affiliated with Medicare. You are responsible for complying with the Centers for Medicare and Medicaid Services (CMS) rules and regulations.
- You may not use CMS in an internet domain name that may give the perception that the website is in anyway affiliated with Centers for Medicare & Medicaid Services (CMS).
- You may not use symbols, colors, or color schemes that may give the perception that the website is affiliated with Medicare, CMS, state, or federal entities.
- Website content must not:
 - ~ Speak disparagingly of Medicare, CMS, UnitedHealthcare or the competition.
 - ~ Include contracts or appointment forms from UnitedHealthcare.

Section 5: How do I Get Marketing and Enrollment Materials?

- ~ Include plan materials, enrollment kits, or benefit guides.
- All CMS marketing guidelines apply to websites. These include, but are not limited to:
 - ~ Do not cross-sell (e.g. market MA products with Funeral Planning information)
 - ~ Superlatives are not allowed (e.g. **the most** recognizable name in market)
 - ~ Scare tactics are not allowed (e.g. **you must** enroll, **required** to elect)
 - ~ Logos and branding must be current
 - ~ Agent titles should be appropriate

Brand and Logo Usage Monitoring and Corrective Action

Usage Monitoring

Random reviews of brand and logo usage, including the review of websites and the use of materials provided at marketing/sales events, is the responsibility of UnitedHealthcare Medicare & Retirement Compliance. The review of websites and social media platform is the responsibility of UnitedHealthcare Agent Oversight.

CMS Website Monitoring

CMS monitors websites that contain UnitedHealthcare information. CMS will notify UnitedHealthcare of any website violations pertaining to Medicare products and UnitedHealthcare will then notify the website owner and the agent manager or up-line of any CMS identified website violations.

Corrective Action

- Agents notified of a UnitedHealthcare compliance issue will be given a limited period of time to correct the issue. CMS reserves the right to request immediate action regarding website content.
- Agents who do not comply may be referred to the Disciplinary Action Committee (DAC) or subject to progressive discipline including corrective and/or disciplinary action, up to and including termination.

Website/Social Media Monitoring

UnitedHealthcare expects you and your up-line to monitor websites for compliance on a routine basis. Each quarter UnitedHealthcare Agent Oversight conducts random and targeted agent website searches and reviews, reports infractions to management for outreach and correction, and produces monitoring activity reports.

- At a minimum, websites are reviewed against the following criteria:
- Website URL have been registered and approved by Marketing
- Compliant and correct use of Company/affiliate logos (including AARP), brands, and product and company names
- CMS and UnitedHealthcare compliant language, disclaimers, and word usage
- UnitedHealthcare Agent Oversight will conduct outreach when a Website infraction is discovered.
- UnitedHealthcare Agent Oversight will forward to UnitedHealthcare Medicare & Retirement Legal, within two business days of observation, website information identifying non-affiliated entities engaging in unauthorized website use of Company information. Legal representatives will review and respond to the incident as required.
- UnitedHealthcare Agent Oversight will maintain results of website reviews on a SharePoint site and will provide a website review summary report monthly to Distribution Oversight leadership.

Agents notified of UnitedHealthcare compliance issue will be given a limited time period to correct the issue. CMS reserves the right to request immediate action regarding website/social media content.

Agents who do not comply with corrective action may be referred to the Disciplinary Action Committee (DAC) or subject to progressive discipline including corrective and/or disciplinary action up to and including termination.

Use of Social Media

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Agent use of social media as a marketing tool, including, but not limited to Facebook, LinkedIn, YouTube, Twitter, blogs, chat rooms, and message boards is subject to CMS regulations and UnitedHealthcare rules, policies, and procedures.

You must not post or discuss plan or benefit information via social media sites, must not display the UnitedHealthcare brand and/or logo, and must not use a social medium's interactive functionality as a means to communicate with a consumer and/or member. CMS considers some forms of contact via social media to be prohibited unsolicited electronic communication (e.g., sending electronic communications to individuals at email addresses or on social media obtained through friends or referrals). You should refer to the *Sales Policy Job Aid - Agent Website Guidelines* for specific instructions related to the creation of social media platforms.

Prior to posting or publishing via or on a social media platform, agents must register their social media platform. See the *Sales Policy Job Aid – Agent Website Guidelines* for social media registration guidelines.

Live Radio/Television Programming

You must receive permission from UnitedHealthcare prior to conducting or participating in live radio or television programming. You must submit a request to your local agent manager or up-line and include the format of the programming and the content description to be delivered during the radio or television programming.

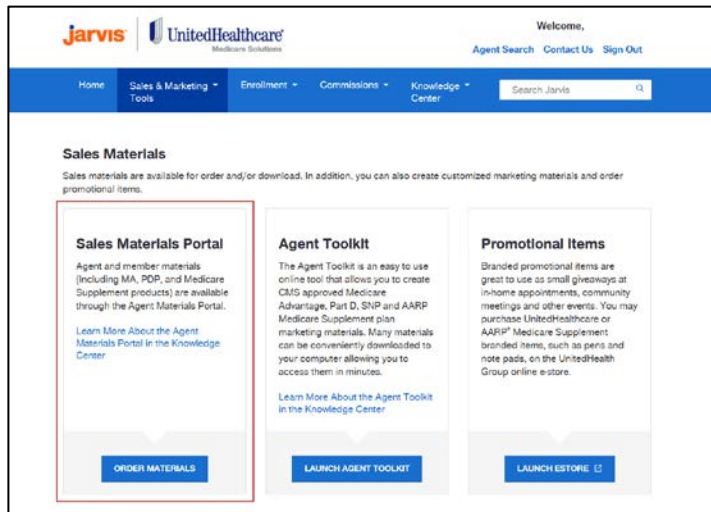
Ordering Marketing and Enrollment Materials and Supplies

Sales Materials

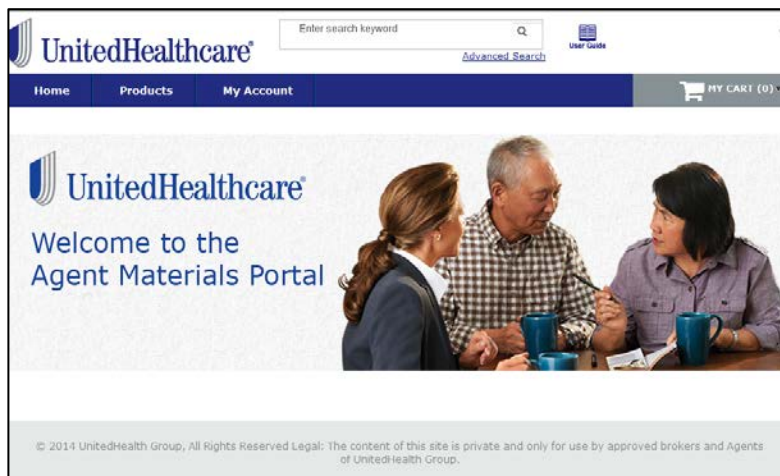
Sales and marketing materials are available through Sales Materials Portal to licensed, contracted and appointed (if applicable) agents once they have taken and passed a product certification test.

Log onto *Jarvis* and select the “Sales & Marketing Tools>Sales Materials” tab. Please note that the look of the section may be different based on your channel.

- The Sales Materials Portal section features the link to access the Agent Materials Portal
- In addition, the section features a link to training resources for the Agent Materials Portal



- The Agent Materials Portal section allows you to search for materials by plan year, state and county, or by item number. Once you find the sales and marketing materials you need, you can order and/or download them. Access is limited to those products in which you are certified and states in which you are licensed and appointed (if applicable). Marketing and enrollment materials may vary by state, (i.e. they may be state-specific).



Section 6: How do I Conduct Educational and Marketing/Sales Activities?

Educational and Marketing/Sales Activities and Events

Event Reporting

Marketing to Consumers with Impairments or Disabilities

Permission to Contact (PTC)

Lead Generation

Scope of Appointment

Medicare Marketing Guidelines

Educational and Marketing/Sales Activities and Events

Educational Activities and Events

An educational activity or event is used to provide objective information about the Medicare program and/or health improvement and wellness. An educational activity or event is designed to inform Medicare consumers about Original Medicare, Medicare Advantage (MA), Prescription Drug Plan (PDP), or other Medicare programs in an unbiased way that does not steer, or attempt to steer, consumers toward a specific plan or limited number of plans.

An educational event must be advertised with the appropriate disclaimer, must always be held at a public venue, and must be open to the public.

Agents Must

- Be contracted, licensed, appointed (if applicable), and certified in order to conduct any educational activity and/or event on behalf of UnitedHealthcare.
- Take and pass the Events Basics module prior to reporting, conducting, and/or participating in an educational event. (Refer to the Certification and Training Section for additional details regarding the Events Basics module.)
- Advertise or promote the event as educational or in a way that would lead consumers to believe that it is solely for educational purposes, when the decision is made to promote the event.
- Report all educational events (see Event Reporting Section).
- All events are subject to Secret Shopping by UnitedHealthcare, the Centers for Medicare & Medicaid Services (CMS) and/or AARP.
- Conduct all educational events in public venues.

Agents Must Not

- Proactively approach or engage the consumer at an informal (table/booth/kiosk) setting.
- Engage in any activity at an educational event that would meet the Centers for Medicare & Medicaid Services (CMS) definition of marketing. For example, you must not:
 - ~ Distribute or display plan-specific materials such as Enrollment Guides or brochures.
 - ~ Attach personal business cards or your contact information to educational materials.
 - ~ Distribute or display business reply cards, lead cards, Scope of Appointment (SOA) forms, sign-in sheets, agent business cards, and/or Permission to Call (PTC) (e.g., collect names, addresses, email addresses, or telephone numbers of consumers).
 - ~ Have any form of “Ask Me” button (or similar) that may lead to the consumer to believe you are a representative of CMS, and/or Medicare, or to ask health plan related questions.
 - ~ Distribute or collect enrollment applications.
 - ~ Discuss plan-specific premiums and/or benefits.
 - ~ Schedule a personal/individual marketing/sales appointment and/or obtain SOA
 - ~ Solicit consumers for personal/individual marketing/sales appointments under the premise that the appointment is for education purposes.
 - ~ Invite consumers to or accept RSVPs for future marketing/sales events.
- Provide cash gifts, gifts easily converted to cash, or charitable contributions made on behalf of a consumer regardless of dollar amount.
- Immediately (i.e., within one hour) follow an educational event with a marketing/sales event in the same general area (e.g., same venue).

Section 6: How do I Conduct Educational and Marketing/Sales Activities?

- Conduct an educational event inside a location that requires the consumer to pay an entrance fee to attend (e.g., a consumer is charged a gate fee to enter a health fair to gain access to an educational event).

Agents May

- Provide educational information, including the UnitedHealthcare-branded “Medicare Made Clear” booklet that is free of plan specific information such as plan specific premiums, copayments, or your contact information.
- Distribute healthcare educational materials (not specific to any plan) on general topics, such as, diabetes awareness and prevention and high blood pressure information.
- Have a banner or table skirt with the plan logo displayed.
- Wear an approved and unmodified shirt, badge, etc. with plan names and/or logos (e.g., purchased from UnitedHealth Group Merchandise eStore accessible via *Jarvis*).
- If requested by a consumer, handout a compliant business card free of any plan marketing or benefit information.
- If asked about plan benefits, premiums, or copayments you may suggest that consumers call UnitedHealthcare or visit the plan website for further information.
- Provide meals or food items (provided they are permitted by the venue) as long as the nominal retail value, when combined with any other giveaways, does not exceed \$15 on a per person basis.
- Provide promotional items with plan names, logos, a toll-free customer service number, and/or website provided the aggregate retail value of the giveaways (including food items) does not exceed \$15 on a per person basis.
- Respond to questions asked at an educational event provided that the scope of the response does not go beyond the question asked and does not include the distribution or acceptance of enrollment applications and/or marketing materials.

Member-Only Educational Event

An educational event that targets members currently enrolled in a particular plan to promote the understanding and use of their plan benefits. The purpose may include presenting information on plan benefits or changes to the member’s plan for the upcoming year. In addition, it may provide an opportunity to strengthen the value of UnitedHealthcare and/or support member retention efforts. For member-only educational events, you must comply with all guidelines noted above in the Educational Activities or Event section and the following exceptions and guidelines:

Agents Must

- Target advertising only to existing plan members.
- Indicate that the event is for educational purposes only. Otherwise, the event will be considered as a marketing/sales event and should be reported and conducted as such.
- Report the event to UnitedHealthcare as Educational (refer to Event Reporting section in this guide).
- Follow all compliance guidelines pertaining to an educational event.

Agents Must Not

- Engage in any marketing/sales and enrollment activities. Note: When conducting a member-only educational event, distributing materials or discussing the plan benefits and costs for the plan in which the member is already enrolled is not considered a marketing activity.
- Market any plan to a non-member or discuss with a member any plan in which they are not currently enrolled.

Agents May

- Discuss plan-specific premiums and/or benefits, including Value-Added Items and Services (VAIS).
- Distribute plan-specific materials to members enrolled in the specific plan.

Section 6: How do I Conduct Educational and Marketing/Sales Activities?

Marketing/Sales Event

A marketing/sales activity or event is designed to steer, or attempt to steer, consumers towards a specific plan or a limited set of plans. Plan materials can only be distributed during eligible marketing periods and enrollment applications can only be collected during eligible election periods. Marketing and/or selling outside of eligible periods is prohibited and is subject to corrective and/or disciplinary action up to and including termination.

Events may be conducted in a variety of venues, but also include any kind of sales booth (e.g. table, kiosk, tabletop display, etc.) located in a specific location such as a retail store, provider office site, or healthcare facility. Events can be sponsored by the plan or another entity. A marketing/sales event is defined by the range of plan information provided to the consumer and the way in which the information is presented to the consumer. A Scope of Appointment form is not to be used at a formal or informal marketing/sales event as the scope of products to be discussed should be indicated on advertising materials for the event and announced at the beginning of formal marketing/sales events or consumer interaction at informal marketing/sales events. If a consumer requests a follow-up appointment, a Scope of Appointment must be obtained (see Scope of Appointment section for additional information).

The following are type of marketing/sales events:

Formal marketing/sales events are typically structured in an audience-presenter style where you formally provide specific plan sponsor information via a presentation on the products being offered. In this setting, you usually present to an audience that was previously invited to attend. As a presenting agent, you must be contracted, licensed, appointed (if applicable), certified, and complete the Events Basics training module with a minimum passing score of 85% within six attempts. These events must be reported to UnitedHealthcare.

Informal marketing/sales events are a less structured presentation and/or in a less formal environment. They typically utilize a booth, table, kiosk, and/or a recreational vehicle (RV) that is manned by an agent who can discuss the merits of the plan's products. Informal marketing/sales events are usually intended for a passer-by audience and agents cannot approach others in the informal marketing/sales events setting. These events must be reported to UnitedHealthcare.

Personal/Individual marketing appointments typically take place in the Medicare consumer's residence; however, they may take place in other venues such as a library or coffee shop. Personal/individual marketing appointments are considered marketing/sales events, but are not reported to the Centers for Medicare & Medicaid Services (CMS) as formal or informal marketing/sales events. Personal/individual marketing appointments require a Scope of Appointment (SOA) form. All SOA forms must be retained, including those for cancelled or rescheduled appointments, consumer no-shows, or appointments that do not result in a consumer enrollment, and made available upon request.

The following guidelines apply to all marketing/sales activities and events.

Agents must

- Be contracted, licensed, appointed (if applicable), and certified in order to represent UnitedHealthcare during any marketing/sales activity and/or event.
- Keep all consumer information secure (e.g., secure completed Scope of Appointment forms and enrollment applications to prevent disclosure of Protected Health and/or Personally Identifiable Information).
- Comply with permission to contact guidelines.
- Use only UnitedHealthcare and CMS approved scripts, sales presentations and marketing materials and ensure that all materials have the appropriate disclaimer.

Section 6: How do I Conduct Educational and Marketing/Sales Activities?

- Use and follow the materials provided by the plan to ensure that all required elements are covered.
- Specify where the Plan Star Ratings and Multi-Language Insert are located in the Enrollment Guide.
- Clearly explain the following during Special Needs Plans (SNP) presentations:
 - ~ Eligibility limitations (e.g., required special needs status).
 - ~ Special Election Period (SEP) to enroll in, change, or leave SNPs.
 - ~ Process for involuntary disenrollment if the member loses his/her SNP eligibility.
 - ~ A description of how drug coverage works with the plan.
- State that you may be compensated for enrollments.
- Provide or make available to all in attendance at all marketing/sales events and appointments, your agent contact information.
- Report all marketing/sales events (formal and informal) (see Event Reporting Section).
 - ~ Take and pass the Events Basics training module for the applicable plan year with a minimum passing score of 85% within six attempts, prior to reporting, conducting, and/or participating in a marketing/sales event. Note: Agents who only participate in the Multi-Carrier Program (to conduct informal sales events at Walmart in-store kiosks) are not required to complete the Events Basics module.
 - ~ Ensure all events, even those with no RSVP collection and/or not advertised, are open to the general public. Note: only events that request RSVP collection are viewable to Telesales agents to promote to the consumer and/or accept an RSVP. You are expected to inform venues that typically have a closed membership, such as Knights of Columbus or Elks Club, that any consumer that wants to attend the event must be permitted entrance to the venue.
 - ~ Conduct marketing/sales events in appropriate venues. Prohibited venues include gambling areas of casinos, for-profit bingo facilities, and areas where health care is provided (pharmacy counter, exam room, etc.). Discretion should be used when selecting a venue to ensure the reputation of UnitedHealthcare is not compromised.
- ~ Make a reasonable attempt to notify front desk staff/employees at the venue of the event, room number, and time of event so the staff can direct consumers appropriately. If allowed, post signage directing the consumer to the event location.
- ~ Post a disclaimer outlining non-discrimination requirements on the basis of race, color, national origin, sex, age or disability according to Section 1557 of the Affordable Care Act (ACA) at all events where UnitedHealthcare Medicare Advantage and Part D health plans are exclusively marketed and sold.
- ~ Include on all advertisements and invitations that are used to invite consumers to attend a group event with the possibility of enrolling those consumers the two required statements, “A sales person will be present with information and applications.” and “For accommodation of persons with special needs at sales meetings call <phone number and TTY number, and hours of operation>.” Such invitations must also clearly state all of the products that will be discussed during the event (e.g., HMO, PDP, SNP, and MA).
- ~ Include on all advertisements and explanatory materials promoting drawings, prizes, or any promise of a free gift that there is no obligation to enroll in the plan. For example, “Eligible for free drawing and prizes with no obligation.” or “Free drawing without obligation.” (See Gifts and Meals section for additional information.)
- ~ Announce at the beginning of the presentation the agent’s name and title, the company they represent, and the product/plan types that will be covered

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during the presentation (e.g., HMO, PFFS, PDP, SNP, MA, MA-PD, POS, and PPO).

- ~ Make available an Enrollment Guide for the plan presented to each consumer in attendance.

Agent Must Not

- Use prohibited statements or use superlatives (e.g., one of the best provider network, the largest health plan.). Make unsubstantiated statements (e.g., “UnitedHealthcare is the best” or “CMS recommends UnitedHealthcare”).
- Solicit or accept enrollment applications from individuals who are not eligible for a qualifying election period (e.g., Annual Election Period (AEP) or Special Election Period (SEP)) as set by CMS.
- Engage in discriminatory practices such as targeting/marketing to consumers from higher income areas or state and/or otherwise imply that plans are unavailable only to seniors and not all Medicare eligible consumers.
- Conduct health screening, including the completion of a Health Risk Assessment (HRA) or other like activities that could give the impression of “cherry picking” which is engaging in any practice that may reasonably be expected to have the effect of denying or discouraging enrollment of individuals whose medical condition or history indicates a need for substantial future medical services (e.g., blood pressure checks, cholesterol checks, blood work).
- Steer consumers to specific providers or provider groups, practitioners, or suppliers. You may provide the names and contact information of providers contracted with a particular plan when asked by a consumer.
- Discuss plan options that were not agreed to by the consumer in advance on the Scope of Appointment (SOA), sales event signage, or promotional notification.
- Market non-health related products (such as annuities or life insurance) while marketing a Medicare related product. This is considered cross-selling and is prohibited.
- Ask for or accept referrals (i.e. name and contact information) from a consumer or offer any incentives as an inducement for referrals.
- Compare one plan sponsor to another by name unless both plan sponsors have concurred.
- Provide any gifts to consumers that are associated with gambling and/or have the potential to result in a conversion to cash (e.g., lottery tickets, pull-tabs, meat raffles). This would include coupons that can be redeemed for meals or items that, in combination, would reasonably be considered a meal.
- For informal or formal marketing/sales events:
 - Require consumers to provide any contact information as a prerequisite for attending the event. This includes requiring an email address or any other contact information as a condition to RSVP for an event online or through postal mail. Any sign-in sheet or agent contact sheet must clearly indicate that providing contact information is optional.
 - Use an RSVP list at an event as a sign-in or attendance sheet. Information on an RSVP list must be protected and not visible to consumers attending an event.
 - Conduct an event at a venue when a free or subsidized meal is being served. If a meal is served as part of the venue’s daily activity, (e.g. senior center, cafeteria, soup kitchen, shelter), the event may not be conducted during the period starting one hour prior to serving time to one hour after serving time of the meal.
 - Provide meals to attendees. (See Gifts and Meals section for additional information.)
 - Conduct an event in any area of a healthcare facility where a patient receives or waits to receive care, including, but not limited to, waiting and examination rooms, pharmacy counters,

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- dialysis center treatment areas, and hospital patient rooms.
- Conduct an event in any location where the reputation of the agent or UnitedHealthcare could be compromised, such as at a casino in a location where gambling is being conducted. It is acceptable to hold an event in an area completely separate from gambling activities, such as a conference room.
- Conduct a marketing/sales event inside a location where a consumer pays an entrance fee to attend (e.g., a consumer is charged a gate fee at a health expo to gain access to a marketing/sales informal event).

Agent May

- Conduct marketing/sales activities and events in common areas of healthcare facilities, (e.g., conference rooms and recreation rooms).
- Provide a nominal gift and refreshments to attendees with no obligation. (See Gifts and Meals section for additional information)
- Distribute approved brochures and enrollment materials.
- Distribute approved business reply cards, lead cards, and sign-in sheets as long as all required disclaimers are included and the consumer understands that completing any of them is completely optional.
- Handout a compliant business cards.
- Discuss plan specific information (e.g., premiums, cost sharing, or benefits).
- Provide educational content.
- Formally present benefit information to the consumers using UnitedHealthcare and CMS approved materials.
- Accept and perform enrollments during a valid marketing and election period.
- Provide and obtain a Scope of Appointment (SOA) form for a subsequent personal/individual marketing appointment; if a consumer requests a one-on-one meeting.
- Market health care related products during marketing activity for Medicare Advantage

or Part D plans provided the consumer indicates their agreement on the Scope of Appointment. Examples of health care related products include medical, dental, prescription, and long-term care.

- For a formal event when only one consumer is present, offer to the consumer the option of conducting the event in a sit-down style, similar to a personal/individual marketing appointment, rather than in an audience-presenter format. However, you must still complete a full presentation of the reported plan.

Informal Marketing/Sales Event

Agents must be licensed, contracted, appointed (if applicable), and certified in order to staff an informal marketing/sales event. In addition to the previous guidelines, the following guidelines apply to informal marketing/sales activities.

Agents Must

- Post a visible notice, indicating the time of return, when leaving the event unattended for any reason (e.g., lunch break, assisting another consumer).
- Post the dates you will be onsite if recurring events utilizing a UnitedHealthcare-provided kiosk are scheduled.

Agents Must Not

- Conduct an event in such a way as to obstruct the consumer's entrance or exit from the venue or to give any impression that attending the event is a requirement to visiting the venue.
- Proactively approach consumers anywhere in the venue. Consumers must initiate contact with you. You may greet passersby (e.g., Good Morning, Hello).
- Move or relocate a kiosk/booth/table from the plan-designated location within the reported venue and/or position a kiosk/booth/table within 15 feet of a pharmacy counter.
- Leave the event unattended when time is advertised or when a sign indicates you will be available.

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Agents May

- Wait behind the booth/table for a consumer to request information.
- Answer questions about UnitedHealthcare plans and products.
- Distribute and collect enrollment applications.
- Provide refreshments if permitted by venue.
- Begin the event with a short introductory presentation conducted in an audience/presenter format, which must not include a plan presentation. The introductory presentation may include an agent introduction and/or Medicare, health care, and/or plan educational content and may be provided by the agent conducting the event or a non-licensed individual such as a provider (all rules related to provider-based activities apply).

UnitedHealthcare MedicareStore and Resource Centers

UnitedHealthcare MedicareStore

A UnitedHealthcare MedicareStore is a physical and more permanent UnitedHealthcare space, in a local market with a location for consumers and members to meet with UnitedHealthcare agents. Consumers can have questions answered, review new benefits, and/or enroll. Formal and/or informal marketing/sales events may take place at these venues.

UnitedHealthcare MedicareStore is managed by the Retail Operations and is considered a UnitedHealthcare office. In addition to all other regulations, rules, policies, and procedures related to marketing/sales activities, the following guidelines apply:

- Days and hours of operations as a UnitedHealthcare office must be reported in UnitedHealthcare's event reporting application. However, when operated as a UnitedHealthcare office, the activity is not considered a formal or informal marketing/sales event.
- You must obtain a Scope of Appointment (SOA) prior to discussing any Medicare

Advantage and/or Prescription Drug Plan with a consumer who visits the UnitedHealthcare MedicareStore.

- If a formal or informal marketing/sales event takes place within a UnitedHealthcare MedicareStore, all guidelines, regulations, rules, policies, and procedures related to marketing/sales events apply.
- Activities and promotions to drive visitors to the UnitedHealthcare MedicareStore must comply with all CMS and UnitedHealthcare regulations, rules, policies, and procedures (e.g., offering free hearing exams to increase store attendance is prohibited because offering a health screening during a marketing/sales activity is prohibited).

UnitedHealthcare Resource Center

A UnitedHealthcare Resource Center is also known as an enrollment center. A resource center is considered an informal marketing/sales event. All rules applicable to informal marketing/sales events, including event reporting apply to a resource center.

Internet-Based (Virtual) Marketing/Sales Events

Conducting marketing/sales events using internet-based virtual technology is limited to formal marketing/sales events. All virtual events and the corresponding presenting agents must be approved by UnitedHealthcare prior to event planning, reporting and advertising. All CMS guidelines and regulations and UnitedHealthcare rules, policies, and procedures related to conducting marketing/sales events apply, including event reporting and cancellation procedures and using plan-approved materials and presentations.

Internet-Based Technology and Electronic Devices to Conduct Non-Face-to-Face Marketing Appointments and Telephonic Presentations

You are permitted to use Skype, WebEx, FaceTime, and other video chat devices or applications to conduct personal/individual marketing appointments when a face-to-face

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appointment is not feasible or necessary to benefit the consumer. You are prohibited from using the consumer portal to enroll the consumer remotely and from enrolling a consumer who is not **physically present** in the United States as of the signature date on the enrollment application (See Consumer Enrollment and Disenrollment Request Process section). You must follow certain guidelines:

- Permission to Call (PTC) must have been previously established or documented with the consumer prior to contact. (Refer to Permission to Call section)
- Scope of Appointment (SOA) must be obtained prior to the start of the plan presentation.
- You must conduct a needs assessment in order to determine and present the best plan suited for the consumer and determine consumer eligibility.
- You must provide an Enrollment Guide via postal mail or email (if the consumer provides specific permission to email) for the plan that will be presented during the appointment.
- You may add your writing number to the enrollment application prior to mailing the Enrollment Guide to the consumer.
- Once the consumer has received the Enrollment Guide, you may contact the consumer (after establishing PTC) and a **complete** sales presentation of the plan must be provided.
- After the sales presentation, you may assist the consumer with the completion of the enrollment application and provide mailing instruction for sending the signed application to you.

Nominal Promotional Gifts and Meals

You may offer promotional gifts to consumers at all marketing/sales activities as long as the gifts are of nominal value and are provided to the consumer regardless if they choose to enroll or not. Nominal retail value is defined as an individual item/service worth \$15 or less (based on the retail value of the item).

The nominal value rule applies to gifts, rewards, incentives, and snacks. A nominal value requires that the following rules must be followed when providing gifts:

- Gifts must not be items or services that are considered a health benefit (e.g., a free checkup, health screening, hearing test, blood pressure checks, and cholesterol checks).
- Gifts must not be food items that in type or quantity, regardless of value, could reasonably be considered a meal.
- The nominal value of the promotional/free gift is determined by its retail value and the aggregate value of all gifts and food items and may not exceed \$15 per consumer or less with a maximum aggregate of \$50 per consumer, per year.
- If a nominal gift is one large gift that is enjoyed by all in attendance (i.e., a concert or play), the total retail cost must be \$15 or less when it is divided by the estimated attendance. For planning purposes, anticipated attendance may be used, but must be based on venue size, response rate, or advertisement circulation.
- Cash gifts of any dollar amount are prohibited and include any form such as gift cards (except gift cards allowed under an approved marketing promotion as noted below), gift certificates, or charitable contributions made on behalf of the consumer regardless of event type or venue. Gift card promotions are not permitted unless approved by Legal; Marketing, Sales, and Product Compliance; and the applicable Regional Vice President of Sales prior to implementation. Any gift card distributed as part of a marketing promotion must not be convertible to cash or redeemed for Medicare-covered items or services such as prescriptions. Any mechanism for collecting the consumer's contact information in order to process the request must not be used for lead generation and/or permission for contact purposes.
- If the gift is in the form of a prize, drawing, or raffle, the agent must submit their proposed giveaway request

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to compliance_questions@uhc.com to receive prior approval. All applicable disclaimers must be published and the drawing mechanism must not be such that the consumer is asked to provide personal contact information.

- You must provide any and all disclaimers if the gift is in the form of a prize, drawing, or raffle. For example:
 - “Eligible for a free drawing and prizes with no obligation.”
 - “Free drawing without obligation.”
- Additionally, the drawing or raffle mechanism must not require the consumer to provide personal contact information.
- Promotional items may include the plan names, logos, toll-free customer service numbers and/or websites.

Meals may not be provided or subsidized during a marketing/sales event or when any marketing/sales activity is performed, even if the meal is not sponsored by the plan and is a normal activity in that location (e.g., soup kitchen, senior center, cafeterias, food banks, nursing homes, and shelters). Meals may be provided at educational events, but the cost of the meal must comply with the nominal gift requirement.

- Providing alcoholic beverages at any event is prohibited
- You may provide light refreshments or snacks at marketing/sales events, as long as you are permitted by the venue, but cannot bundle them in a manner that would constitute a meal. The following are examples of snacks:
 - Fruit or raw vegetables
 - Pastries, cookies, or small dessert items
 - Cheese, chips, yogurt, or nuts
 - Crackers or muffins
- The aggregate nominal retail value of food items in combination with any other gift may not exceed \$15 per consumer.

You are allowed to provide refreshments and light snacks. You must use your best judgment on the appropriateness of food products provided and must ensure that items provided could not be reasonably considered a meal and/or that multiple

items are not being bundled and provided as a meal.

Meals may be provided at educational events, provided the event meets CMS strict definition of educational.

It is recommended that you maintain invoices of any give-aways so you can validate the cost versus retail value if you are ever asked to confirm the cost.

Provider-based Activity at a Marketing/Sales Activity or Event

The term “Provider” is a broad term that includes, but is not limited to any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier,) providing covered services and any organization, institution, or individual that provides health care services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of services covered. Providers represent their organization and are neither representatives of any plan nor may they endorse any plan.

Providers must remain neutral and cannot steer beneficiaries to enroll in a specific plan or provider group.

Providers at a marketing/sales event may:

- Provide general health information
- Refer to their affiliation with the plan, but should not provide additional information (e.g., why they contracted with the plan).
- Discuss their practice in generic, factual terms such as name, clinic affiliation, and areas of medical expertise as it relates to the topic being discussed.
- Display information about their practice, service, or product on tables for consumers to take. There must be a physical separation between provider material and plan material.

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- Provide contact information for a plan marketing representative (e.g. agent), as long as the provider is making similar opportunities available for all contacted carriers (e.g., list contact information for a plan marketing representative contracted with all carriers with which the provider is also contracted, or list contact information for multiple plan marketing representatives contracted with different carriers).

Providers at a marketing/sales event must not:

- Promote health plans or events.
- Distribute plan materials or assist with enrollment activities (including collecting enrollment applications).
- Speak to or answer questions related to UnitedHealthcare plans, plan benefits, or pricing.
- Provide any health screenings or tests.
- Sell products or offer demonstration devices that consumers can take with them.
- Discuss specific products/services or how the products/services relate to plan or plan benefits.
- Discuss plan pricing or plan premiums
- Actively promote their practice, service, or product (e.g., distribute business cards), but may passively promote their practice, service, or product by displaying material for a consumer to take.
- Use superlatives when discussing their practice or the plan.
- Directly accept compensation for attending events.
- Give any gifts or services to consumers.
- Accept appointments for future clinical services while a guest at an event.

Note: An Institutional Special Needs Plan (I-SNP) is permitted to offer plan information at the time of admission, due to the institutional nature of the plan.

Tribal Lands Marketing

Tribal land is sovereign. As the Bureau of Indian Affairs explains, “Tribal sovereignty ensures that any decisions about the tribes with regard to their property and citizens are made with their participation and consent. Tribes, therefore, possess the right to form their own governments; to make and enforce laws, both civil and criminal; to tax; to establish and determine membership (i.e., tribal citizenship); to license and regulate activities within their jurisdiction; to zone; and to exclude persons from tribal lands.” (Reference: <http://www.bia.gov/FAQs/index.htm>.)

Prior to conducting marketing/sales or educational activities on tribal land, you must:

- Familiarize yourself with the customs and instructions of the tribe as they pertain to such activities and
- Contact tribal elders to confirm custom and instructions, as well as to receive permission to market, sell, or conduct educational activities.

In addition, you must also adhere to all other applicable federal, state, and UnitedHealthcare rules, regulations, guidelines, and policies and procedures when marketing, selling, or conducting educational activities on tribal land.

Marketing in a State with a Medicare-Medicaid Plan (MMP)

An MMP is a Centers for Medicare & Medicaid Services (CMS) and state run test demonstration program where individuals receive both Medicare Parts A and B and full Medicaid benefits. Eligible MMP members are, generally, passively enrolled into the state’s coordinated care plan with the ability to opt-out and choose other Medicare options. MMPs are designed to manage and coordinate both Medicare and Medicaid and include Part D prescription drug coverage through one single health plan, MMP demonstrations and eligible populations vary by state.

- As of May 20 2015, twelve states have a signed Memorandum of Understanding

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(MOU) with CMS establishing parameters of state demonstrations and they include: California, Colorado, Illinois, Massachusetts, Michigan, Minnesota, New York, Ohio, South Carolina, Texas, Virginia, and Washington. Eligibility and marketing requirements for MMPs vary by state. Requirements of MMP programs are determined jointly by CMS and the applicable state. You are responsible for ensuring that you are aware of state marketing requirements and should obtain that information through individual state MMP websites or through your agent manager. UnitedHealthcare is a participating carrier in Ohio and Texas (see sections below). In states where an MMP is available, regardless if UnitedHealthcare is a participating carrier, you must comply with the following guidelines:

- ~ You **must not** disparage an MMP, the state Medicaid program, or Medicare when marketing to consumers or inappropriately influence the consumer/member's decision-making process to opt out of the MMP.
- ~ You must refer consumers/members who want to opt out of the MMP to the state Medicaid consumer information center. Note: It is best practice to refer consumer/members with MMP-related questions to the state Medicaid consumer information center, however they may contact CMS.
- ~ Specific marketing rules apply when a Medicaid consumer resides in an area where an MMP exists. You must be aware if an MMP is available and if UnitedHealthcare is participating in the MMP.
- Ohio "MyCareOhio" MMP (effective May 2014)
UnitedHealthcare participates in MyCareOhio, Ohio's MMP, in Columbiana, Cuyahoga, Geauga, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit, Trumbull, and Wayne counties. If you encounter a Medicaid-eligible consumer who resides in

one of the counties where UnitedHealthcare is a participating MMP carrier, you must determine if the consumer is enrolled in or is pending enrollment in an MMP offered by UnitedHealthcare by executing the following procedures:

- ~ You must contact the Producer Help Desk (PHD) (1-888-381-8581 ext. 1, ext. 3) to verify the consumer's MMP enrollment status.
- ~ If the consumer is enrolled or has a pending enrollment in a UnitedHealthcare MMP, you must not conduct an appointment or discuss other Medicare Advantage options (including SNPs) until the consumer has been contacted by the UnitedHealthcare Members Matter team. The PHD will forward a referral containing your email address and consumer information to the UnitedHealthcare Members Matter team and document your contact in a Producer Contact Log (PCL) Service Request (SR). The Members Matter team will indicate the outcome of their interaction with the consumer in a secure email to you. The email will advise you if you may resume contact with the consumer to conduct marketing activities. If the Members Matter team resolves the concern or issue that motivated the consumer to consider plan options other than the MMP, the consumer will be invited to rescind the agent marketing activity. You must not contact a consumer who rescinds their marketing request. (Upon consumer request, the Members Matter representative may transfer the consumer to Telesales.)
- ~ In a state where UnitedHealthcare participates in a MMP, UnitedHealthcare may analyze agent-assisted enrollments in any UnitedHealthcare plan, including Medicare Advantage, SNP, or Prescription Drug Plan, to determine proper agent procedures. Agents who do not follow the procedures outlines in this guide may be subject to disciplinary action.

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- Texas “STAR+PLUS MMP” (effective March 2015)
STAR+PLUS MMP is available in the following counties: Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant.
UnitedHealthcare is only participating in Harris County.
 - ~ In general, a consumer must meet all of the following criteria to be eligible to be enrolled in the MMP:
 - Reside in one of the counties where STAR+PLUS MMP is available.
 - Have attained age 21 or older.
 - Are eligible for or enrolled in Medicare and receive full STAR+PLUS Medicaid benefits.
 - Do not have third-party insurance (other than Medicare and Medicaid).
 - ~ When marketing a Medicare Advantage plan, including a Dual SNP, to a “STAR+PLUS MMP” eligible consumer, you must support the efforts of Texas to enroll eligible consumers and must not:
 - Disparage the MMP program or make material misrepresentations about the program’s possible impact on MA and/or PDP members.
 - Interfere with the state enrollment process.
 - Inappropriately promote/retain membership in an MA plan if that is not the best plan for the consumer.
 - Call current MMP members to promote other Medicare plan types.
 - ~ You must direct consumers with MMP enrollment questions to the STAR+PLUS MMP help line at 1-877-782-6440 or to the Texas Health and Human Services website.
 - All events, educational or marketing/sales, formal or informal must be reported to UnitedHealthcare event reporting application prior to advertising, and no less than 14 calendar days prior to the date of the event.
 - You should submit a completed Event Request Form (available on *Jarvis*), no less than 21 calendar days in advance of the event in order to meet the 14 calendar day reporting requirement.
 - The completed Event Request Form can be submitted to UnitedHealthcare’s event reporting application directly from the Event Request Form or can be saved and sent to the UnitedHealthcare local market for entry.
 - Each informal marketing/sales event (e.g., kiosk, booth) shift must be reported separately with a start and end time.
 - The agent who will conduct the event (i.e., presenting agent) must be identified and listed as the Presenter on the Event Request Form.
 - Agents who report an event within 14 calendar days of the date of the event without an approved exception (see Exception to Event Reporting section) are subject to corrective and/or disciplinary action up to and including termination. It is non-compliant to conduct unreported events.
 - All events are subject to surveillance and evaluation by UnitedHealthcare, CMS, and/or AARP.
- * Sales events reported by Market Point for the Multi-Carrier Program presented by Medicare Advantage products must be submitted to UnitedHealthcare in accordance with the requirements outlined in the “Multi-Carrier Program – Sales Event Submission and Reporting” agreement.

Event Reporting

Reporting New Events*

All educational or marketing/sales events, formal and informal, must be reported.

Exception to Event Reporting

Events must be reported according to the guidelines outlines above. The following process is available when extenuating circumstances require a new event to be reported via the Event Request Form within 14 calendar days of the desired event date.

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- An exception request must be initiated by or on behalf of the agent and submitted to the regional Senior Vice President (SVP) for approval.
- After the SVP approval is given, the request must be submitted via email to AgentOversightAdmin@uhc.com with the completed Event Request Form.
- The exception request and event details are forwarded to the Director of Agent Oversight and the submitter is notified of the approval/disapproval.
- Approved events are forwarded to the PHD for entry into UnitedHealthcare's event reporting application.

Request for American Sign Language (ASL) Interpreter

Request an ASL interpreter on behalf of a consumer.

- Upon reasonable request by a consumer, an ASL interpreter will be provided at a formal marketing/sales event or in-person personal/individual marketing appointment at no charge to the consumer.
- Consumer requests for an ASL interpreter must be entered into bConnected 14 or more calendar days prior to the formal marketing/sales event or in-person marketing appointment.
- Agents without access to bConnected or agents that have requests within 14 calendar days of the event or appointment must submit an American Sign Language Interpreter Request Form via email to the Producer Help Desk at PHD@uhc.com.
- Telesales agents will request an interpreter through ASL Services, Inc. (a national vendor used to conduct interpreter services) when confirming the consumer's RSVP hard-set appointment to a formal marketing/sales event.
- Within three business days after the request has been made, ASL services, Inc. will contact the agent to confirm the interpreter request and event/appointment logistics.
- To cancel an interpreter request, the agents with bConnected access must close the

contact in bConnected. Agents without access to bConnected must contact the PHD to cancel the appointment

- Cancellations with less than three business day's notice will be billable for the scheduled/appointment or a two-hour minimum.
- Using a third party individual who is not an employee of the UnitedHealth Group or an approved ASL interpreter vendor is prohibited.

Making Changes to a Reported Event

- Changes to a reported event must be entered in UnitedHealthcare's event reporting application no less than three business days prior to the previously scheduled date of the event.
- Changes may include updates, corrections, and cancellations (see following section on requirements to cancel a reported event).
 - ~ A change to venue location, date, and/or start time of an event is considered a **cancellation** and requires cancellation of the event and entry of a new event (reporting timeframe rules would apply).
- You must submit an Event Request Form to UnitedHealthcare no less than eight business days prior to the date of the event to meet the three business day reporting requirement.
- If the three business day requirement cannot be met, you must immediately contact your agent manager or supervisor to discuss any required actions.
- Agents who fail to report changes to an event or report changes late are subject to corrective and/or disciplinary action up to and including termination.

Cancellation of a Marketing/Sales Event

Every effort should be made to avoid cancelling a reported event. If possible, another qualified agent should be utilized to conduct the event. Cancelling an event within three business days of the scheduled start time is prohibited except in the case of inclement weather. In such cases, the agent

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is expected to exercise appropriate discretion when deciding a course of action.

Event Cancellation Process

- A change to the venue, date, and/or start time of an event is considered a cancellation and all cancellation requirements apply.
- You must submit an Event Request Form to UnitedHealthcare no less than eight business days prior to the date of the event to meet the three business day reporting requirement.
- If the three business day requirement cannot be met, the agent must immediately contact their agent manager or supervisor to discuss required action(s).
- The agent manager/supervisor is responsible for ensuring any necessary cancellations are made to reported events upon termination of an agent.
- Agents who fail to cancel an event or report cancellations late are subject to corrective and/or disciplinary action up to and including termination.
- Event cancellation due to inclement weather or other circumstances outside of the agent's control (e.g. venue will not allow the agent to be present) must be approved by the regional Senior Vice President and the following process completed:
 - ~ You must submit an email request to AgentOversightAdmin@uhc.com and must include the completed *Event Request Form*.
 - ~ The email request will be forwarded to PHD to cancel the event in bConnected.
 - ~ After cancellation in bConnected, you will be notified.

Event Change/Cancellation Notification Requirements

Consumer notification of a changed/cancelled marketing/sales event should be made, whenever possible, more than seven calendar days prior to the originally scheduled date and time. The following items describe the agent's requirements depending upon the length of time between the date/time of cancellation and the date/time of the originally scheduled event. Changes requiring

consumer notification do not include change of presenting agent:

- You are responsible for ensuring notification to all consumers that RSVP to an event that has been cancelled (or the venue, date, or time changed). Only consumers who provided Permission to Call (PTC) can be contacted by telephone.
- If the event has been advertised by any means, you are responsible for communicating the change/cancellation of the event through the same means. For example, if the event was advertised through a newspaper advertisement, the change/cancellation must also be advertised through the same newspaper. If it is not feasible to advertise the change/cancellation through the same means, you are responsible for working with your manager/supervisor on appropriate notification, within reason.
- All steps taken to notify consumers must be documented (noting date, time, and method of notification). All cancellation notification documentation must be made available upon request.
- If the change/cancellation is reported to UnitedHealthcare within seven days of the original schedule date, a representative of the plan must be at the venue at the scheduled start time. The representative must remain at the venue of a formal marketing/sales event for at least thirty minutes after the scheduled start time to advise anyone arriving for the event of the change/cancellation and redirect him or her to another meeting in the area or provide a sales agent's business card. For informal events, a representative must remain for the entire scheduled time of the event. **Note:** This requirement does not apply in cases of cancellation due to inclement weather; however, the agent must attempt to notify the venue and request a sign/notice be posted.
- If the change/cancellation is reported and RSVPs have been notified more than seven calendar days from the original date of the event, then there is no expectation that a

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representative of the plan should be present at the site of the event.

If the cancellation is due to inclement weather, arrange with the venue to post signage indicating cancellation.

Marketing to Consumers with Impairments or Disabilities

UnitedHealthcare is devoted to serving our consumers with integrity and sensitivity. You are responsible for ensuring that all regulations, policies, and/or procedures are complied with when conducting marketing activities with any consumer with a linguistic barrier and/or disability.

You must be aware of and sensitive to the needs that might reasonably be expected within the Medicare eligible population. Upon request or becoming aware of a situation requiring special accommodations, you must take appropriate actions based on the consumer's linguistic barrier or disability (e.g., obtaining language translation services or rescheduling an appointment to ensure the consumer's authorized representative is present). If, during an appointment with a consumer, you become aware of and are unable to accommodate the consumer's needs, you must politely excuse yourself and request to reschedule the appointment in order to be prepared to meet the needs of the consumer with appropriate accommodation and/or materials.

You must 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.

You may not target consumers from higher income areas or state/imply that plans are only available to seniors rather than to all Medicare beneficiaries. Only Special Needs Plans (SNP)

and Medicare – Medicaid Plans (MMP) may limit enrollments to consumers meeting eligibility requirements based on health and/or other status. Basic services and information must be made available to consumers with disabilities, upon request.

Consumers with Linguistic Barriers

In accordance with the Centers for Medicare & Medicaid Services (CMS) and UnitedHealthcare policies, the UnitedHealthcare Marketing Department and Regulatory Affairs Department will review the demographic data for each geographic area (county) in which a Medicare Advantage (MA) plan is offered and determine the primary language(s) of the area. If the primary language of five percent or more of the Medicare consumer population of the geographic area is a language other than English, the required materials for enrolling consumers and renewing members (e.g., Summary of Benefits, enrollment application (including Statement of Understanding), Evidence of Coverage (EOC), Annual Notice of Change (ANOC), Star Ratings, the comprehensive or abridged Formulary, Provider Directory and Pharmacy Directory) will be translated into the identified language. After approval of the English versions, the translated materials will be submitted to CMS for approval.

In addition, UnitedHealthcare provides information regarding the availability of interpreter services in the Multi-Language Insert with the Summary of Benefits and the ANOC/EOC. The Multi-Language Insert instructs members how to obtain free interpret services and it is translated into multiple languages.

Written Materials (Medicare Advantage Plans)

- If UnitedHealthcare is required to provide enrolling consumers and renewing member's materials in an alternate language for an identified geographic area, approved materials in the non-English language will be available for order and/or download in the same location as the English version (e.g., *Jarvis*).

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- To request the development of custom, non-English materials or the translation of approved materials into a non-English language, you must submit a request to your agent manager for approval from the Sales Regional Vice President.

Translation / Interpreter Services

When a consumer speaks a language other than English and is having difficulty understanding or maintaining a conversation in English and you are not conversant in the non-English language, you should utilize one of the following resources:

- The consumer may be accompanied by an individual, of their choosing, who can translate/interpret for the information and/or materials. You should make sure the individual assisting the consumer is capable and competent, which generally means the individual is an adult and is capable of translating the appropriate meaning of content from English to the non-English language and vice versa. For example, a relative such as an adult child.
- Non-bilingual field agents may:
 - ~ Direct the consumer to the multi-language insert to obtain no-cost interpreter service through the UnitedHealthcare Telesales call center.
 - ~ Refer the consumer to a bi-lingual field agent contracted with UnitedHealthcare. Note: Permission to Contact (PTC) rules apply.
 - ~ The agent may, through the assistance of their agent manager, enlist the assistance of a bilingual UnitedHealthcare employee. Agents are permitted to use bilingual employees of the same agency or up-line or an interpreter services vendor contracted by their agency/up-line. Agents are prohibited from using individuals who are not employees of UnitedHealthcare (or, for EDC agents, their agency/up-line) or a contracted vendor.
 - ~ During a phone conversation or at a personal/individual marketing appointment, access translation services

through UnitedHealthcare's Internal Interpretation Services.

- Dial 1-877-530-9750 (24 hours per day, seven days per week)
- Select the appropriate prompt based on the desired language; and/or
- If routed to Language Line Solutions (Teleperformance), enter access code based on channel and select appropriate prompt based on the desired language
 - Non-employee agents – 9 digit region code
 - West – 016614377
 - Central – 026614377
 - Northeast – 036614377
 - Southeast – 046614377

If the consumer prefers to communicate in a language other than English, the agent should ensure the consumer's preference is indicated in the appropriate field on the enrollment application.

Consumers with Disabilities

Upon request, basic plan information must be made available in alternate forms to consumers with disabilities, such as visual or hearing impairments. To ensure compliance and sensitivity, you must abide by the following policies.

An agent who encounters a hearing impaired consumer:

- Member Services makes available a TDD/TTY line to respond to marketing and membership questions from hearing impaired individuals. The TDD/TTY telephone number will be listed on advertising materials and the enrollment application per CMS requirements.
- May provide the enrollment guide to enable the consumer to read the materials.
- May allow the consumer to be accompanied by an individual of their choosing, who can translate/interpret the information and/or materials. For example, a relative such as an adult child.

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- If the consumer has an Authorized Representative/Power of Attorney (POA), the agent may provide the enrollment guide directly to the consumer's Authorized Representative/POA for review and enrollment purposes.
- May request an American Sign Language Interpreter (ASL) Interpreter (See Request for American Sign Language (ASL) Interpreter section).

Vision Impaired:

An agent who encounters a visually impaired consumer may:

- Read the complete enrollment guide verbatim to the consumer.
- Allow the consumer to be accompanied by an individual, of the consumer's choosing, who can read/interpret the information and/or materials. For example, a relative such as an adult child.
- If the consumer has an Authorized Representative/POA, provide a complete enrollment guide to the consumer's Authorized Representative/POA for review and enrollment purposes.
- Direct the consumer to Customer Service to request enrollment and benefits information in an alternative format. The requested material is provided at no charge to the consumer.

Physically Impaired:

You must select event sites that are accessible to a physically impaired individual. Accessibility features include appropriate parking, restroom facilities, doorways, ramps, and elevators. Upon reasonable request, you must provide a wheelchair to a disabled individual at a formal marketing/sales event to provide an opportunity for the individual to attend the event. If the facility selected is not handicap accessible, the event must be rescheduled or cancelled until a handicap accessible location is found. You should choose a site that is Americans with Disabilities Act compliant. The following are accessibility features to consider when selecting a site:

- Ramps and/or elevators as an alternative to stairs.

- Handrails along stairways and/or ramps.
- Appropriate lighting and noise levels.
- Appropriate seating options (e.g., not just booths or stools, include stand-alone chairs and tables).
- Handicap or senior parking near entrances.
- Doors that open automatically or a resource available to welcome and assist the consumer.
- Restrooms which include handicap stall options.
- Walkways, entrances, and hallways that are clear and dry.
- Appropriate clearance in aisles and between rows for wheelchair clearance.

Cognitively Impaired:

If there is any question about the consumer's cognitive ability, the agent should work with the consumer's Power of Attorney (POA), authorized representative, or responsible party. You should be aware that cognitively impaired consumers may live independently or within a residential facility. If the consumer has an authorized representative/POA, you should reschedule the appointment for a time when the consumer's authorized representative/POA can be present.

Permission to Contact (PTC)

Overview

Permission to Contact (PTC) is permission given by the consumer to be called or otherwise contacted by a representative of UnitedHealthcare for the purpose of marketing a UnitedHealthcare Medicare Solutions product, including any Medicare Advantage, Prescription Drug Plan, or Medicare supplement insurance product.

- PTC must be provided by the individual requesting contact and cannot be given on behalf of another individual (e.g., a husband cannot grant permission on behalf of his wife as each spouse must provide individual PTC).
- PTC is limited in scope to the products identified in the PTC mechanism (e.g., business reply card (BRC)).

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- PTC is considered short-term, method-specific, event-specific, and may not be treated as open-ended permission for future contacts.
- PTC expires once contact is made or 90 days after receipt by the company for consumers requesting information on a Medicare Supplement insurance product or who are on the federal Do-Not-Call Registry or nine months after receipt for a Medicare Advantage and Prescription Drug Plan, whichever comes first. A new PTC must be obtained prior to contacting the consumer in the future.
- PTC must be documented (in bConnected if available to the agent) and must be retained and available to UnitedHealthcare upon request for the remainder of the selling year plus ten additional years.

Unsolicited Contact

Unsolicited contact with a consumer is prohibited. Unsolicited is direct contact with a consumer that was neither requested nor initiated by the consumer. Permission to Call (PTC) must be secured prior to making contact with the consumer and renewed in order to make on-going contact.

- Unsolicited contact includes in-person (e.g. door-to-door marketing), telephonic (e.g. outbound telemarketing), electronic (e.g., email, leaving voicemail messages, and text messages) solicitation.
- Postal mail and other print media (e.g., advertisements, direct mail) are not considered unsolicited contact.

In the absence of document PTC, the following are examples of prohibited unsolicited contact:

- Approaching a consumer in a common area such as a parking lot, hallway, lobby, or sidewalk.
- Depositing marketing materials (e.g., flyer, door hanger, leaflet) outside a residence, under a door to a residence, on a vehicle, or similar. The Centers for Medicare and Medicaid Services (CMS) does permit leaving materials at a consumer's residence when you had a properly scheduled

personal/individual marketing appointment and obtained Scope of Appointment (SOA) agreement, but the consumer was a no show.

- Telephoning, texting, or emailing a consumer whose contact information was not compliantly obtained.
- Contact via telephone, text, or email with a consumer who attended a marketing/sales or educational activity/event or to whom marketing material was mailed, even if the consumer requested the item, unless the consumer gave permission for a follow-up contact and the PTC was documented.
- Using contact information in bConnected for a consumer with whom you do not have a relationship, unless UnitedHealthcare has delegated PTC and authorized an outbound call as part of a marketing campaign.
- Using contact information provided by UnitedHealthcare to market non-UnitedHealthcare Medicare Solutions products, including non-health related products.
- Engaging in any "bait-and-switch" tactics (i.e., marketing a product that does not require PTC in order to convert the marketing effort to a product that does require PTC). For example, marketing a non-UnitedHealthcare Medicare Solutions Medicare Supplement Insurance product through cold calling, text, email, or door-to-door and then converting the marketing effort to any UnitedHealthcare Medicare Solutions product, including UnitedHealthcare Medicare Supplement Insurance plans.
- Engage in "warm-transfers" to or from an individual that is not credentialed to offer a specific UnitedHealthcare Medicare Solutions product. For example, a disability attorney warm transferring a consumer to an agent that offers Dual Special Needs Plans (DSNP). Another example, a Medicare Supplement Insurance agent warm transfers a consumer to an agent who offers Prescription Drug Plans (PDP).
- Contact a former member who voluntarily disenrolled or a current member in the process of voluntarily disenrolling to market

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a product or plan or to dissuade them from disenrolling to retain their membership. In addition, an agent must not ask a disenrolling member for PTC to market plans in the future. Note: plan sponsors are permitted to contact their former members after the disenrollment effective date to conduct disenrollment surveys for quality improvement purposes, or if former members have been involuntarily disenrolled to resolve eligibility issues.

Acceptable Contact

PTC must be obtained prior to making direct contact with the consumer in-person or by telephone, email, voicemail, or text. PTC must be renewed in order to make on-going direct contact and is always limited to the method of contact permitted (i.e., permission to email), scope of products, and time frame contained within the permission. Agents must comply, to the extent applicable, with the National Do-Not-Call Registry and abide by federal and state calling hours.

When PTC is documented, you may:

- Telephone a consumer who requested a call* (e.g., inbound call request made through a plan customer service representative).
- Contact a consumer who submitted a compliant Business Reply Card* (BRC). Telephonic contact is prohibited if the consumer did not provide a telephone number or the telephone number provided is invalid.
- Contact a consumer who submitted an online contact form*. Telephonic contact is prohibited if the consumer did not provide a telephone number or the telephone number provided is invalid.
- Follow up with a consumer who requested an Enrollment Guide* either in-person at a marketing/sales event, online, telephonically, or by BRC (Note: PTC must be obtained at the time the guide was requested).
- Contact your current clients from another business relationship with whom you have a current, active contract or business

relationship in other products (i.e., the consumer is a current in-force life, homeowners, or dental insurance policy client of the agent). You should be prepared to provide proof that the consumer was a current client at the time you contacted them to market a UnitedHealthcare Medicare Solutions product.

~ If you are in the process of establishing a new relationship, PTC must be obtained and documented.

* Contact is always limited to the product identified in the PTC.

Delegation of PTC occurs when UnitedHealthcare provides the member's contact information (i.e., telephone and phone number) to an agent.

- UnitedHealthcare (i.e., the plan sponsor) may contact any existing UnitedHealthcare member, who meets the criteria listed below. An agent, who is not the Agent of Record (AOR), may only call an existing member in one of the categories below if PTC has been delegated to the agent by UnitedHealthcare. The agent may only use the member's Protected Health or Personally Identifiable Information (PHI/PII) to the extent necessary to conduct business on behalf of UnitedHealthcare. Any other use of PHI/PII obtained through delegated PTC is prohibited.

~ An aging-in Commercial member

~ A Medicare Advantage (MA) or Prescription Drug Plan (PDP) member to discuss other MA or PDP products plan benefits or to inform them of general plan information.

~ A current Medicare supplement insurance plan member to discuss MA or PDP products plan benefits or to inform them of general plan information.

~ Medicaid/MMP members enrolled in a UnitedHealthcare product

Lead Generation

Overview

You are responsible for ensuring any lead obtained meets all compliance regulations, including leads obtained from or provided by your up-line, prior to acting on the lead to market any UnitedHealthcare Medicare Solutions product.

Actionable Lead

A lead is the name and contact information of a consumer who might be contacted to market UnitedHealthcare Medicare Solutions products. To be considered actionable, the lead must be obtained through means compliant with CMS regulations and UnitedHealthcare rules, policies, and procedures. Specifically, PTC has been obtained through compliant methods and has been documented.

Lead Validation

Prior to use, you must validate that the lead was obtained through compliant means. You must document or obtain documentation that confirms that the lead source has qualified the lead(s) to ensure that the consumer, whose contact information has been provided, proactively requested contact for the purpose of marketing Medicare insurance products. Only compliantly-obtained leads may be acted upon through direct methods of contact. Agent assisted enrollments that result from the use of non-compliant leads may result in corrective and/or disciplinary action for you and/or their up-line.

Compliant means include:

- Consumer submitted a compliant BRC (paper or electronic) or lead card that indicated a valid telephone number or email address and included scope of products. Only EDC agents receiving leads from their up-line should request documentation from their up-line that attests that the leads were obtained compliantly and are actionable.
- Consumer placed an inbound call or text, email, or voice message requesting a return call to discuss Medicare insurance products.

- The consumer is your current client by virtue of having a current, active contract or business relationship in another product.

Non-compliant means include, but are not limited to:

- You receive the consumer's telephone number or email address from an individual other than consumer. For example, a provider gives a list of patients to an agent or a client gives their neighbor's contact information to the agent.
- Using other sources to look-up a telephone number or email address if the contact information provided is not accurate or in-service.
- You obtain contact information received compliantly for another product line or business, but use it to market Medicare insurance products. For example, an agent is also a financial planner and uses non-client contact information obtained through their financial planning business for marketing Medicare insurance products.

Lead Retention Requirements

- BRC or lead cards must be retained and available to UnitedHealthcare upon request for the remainder of the selling year plus ten additional years.

Lead Referral Programs

UnitedHealthcare Sponsored Program

- UnitedHealthcare does not currently sponsor a lead referral program.

AARP Medicare Supplement Program

- A weekly referral campaign designed to pass lead information (prospects requested information on AARP Medicare Supplement) to bConnected for agent follow-up. Note: Only available in select states.

Agent Initiated Programs

- You may choose to use a third party lead generating option, but are responsible for ensuring the leads are obtained compliantly,

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within compensation limits, do not violate any applicable fraud and abuse laws, including the federal anti-kickback statute, and are compliant with any and all applicable state and federal regulations. All PTC guidelines apply if designing and/or conducting an outbound call campaign using a purchased or otherwise obtained lead list. In the absence of documented PTC for a consumer on a lead list, only postal mail can be used to market any UnitedHealthcare Medicare Solutions product to the consumer.

Compensation in Exchange for Lead

- You are not permitted to provide any gift (i.e., cash, gift card) to a consumer/member in exchange for a referral (i.e., contact information including name and telephone number/email).
- You must comply with CMS regulations related to compensation limits, commission splitting, and/or payments to non-licensed/appointed agents.
- UnitedHealthcare recommends you consult with local legal counsel to determine the compliance of any compensation arrangements they make with referrers.

Community and State Medicaid Leads for Calling Campaign

On a monthly basis, member Medicaid contact lists are provided to Medicare & Retirement Sales Directors by Community & State Regional Directors for call campaigns. Sales Directors are responsible for the compliant execution of any Medicaid call campaigns in their market. Should the Sales Directors entrust the call campaigns to an Agent Manager within their hierarchy, they must also be aware of and abide by the following guidelines:

- Call campaigns may only occur in a UnitedHealthcare facility/office location as the control and security of the leads are critical.
- All call campaigns must be proctored and monitored by an Agent Manager or Sales Director during the call campaign (i.e. call

blitz). Proper coaching and talking points for the agents are the responsibility of the market Sales Director. Agents must not be allowed to stay late or be left alone to make calls without a local sales leader present at all times.

- The member contact lead lists contain Personally Identifiable Information (“PII”) and Protected Health Information (“PHI”) and must not be transmitted via email or any other medium to non-employees of UnitedHealthcare.
- Permission to contact the Medicaid leads expires the last day of the month the leads were obtained. Once expired, leads must not be used for any purpose, including closed/lost campaigns in bConnected.
- Medicaid lead data shared with agents participating in call campaigns may include only the minimum personal member information needed to conduct the campaigns (e.g., name, address, telephone, and HIC number to verify Medicaid level of eligibility). Any additional data must be deleted prior to agent distribution.
- Only agents that have an active current bConnected account may participate in call campaign activity. The agent must commit to the utilization of bConnected to report both successful and unsuccessful attempts in converting a lead to an appointment or follow-up activity.
- Leads that result in an appointment or other follow-up activity must be entered into the agent’s bConnected account within 24 hours and follow-up activity will be managed through bConnected from that point.
- Lead lists must not be copied, scanned, photographed, photocopied, or allowed to be used in any other format than what was provided by the sales leader proctoring and monitoring the calls. Lead lists must not leave the building and must be returned to the Agent Manager or Sales Director upon completion of the call campaign.
- Paper leads may be provided to participating agents in attendance at the call campaigns, however, must then be destroyed by inserting them in secured and approved

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shredding receptacles upon completion of the call campaign.

- The sales leader proctoring and monitoring the call campaign must be able to provide an accurate accounting and tracking of all leads and outcomes at any point during the campaign. In addition, the sales leader is responsible for securing and destroying the paper leads upon completion of the campaign.

Local Market Outbound Calling Campaigns

The purpose of a local calling campaign (i.e. call blitz) is to re-warm leads, for sales market to increase applications, make appointments, and to build an agent's pipeline through targeted calls. The strategy may be modified according to market changes/opportunities that arise. The following guidelines apply:

- Call campaigns must take place in a controlled non-public facility/office location through the coordination of local sales leaders with appropriate measures taken to secure privacy of both member and UnitedHealthcare information (e.g., acceptable site is an agency setting; unacceptable site is a coffee shop or restaurant).
- A call campaign leader, generally an agent manager or Sales Director, must be identified and present during the entire outbound call campaign timeframe. Your call activity must be monitored and coached immediately when necessary. You are not allowed to stay late or to be left alone without a local sales leader present at all times.
- The member contact lead lists contain Personally Identifiable Information (PII) and Protected Health Information (PHI) and must not be transmitted via email or any other medium to non-employees of UnitedHealthcare.
- Lead lists must only include minimum required information to conduct the call campaigns and must be properly labeled and numbered (e.g., name, address,

telephone, and HIC number to verify Medicaid level of eligibility). Any additional data must be deleted prior to agent distribution.

- Paper lead lists provided to participating agents must not be copied, scanned, photographed, photocopied, or allowed to be used in any other format than what was provided by the sales leader. Lead lists must not leave UnitedHealthcare possession or the location of the call campaign and must be returned to the agent manager or Sales Director upon completion of the calling session.
- You must have access to bConnected to participate in a call campaign unless approved by the Sales Director. Agents must use bConnected to record lead and contact activity (e.g., scheduling a home appointment). Upon completion of the calling campaign, all lead and contact activity must have been recorded in bConnected
- PTC status must be affirmed in bConnected criteria with a PTC status of Yes (Y). Consumers that have revoked or changed their PTC must be filtered from the call campaign with contact status updates made to bConnected.
- The paper lead lists must be immediately and securely destroyed (i.e., approved shredding receptacles) once the calling campaign is completed and activity record in bConnected.
- You must not market any other products while calling on behalf of UnitedHealthcare Medicare Solutions.
- The sales leader or delegate (e.g., sales support coordinator) will manually track performance and communicate results of the calling campaign to the Regional Vice President, Regional Operations Director, and to the Sales Director.

Lead Collection Stations

Lead boxes and/or collection stations must comply with all CMS regulations and UnitedHealthcare rules, policies, and procedures related to obtaining

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PTC, contacting consumers, use of marketing materials, and marketing/sales activities. The following guidelines apply to the use of lead collection boxes and/or collection stations:

- The lead box or collection station must be secured in such a manner as to prevent the unauthorized access and use of any consumer's contact information. The collection box must be locked and either integrated in a fixture or attached to a fixture in such a manner that prevents unauthorized removal of the box and/or its contents.
- Permission from the venue must be obtained prior to placing a lead card box or collection station in any location.
- Rules pertaining to marketing materials in provider locations apply (e.g., stations cannot be placed where consumer receive care or wait to receive care).
- Only UnitedHealthcare and/or CMS approved lead cards and marketing materials are permitted.
- Information provided on lead cards must be considered private and must only be used for the purpose intended.
- Providers must not steer consumers to the lead box or collection station.
- Providers must not handle in any manner the leads collected (e.g., empty lead box, forward leads to the agent).
- You must check on an empty lead box or collection station no less than weekly.
- You must immediately report to UnitedHealthcare any suspected or known breach or theft of the lead box, collection station, and/or individual lead cards.

Provider-Based Activities

A provider includes, but is not limited to physicians, staff, hospitals, nursing homes, pharmacies, and vendors contracted with the Plan to provide services to plan members and sub-contractors.

Providers must remain neutral parties in assisting plan sponsors with marketing to consumers or assisting with enrollment decisions. Providers may

not be fully aware of all plan benefits and costs, which could result in consumers not receiving all required information to make an informed decision about their health care options.

Providers may:

- State the names of all of the plans with which they contract and/or participate.
- Assist their patients who are applying for Low Income Subsidy (LIS) assistance.
- Make available and/or distribute plan marketing materials (not including Enrollment Guide) in non-patient care areas, including plan affiliation materials for a subset of contacted plans as long as providers offer the option of making available and/or distributing marketing materials from all plans in which they participate.
- Refer their patients to other sources of information, such as State Health Insurance and Assistance Programs (SHIPs), plan marketing representatives, State Medicaid Office, local Social Security Office, and CMS.

Providers must not:

- Offer or accept Scope of Appointment (SOA) forms, Business Reply Cards (BRC), or lead cards
- Call an agent on behalf of a consumer
- Distribute or accept enrollment applications for Medicare Advantage/Medicare Advantage-Prescription Drug plans or Prescription Drug Plans.
- Make phone calls, direct, urge, or attempt to persuade consumers to enroll in a specific plan based on financial or any other interest of the provider.
- Mail marketing materials on behalf of a plan or agent.
- Offer anything of value to induce consumers/members to select them as their provider.
- Offer inducements to persuade consumers to enroll in a particular plan or with a particular plan sponsor
- Conduct health screenings as a marketing activity

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- Accept compensation directly or indirectly from the plan or agent for conducting consumer enrollment activities.
- Identify, provide names, or share information about existing patients with the plan or agent for marketing/sales purposes.
- Distribute marketing materials, including agent business cards, within an exam room setting.
- Steer or attempt to steer a consumer/member toward a particular agent or agency unless the agent/agency is appointed with all of the provider's affiliated carriers.

Providers must remain neutral parties in assisting plan sponsors with marketing to consumers or assisting with enrollment decisions.

You must not steer or attempt to steer a consumer/member toward a particular provider, or limited number of providers, offered by either the plan sponsor or another plan sponsor, based on the financial interest of the provider and/or agent.

Social Media Lead Generation

You must not use the social media platform's interactive functionality as a means to communicate with consumers and or/members. You are prohibited from posting any plan or benefit information or displaying branded marketing materials on a social media platform.

Scope of Appointment

Scope of Appointment – Personal/Individual Marketing Appointment Initiated by Agent

The scope of products that may be presented at a personal/individual marketing appointment (i.e. one-on-one plan presentation whether in-person or telephonic, pre-scheduled or spontaneous, and regardless of the venue) when Medicare Advantage and/or Prescription Drug Plan products might be discussed must be agreed to by each Medicare-eligible consumer present prior to the start of the appointment. The agreement is referred

to as Scope of Appointment and must include any Medicare-related product, such as Medicare Advantage, Part D, and Medicare Supplement, and/or any other health-related product, such as dental, vision, and hospital indemnity, that the consumer agrees may be presented at the appointment. Except for consumer convenience, the Scope of Appointment must be obtained at least 48 hours prior to the appointment.

When a Scope of Appointment is received within 48 hours of the appointment, the reason for not receiving it 48 hours or more before the appointment must be documented. The Scope of Appointment may be obtained using a form. The completed Scope of Appointment is valid until the appointment is held or until the end of the applicable selling season. Note: a Scope of Appointment form is not to be used at marketing/sales events as the scope of products to be discussed should be indicated on advertising materials for the event and announced at the beginning of formal marketing/sales events or consumer interaction at informal marketing/sales events.

You must advise and get an agreement from the consumer, including current members, of the Medicare Advantage (MA) and/or Prescription Drug Plan (PDP) products that will be discussed during a scheduled personal/individual marketing appointment.

A SOA is required for personal/individual sales appointments where you intend to present MA and/or PDP products. The completed SOA is required to be obtained 48 hours prior to the appointment. A SOA may be sent to a consumer via postal mail, fax, or email (permission to email must be obtained and documented). Situations that require a completed SOA include but are not limited to:

- A completed SOA form is required for any personal/individual marketing appointment for any MA and/or PDP plan.
- A completed SOA form is required from each attending Medicare-eligible consumer.

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- ~ If your appointment is with a husband and wife, you must obtain a SOA form from both consumers.
- A new SOA form is required for any and all subsequent face-to-face personal/individual marketing appointments; even to discuss previously discussed products.
- If setting a future or second appointment, you must fill in all required fields on an approved SOA form, identify all products that might be discussed with the consumer at the future appointment, and secure the consumer's agreement to discuss the identified products.
 - ~ Send the consumer the SOA form to the consumer for signature and receive it back from the consumer prior to the appointment.
 - ~ The future or second appointment cannot occur within 48 hours of the initial appointment.
- In certain circumstances, an exception can be made when obtaining the consumer's signature in advance of the meeting is not feasible you may secure the consumer's signature in-person immediately prior to the start of the appointment and indicate on the form the reason why the signature could not be obtained in advance.

Scope of Appointment (SOA) Form

You must obtain a completed and signed Scope of Appointment form from each Medicare-eligible consumer present at a telephonic or in-person one-on-one plan presentation of a Medicare Advantage and/or Prescription Drug Plan product.

- You must use a UnitedHealthcare, CMS-approved Scope of Appointment form for the current contract year available in Enrollment Guides and on the *Jarvis*. External Distribution Channel agents may use the generic Scope of Appointment form and coversheet also available on *Jarvis*.
- The Scope of Appointment form may be transmitted to the consumer for signature via postal mail, fax, or, email, if consumer permission to email is received and documented.

Scope of Appointment (SOA) - Consumer-Initiated Situations

There are situations that allow and require the agent to complete a SOA form and secure the consumer's signature immediately prior to discussing any products. The agent must note on the form the particular situation (e.g. walk-in). Situations in which the 48 hour waiting period is waived and the SOA form must be signed before the meeting may begin include:

- A consumer walk-in to an agent office or UnitedHealthcare MedicareStore.
- A consumer makes an unscheduled, inbound telephone call or the agent is responding to a consumer's request to be called that results in a plan presentation.
- An unexpected Medicare eligible consumer is in attendance at an otherwise properly solicited, scheduled, and documented appointment.
- The **consumer requests** the presentation of previously unidentified and agreed upon Medicare Advantage or Part D product, at an otherwise properly solicited, scheduled, and documented appointment.
- The consumer requests an individual meeting following a marketing/sales event presentation that is held at another location and/or at a different time.

Scope of Appointment (SOA) Expiration

- A SOA is valid until used or until the end of the applicable election period. For example, on October 1 you schedule an appointment for October 16 and mail a SOA to the consumer. The consumer signs the SOA and you receive it back on October 8. On October 15, the consumer calls and reschedules the appointment for October 17. On October 17, you and the consumer meet. The SOA sent out October 1 and received October 8 is valid for the October 17 appointment.
- A SOA must not be confused with PTC. The SOA does not give you permission to contact the consumer after the meeting. PTC should

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be renewed with the consumer with every contact. In addition, a SOA may be enclosed in a direct mail campaign (in the same envelope), but the PTC would need to be documented and established separately.

Scope of Appointment (SOA) Form Submission and Retention Requirements

All SOA forms must be retained, including those for cancelled or rescheduled appointments, consumer no-shows, or appointments that do not result in a consumer enrollment, and made available upon request by CMS or compliance areas of the company. It is your responsibility to submit the SOA forms for electronic storage in UnitedHealthcare's centralized document management system.

Submission Requirements

The following guidelines apply to the submission of SOA forms:

- SOA forms must be faxed (866-994-9659) within 2 business days following the appointment. **Do not** submit the SOA form with an enrollment application or submit a hardcopy.
- The SOA form may be a multi-page document. **All** pages must be submitted.
- Forms from more than one appointment and/or consumer can be combined in a single fax. However, if an office manager/sales coordinator is submitting forms on behalf of several agents, each agent's forms must be sent in a separate fax.
- EDC agents using the generic SOA form must include the corresponding cover sheet.

Featured Guidance: Scope of Appointment (SOA) forms should not be submitted with enrollment applications. Submitting a SOA form to an enrollment center may cause delays in enrollment processing and creates additional work.



Retention Requirements

In addition to submitting SOA forms for electronic storage in a centralized document management system, the Plan and you are required to retain and store a copy of the SOA forms for a minimum of ten years from the date of the appointment. You must be able to provide a SOA within 48 hours of request by the Plan or CMS.

48 Hour Cooling Off Period

Scope of Appointment (SOA) cooling off period:

At an appointment, you are not to discuss, leave enrollment documentation, or conduct marketing activity related to a healthcare product not previously identified and agreed upon by the consumer at the time the appointment was originally scheduled.

If, however, the **consumer requests** the presentation of previously unidentified and agreed upon products, you must secure a new SOA and then can proceed with the discussion. If during an appointment **you determine** that a MA or PDP outside of the original SOA may be a better fit, the following would apply:

- A future appointment may be scheduled to discuss the newly identified healthcare related product as long as the new appointment is no less than 48 hours in the future from the present appointment. A new SOA will need to be immediately obtained for the future appointment.
- A new SOA form must be completed, signed by the consumer, and submitted for the future appointment scheduled to discuss the newly identified healthcare related product.
- An Enrollment Guide may be left with the consumer. No discussion or related marketing activity may be conducted.

Product Cross-Selling

Marketing and/or selling non-healthcare related products during marketing activity related to Medicare Advantage, Part D, or Medicare

Section 6: How do I Conduct Educational and Marketing/Sales Activities?

Supplement Insurance is strictly prohibited. Discussion of non-healthcare related products initiated by a consumer at a personal/individual marketing appointment requires a separate appointment at least 48 hours later (but would not need a Scope of Appointment form).

Telephonic Presentation

You must obtain a Scope of Appointment (SOA) form from the consumer prior to telephonically presenting a Medicare Advantage (MA) or Prescription Drug Plan (PDP).

Only UnitedHealthcare approved and authorized call centers can conduct telephonic enrollments and must meet scripting, compliance, and other requirements. However, you may conduct a telephonic sales presentation and complete an enrollment with the consumer via postal mail.

While face-to-face appointments are recommended, a telephonic sales presentation may be conducted by a field agent. The following are details surrounding a telephonic sales presentation. Please remember that a Telephonic Sales Presentation is not a Telephonic Enrollment and should only be used in situations that benefit the consumer. A field agent cannot conduct a telephonic enrollment. However, if a face-to-face appointment is not feasible, a field agent may conduct a telephonic sales presentation (but must follow certain guidelines):

- Permission to call must have been previously established and documented or the consumer must call you directly.
- You should conduct a needs assessment, in order to determine the plan best suited for the consumer, and review Medicare eligibility to enroll.
- You should then proceed to mail out the enrollment guide that he/she will review during the telephonic sales presentation. You are encouraged to also mail the “Clarity Workbook” as well.
- You may **only** add your writing number to the Enrollment Application when mailing out the enrollment guide to the consumer.

- Once the consumer has received the enrollment guide, you must conduct a complete sales presentation, which can be done telephonically (agent should have permission to call if calling the consumer). You are encouraged to also incorporate the “Clarity Workbook” into the sales presentation.
- You **may then** assist the consumer with the completion of the Enrollment Application and give instructions for mailing the application back to you.

Medicare Marketing Guidelines

Medicare Marketing Guidelines

The 2017 Medicare Marketing Guidelines are posted at

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

The Medicare Marketing Guideline may be updated at any time by the Centers for Medicare and Medicaid Services (CMS).

Frequently Asked Questions

For the latest Compliance guidance and for copies of published Focus News, please refer to the [Agent Communication section of the “Knowledge Center” tab on Jarvis](#).

Compliance Questions

Contact for questions regarding marketing or for access to Medicare marketing guidelines; for privacy, security or fraud, waste and abuse issues; or for ethics-related questions.

Compliance_Questions@uhc.com

Section 7: How do I take an Enrollment Application?

Enrollment Methods

Election Periods

Enrollment Process – Medicare Advantage and Prescription Drug Plans

Enrollment Process – AARP Medicare Supplement Insurance Plans

Pre-Enrollment Verification Process

Post-Enrollment Consumer Experience for Medicare Advantage Plans

General Medicare Advantage and Prescription Drug Plan Enrollment Application Elements

Medicare Advantage and Prescription Drug Plan Enrollment Application Cancellation, Withdrawal, or Disenrollment Requests for CMS Regulated Plans

Customer Service Resources

Section 7: How do I take an Enrollment Application?

Enrollment Methods

Enrollment applications cannot be solicited or accepted outside of a valid election period. Marketing and/or selling outside of eligible periods is prohibited and subject to corrective and/or disciplinary action up to and including termination. You must be contracted, licensed, appointed (if applicable) in the state in which the consumer resides, and you and non-licensed representatives must be certified in the product in which the consumer is enrolling at the time the enrollment application is completed.

An enrollment application should be completed only after you have thoroughly explained to the consumer the plan benefits and rules, confirmed eligibility, disclosed agent and product specific information and disclaimers (e.g., Star Rating), and the consumer has agreed to proceed with the enrollment.

A non-licensed representative is prohibited from engaging in any activity that is considered selling, marketing, or steering. For example, the non-licensed representative is permitted to give factual information about a plan, such as the monthly plan premium, but is not permitted to recommend a particular plan based on the needs of the consumer or as a result of any question the consumer asks.

All paper enrollment applications must be submitted via fax or overnight delivery to UnitedHealthcare within 24 hours of receipt. The enrollment application is considered in receipt the date you take receipt and sign the enrollment application. NMA/FMO offices using eModel Office should process a paper enrollment application the same day it is received from the agent whenever possible, but no later than 24 hours after receipt. Medicare Advantage (MA) and Prescription Drug Plan (PDP) enrollment application received by the enrollment center more than three calendar days after the agent's signature are considered a late application and you may be subject to disciplinary action.

Enrollment applications received by Enrollment more than three calendar days (sixteen days for AARP Medicare Supplement) after your signature will be considered a late enrollment application and you may be subject to disciplinary action. (Effective 12/16/16)

Electronic Enrollment

UnitedHealthcare offers several options for you to submit enrollment applications electronically. Submitting enrollment applications electronically allows for quicker processing time, reduction in errors and paperwork, and faster commission payments. There are two types of electronic enrollment tools available based on the product lines:

- UnitedHealthcare® LEAN™ - Medicare Advantage (MA) Plans, Medicare Advantage with Prescription Drug (MA-PD), and Prescription Drug Plans (PDP)
- Online Enrollment for AARP® Medicare Supplement Plans - AARP® Medicare Supplement Insurance Plans, insured by UnitedHealthcare

Section 7: How do I take an Enrollment Application?

UnitedHealthcare® LEAN™

LEAN (Landmark Electronic Application Navigator) is the electronic enrollment tool for UnitedHealthcare Medicare Solutions enrollments. LEAN was designed to simplify the enrollment application for agents as well as provide tools and guardrails to enable an easy and compliant enrollment. LEAN is now available for licensed sales agent.

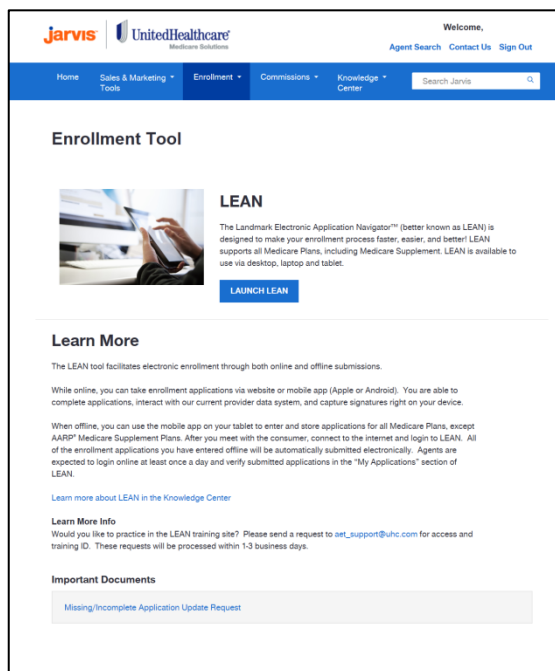
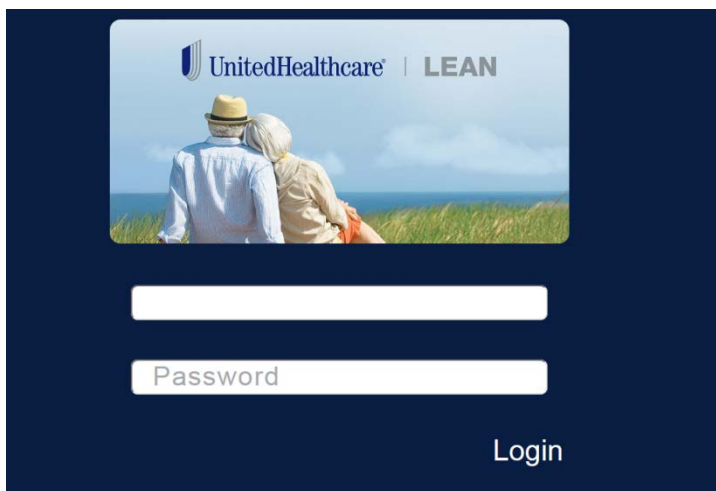
LEAN is compatible with all modern browsers and operating systems and is available as a website and a Mobile App in both the Apple App Store and Google Play. Please refer to the **Enrollment Tool section under the “Enrollment” tab on Jarvis** for more information on LEAN, including instructional information and training. Trainings are also available on the National Training Calendar. Any technical support questions for LEAN can be directed to the PHD.

LEAN is a free app to download, the only requirements are to use a compatible device an internet connection, and an active Agent Writing ID (for compatibility information please see full documentation on **Jarvis**). The login information for LEAN is the same login as **Jarvis** (Login = Writing ID and Password = **Jarvis** Password).

LEAN can be used to electronically enroll consumers in a broad range of plans including all UnitedHealthcare Medicare Solutions Medicare Advantage (MA) Plans, Medicare Advantage with Prescription Drug (MA-PD) Plans and Prescription Drug Plans (PDP), but cannot be used to enroll consumers into AARP Medicare Supplement Insurance Plans.

LEAN has been updated and now functions offline on tablets. Mobile app users need to visit the App Store (Apple) or Google Play (Android) and search for LEAN to re-download and reinstall. As part of this update, previous versions of the LEAN app are no longer supported. Agents who use the website version of LEAN are not affected. Additionally, any applications saved in "My Applications" are still visible. Before using LEAN offline for the first time, you must log in to LEAN while online. LEAN will authenticate your log-in for later offline use.

- Access LEAN on Jarvis



- LEAN login home page

Section 7: How do I take an Enrollment Application?

Online Enrollment for AARP Medicare Supplement Insurance Plans

UnitedHealthcare is pleased to introduce an online enrollment application for AARP Medicare Supplement Insurance Plans. This online enrollment application will help improve processing time, avoid errors, and enroll consumers quicker – allowing you to avoid delays of commission payments.

The AARP Medicare Supplement online enrollment application is available via **LEAN**.

You can search plan selection using zip code in the Plan Search under the “Sales & Marketing Tools” tab on **Jarvis**.

The AARP Medicare Supplement online enrollment application is currently available in most states except MN and WI. The tool requires that the consumer sign up for EFT for a minimum of one monthly premium payment. If the online enrollment application is not available for your state or if a consumer does not want to complete the EFT form, please submit a paper enrollment application. Paper enrollment kits can be ordered from the Sales Materials Portal on **Jarvis**.

Traditional Paper Method

An electronic method of enrollment application submission should be utilized whenever possible to maximize efficiency and reduce error rates and processing time. Paper enrollment applications should only be submitted when absolutely necessary.

You may be paid a lower new-business commission if a new business enrollment application is submitted through the paper enrollment process when an electronic method is available.

If the paper method is absolutely necessary, there are three ways to submit a paper enrollment application once the hard copy is received. Choose only one of the following submission options:

- Regular Mail – to address on enrollment application
- Overnight – to address on enrollment application

- Fax – to the number provided to you in your sales materials

Paper enrollment applications for AARP Medicare Supplement Insurance Plans can be submitted via regular mail or overnight delivery using the pre-addressed enrollment application envelope contained within the Enrollment Guide (UnitedHealthcare Insurance Co., PO Box 105331, Atlanta, GA 30348-9534).

All enrollment applications must be submitted promptly to UnitedHealthcare. Enrollment applications received by Enrollment more than three calendar days (sixteen days for AARP Medicare Supplement) after your signature will be considered a late enrollment application and you may be subject to disciplinary action. (Effective 12/16/16)

Enrollment Application Retention

As the plan sponsor, UnitedHealthcare is required by the Centers for Medicare and Medicaid Services (CMS) to retain copies of enrollment applications for 10 years. Once you have validated UnitedHealthcare has received and processed the paper enrollment application, you are permitted to securely dispose of the application. Prior to validation of receipt, you must securely retain the enrollment application.

Disposal and Storage of Enrollment Applications

For agents and agencies, it is strongly recommended that all paper enrollment applications be disposed of securely (e.g., shredded), after confirmation that the enrollment application has been received by UnitedHealthcare. Generally, disposal can occur approximately 3 weeks after submission to UnitedHealthcare. Verify receipt of the paper enrollment application by referring to your commission statement or by validating enrollment status on **Jarvis**. If you choose to retain a paper enrollment application, do so in a secure manner to ensure the protection of the consumer/member’s Protected Health Information (PHI) and Personal Identifying Information (PII).

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UnitedHealthcare Public Website

A web-based enrollment is a *consumer* initiated and effectuated electronic enrollment method using the internet. UnitedHealthcare's public websites and enrollment tools are for consumer use only and are not electronic methods for agent use. A web-based enrollment can only be conducted via the plan's

Website www.UHC Medicare Solutions.com.

- Agents are prohibited from completing the web enrollment on behalf of the consumer or at the consumer's request. However, an agent may be on the telephone in order to assist the consumer with a web enrollment.
- Agents **must not** be physically present with the consumer when a consumer is completing a web-based enrollment and must not engage in any screen sharing with the consumer through an internet connection (e.g., the consumer gives the agent control of the consumer's computer to complete a web enrollment via WebEx) unless agreed to by the Vice President of Operational Support and Forecasting and the Compliance Officer.
- Completing a web enrollment through the web-based enrollment tool on behalf of a consumer may be considered fraud.
- To receive credit for a web-based enrollment, the agent is responsible for conducting a thorough needs analysis, presenting all aspects of the plan, providing the consumer with their writing number, and instructing the consumer to go to the enrollment landing page to begin the enrollment process. For UnitedHealthcare-branded products the agent must direct the consumer to www.MyMedicareEnroll.com. If the consumer enters the agent's writing number into the enrollment form, it signifies that the agent assisted in the enrollment and is responsible for any complaints, rapid disenrollments, and other compliance issues related to the enrollment.
- UnitedHealthcare is not responsible for any issues related to incomplete or inaccurate agent identification information entered during the consumer portal enrollment process. Failure to input the correct agent

identification number cannot be reversed after the enrollment form has been submitted for processing whether by agent or consumer error.

- Consequences resulting from inappropriate agent use of the web-based enrollment methods include, but are not limited to, corrective and/or disciplinary action up to and including termination.

Appropriate times that an agent may encourage a Web-based enrollment may include:

- Consumer Readiness – when you have conducted an in-person presentation, but the consumer was not ready to enroll at that time.
- Time Constraints – when it is not feasible for the consumer to meet face-to-face with you or for the consumer to mail in a paper enrollment application.
- Other Factors – other instances where time, distance, or consumer preference prevents the consumer and the agent from meeting face-to-face to complete an enrollment.

Force Majeure Resilience Program

A force majeure event means an act of God, riot, civil disorder, or any other similar event beyond the reasonable control of the field sales channels, if a field sales channel does not cause the event, directly or indirectly. A force majeure event affects travel and a field agent's ability to meet with a consumer for a prescheduled marketing/sales event or appointment, which has the potential to affect a field agent and/or consumer's ability to submit a Medicare Advantage or Prescription Drug Plan enrollment application by the Annual Enrollment Period (AEP) deadline.

Agent Notification and Approved Alternative Resources

If you reside and work in the impacted business market(s), you will be notified by your local sales leadership that if, because of the force majeure event, you are unable to meet in-person with a

Section 7: How do I take an Enrollment Application?

consumer as previously scheduled, you are allowed to use the following approved alternative resources for meeting with and enrolling the consumer.

- You must notify the consumer that due to the force majeure event the previously scheduled marketing/sales event or appointment is canceled. **You must have documented permission to call in order to call the consumer.** Refer to the Permission to Contact and Lead Generation Activities section for details related to permission to call. If you are cancelling a reported event, you must follow all cancellation requirements. Refer to the Educational and Marketing/Sales Activities and Events section for details related to event reporting and cancellation.
- For consumers interested in enrolling, you must conduct a needs assessment with the consumer in order to determine and present the best plan suited for the consumer and determine consumer eligibility.
- If the consumer requests to enroll in a UnitedHealthcare Medicare Solutions product, you must provide the consumer with the following enrollment method options:

~ **Consumer Portal**

You can direct the consumer to use the Consumer Portal (www.MyMedicareEnroll.com) to enroll in a plan. You can provide the consumer with your name and agent ID and instruct the consumer to enter it in the application, so that you are recognized as Agent of Record. Refer to the UnitedHealthcare Public Website section for additional information on web enrollments. This option is not available for all plan types/brands.

~ **Paper Enrollment Application**

You can assist the consumer in completing a paper enrollment application if the consumer has an Enrollment Guide (hard copy or PDF) for the plan in which the consumer is enrolling.

- You should direct the consumer to enter your agent ID in the applicable field. Note: You must not enter your name and/or signature on the paper enrollment application prior to receipt of the paper application from the consumer. If the consumer submits the paper application directly to the company, the agent ID alone is acceptable.
- You must advise the consumer that you or UnitedHealthcare must receive the AEP enrollment application on or before December 7.

~ **UnitedHealthcare Telesales**

You can direct the consumer to enroll via a UnitedHealthcare Telesales agent by dialing 855-877-3045. To facilitate a successful hand-off, you must:

- Provide your agent ID to the consumer to provide to the Telesales agent. Note: If the consumer does not provide a field agent ID to the Telesales agent, a sales reporting process will be used to send the commissions team the required information (showing the telephonic enrollments process as part of this policy) to make the appropriate AOR matches and adjustments.
- Explain that the Telesales process will likely take between 45 and 90 minutes to complete.
- Remind the consumer of the AEP deadline.
- Inform the consumer that Telesales phone lines may experience some delay due to the AEP deadline.

Commissions and Incentive Considerations

- Commissions will use the AOR (on file), the agent's agent ID, and the agent's contact information to reinstate the field agent's commission for all impacted consumers. (Refer to the compensation section for details related to non-employee agent commission eligibility and payment.)
- The AOR will be changed in April of the following year and a new commission will

Section 7: How do I take an Enrollment Application?

be paid if the agent meets eligibility requirements for the member's new plan.

- You must service the member in order to receive a commission/incentive.

UnitedHealthcare reserves the right to remove you as the AOR and to discontinue paying you commissions if it is determined that you are not servicing the member.

Election Periods

You must determine if the consumer is enrolling during a valid election period and indicate the election period on the enrollment application and reason code, if applicable.

Election Periods Available to Medicare Consumers

There are specified election periods available for Medicare eligible consumers. The election periods include an Annual Election Period (AEP), Medicare Advantage Disenrollment Period (MADP), an Initial Coverage Election Period (ICEP), Initial Election Period (IEP), or a Special Election Period (SEP) based on specific eligibility criteria. Note: Medicare Supplement products are not restricted to the Centers for Medicare & Medicaid Services (CMS) election periods and may be enrolled throughout the year.

Annual Election Period (AEP)

AEP, which runs from October 15 through December 7, enables consumers to change or add Prescription Drug Plans (PDPs), change Medicare Advantage plans, return to Original Medicare, or enroll in a Medicare Advantage plan for the first time even if they did not enroll during their Initial Election Period.

Medicare Advantage Disenrollment Period (MADP)

MADP, which occurs January 1 through February 14, gives consumers an annual opportunity to disenroll from their Medicare Advantage plan and return to Original Medicare. Regardless of whether the Medicare Advantage plan included Part D drug coverage, consumers using the MADP to disenroll from their plan are eligible for a

coordinating Part D SEP which allows them to enroll in a PDP during the same timeframe.

Initial Coverage Election Period (ICEP) and Initial Election 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 is due to turning 65 or by becoming eligible due to a qualifying disability. Eligible consumers can enroll into a Medicare Advantage Plan (MA) of their choosing, including a Medicare Advantage Prescription Drug Plan (MAPD). Those already enrolled into Medicare due to disability have a second IEP upon turning 65. Note: based upon specific eligibility criteria and election choices, ICEP and IEP may occur together or may occur separately.

Special Election Period (SEP)

A SEP allows consumers to make an election change in accordance with applicable requirements anytime during the year, including during the period outside of the OEP. The SEPs vary in the qualifications to use them as well as the types of elections allowed. Situations such as dual-eligible status and institutionalization provide the ability to switch plans at any time during the year. All SEPs are determined and announced by CMS.

5-Star Special Election Period (SEP)

The 5-Star SEP is an election period available to consumers/members that allows them to enroll in a 5-Star rated plan. Consumers/members can use the 5-Star SEP to enroll in a 5-Star plan one time during the benefit year when changing from a plan that does not have a 5-Star rating. Consumers/members can only join a 5-Star Medicare Advantage (MA) plan if one is available in their area.

Consumers/members may lose their prescription drug coverage if they move from a MA plan that has drug coverage to a MA plan that does not. Consumers/members will have to wait until the next open enrollment period to obtain drug coverage and consumers may have to pay a Late Enrollment Penalty (LEP).

Enrollment Process – Medicare Advantage and Prescription Drug Plans

The enrollment application should be completed only after you have thoroughly explained to the consumer the plan benefits and rules, confirmed eligibility, disclosed agent and product specific disclaimers, and the consumer agrees to proceed with enrollment.

Incomplete, incorrect, or illegible enrollment applications delay or prevent processing and may result in membership in an incorrect plan and/or the inability to pay the agent commission for the sale.

General Consumer Eligibility

At the time of enrollment, you must explain to the consumer that eligibility requirements must be met in order to enroll:

- Valid Election Period: You must determine if the consumer has a valid election period and indicate the election period on the enrollment application and reason code, if applicable.
- Medicare Part A and/or Part B: You must indicate the consumer's Medicare number and entitled to Medicare Part A and Part B effective dates on the enrollment application. The consumer must be entitled to Medicare Part A and/or enrolled in Part B as required for the plan or plans in which the consumer is enrolling.
- Service Area: You must confirm the consumer currently resides in the plan's service area, based on the consumer's permanent address on file with Medicare.
 - ~ You are prohibited from enrolling a consumer who is not physically present in the United States as of the signature date on the enrollment application. You should direct consumers who are out of the country to UnitedHealthcare's Telesales call center or the public website to complete an enrollment application. Consumers must be advised that in most cases, Medicare and UnitedHealthcare will not pay for health care or supplies obtained outside of the United States. Medicare drug plans do not cover prescription drugs bought outside of the United States.
 - ~ In the case of homeless consumers, a post office box, the address of a shelter or clinic, or the address where the consumer receives mail (e.g., Social Security check) may be considered the place of permanent residence.

Verification and Documentation of Special Needs Eligibility

At the time of enrollment, you must explain to the consumer enrolling in a Special Needs Plans (SNP) that certain eligibility requirements must be met in order to enroll and explain the applicable disenrollment process if eligibility cannot be verified and/or if the consumer loses eligibility once enrolled.

- Chronic Special Needs Plan (CSNP) Qualifying Condition Verification
In addition to meeting the Medicare requirement identified above, consumers must have at least one of the qualifying conditions covered under the specific CSNP. You must:
 - ~ Complete a review of the CSNP and determine the consumer's eligibility.
 - ~ Enroll only those consumers who have at least one qualifying condition.
 - ~ Explain to the consumer that:
 - UnitedHealthcare verifies qualifying chronic conditions on a post-enrollment basis, meaning the consumer will be enrolled if all conditions of enrollment are met except the verification of a qualifying condition.

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- UnitedHealthcare will attempt to verify the qualifying chronic condition with the consumer's physician for up to two months after the plan effective date.
- If attempts to confirm the member's eligibility are unsuccessful, initial and final notice letters of involuntary termination will be sent to the member with notification to you.
- The member will be terminated after the second month of enrollment if a qualifying condition cannot be verified. However, the member will remain enrolled in the plan if verification is obtained at any time within the first two months of enrollment.
- ~ Submit completed Chronic Condition Pre-Assessment and Chronic Condition Release of Information forms with the enrollment application.
- **Dual Special Needs Plan Medicaid Status Verification**

Specific verification and documentation requirements must be met to enroll a consumer in a Dual SNP. In addition to meeting the Medicare requirement identified above, consumers must also have Medicaid (may be identified differently depending upon the state) to enroll in a Dual SNP. You must:

 - ~ Complete a review of the Dual SNP and determine the consumer's eligibility.
 - ~ Enroll only those consumers who have the appropriate level (e.g., full or partial) of Medicaid based on the specific Dual SNP. Eligibility may vary by plan; therefore, you must refer to plan documents to ensure plan eligibility and that the consumer cost sharing level makes the plan suitable for the consumer. You may validate Medicaid status at the point-of-sale by contacting the Producer Help Desk during normal hours of operation. Telesales agents must follow established processes when conducting Medicaid status validation.
 - ~ Include the consumer's Medicaid number (from their Medicaid card) appropriately on the enrollment application.
 - ~ Explain to the consumer that if their Medicaid status is not verified at the time of enrollment, the consumer will not be enrolled into the plan and if they lose their Medicaid status after enrollment, they will be involuntarily disenrolled.
- **Enrollment of Consumers Residing in a Medicare and Medicaid Plan (MMP) Area**

An MMP is a Centers for Medicare & Medicaid Services (CMS) and state run test demonstration program where individuals receive Medicare Parts A and B and full Medicaid benefits and are, generally, passively enrolled into the state's coordinated care plan with the ability to opt-out and choose other Medicare options. Designed to manage and coordinate both Medicare and Medicaid and include Part D prescription drug coverage through one single health plan, MMP demonstrations and eligible populations vary by state.

 - ~ States (or an enrollment broker with whom the state contracts) administer the MMP enrollment process, disenrollments, cancellations, and opting-out of passive enrollment.
 - ~ Agent-assisted enrollment of a consumer in a UnitedHealthcare Medicare Solutions plan must only occur after referring to applicable marketing guidelines noted in this guide and complying with federal and state regulations and UnitedHealthcare rules, policies and procedures. (Refer to the Educational and Marketing/Sales Activities and Events section for marketing guidelines applicable to MMP programs.)
- **Institutional/Institutional Equivalent Special Needs Plan Eligibility Verification**
 - ~ **Institutional Special Needs Plan (ISNP)**

A consumer must reside in a contracted Skilled Nursing Facility (SNF) for at least ninety days, or is likely to stay in the contracted SNF for a minimum of ninety days based on the consumer's Minimum Data Set (MDS) assignment, in order to enroll in an Institutional SNP. Note: Effective 05/01/2016, if the consumer has not resided in the contracted SNF for at least ninety days at the time the enrollment application is taken, to serve as confirmation of eligibility, the agent must obtain and submit a copy of the applicable pages of the MDS assessment (Sections A0100

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through A1100 and Q0300 through Q0400) or an approved letter of confirmation from the SNF on the organization's letterhead signed by one of the following: Nursing Home Administrator, MDS Coordinator, Director of Admissions, Director of Nursing, Social Services (Director or Social Worker) or Business Manager that indicates that the nursing facility expects the consumer to require a stay for 90 days or longer.

Eligibility is based on a validation of their likelihood of residing in the contracted SNF for ninety days or more as indicated by the checked box. For consumers that have resided in the nursing home for at least ninety days, no eligibility documentation is required at time of enrollment.

* You are permitted to work directly with the contracted SNF to obtain the information needed to complete the enrollment application provided the consumer or their authorized representative has signed an Authorization for Disclosure of Healthcare Information form. The form expires seven days from the signature date and provides authorization to the nursing home to provide the agent the consumer's Medicare number (HICN), Medicaid number (if applicable), date of admission to the identified nursing home, and current insurance plan to help facilitate the consumer's enrollment into the UnitedHealthcare Nursing Home Plan.

- ~ Institutional Equivalent Special Needs Plan (IESNP)
You must determine eligibility, as it relates to the "Level of Care" requirement, at the point-of-sale.
 - o You must follow state-specific guidelines for determining plan eligibility as it relates to the "Level of Care" requirement and must document the proof source of eligibility in bConnected.
 - o The Optum Director of Sales Operations will maintain the state-specific requirements and makes them available on the Optum Sales SharePoint site for agent reference.
 - o State required "Level of Care" documentation is performed and retained by an outside identified entity. Documentation is retained by the entity for 10 years and made available upon request within 48 business hours.
 - o Eligibility determination is only required at the point-of-sale. Recertification of eligibility during the course of membership is not required. However, the member must reside in an approved facility to access the plan.

Explain Benefits, Rules, and Member Rights

You must provide and explain all plan benefits and rules thoroughly prior to completing and accepting an enrollment application. Elements you must explain include, but are not limited to:

- Election period and effective date for enrollment.
- Plan eligibility requirements.
- Cost sharing including deductible, coinsurance, copayments, and premiums.
- Provider network, if applicable, and coverage and cost-sharing when utilizing in- or out-of-network providers.
- Formulary, drug tiers, step therapy, quantity limits, prior authorization, exception requests, coverage stages (including the coverage gap), and late enrollment penalty if the plan has prescription drug coverage.
- Verify all of the consumer's current prescription medications are on the formulary and in what tier and look up the consumer's pharmacies to verify if they are in the network.
- Selection of a Primary Care Physician (PCP) if required by the plan and any referral requirements.

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- For network-based plans, verify if all of the consumer's doctors are in the network. Determine if the consumer would be willing to change to a network doctor if the current doctor(s) are not.
- The plan's Star Rating, including where to find the rating in the Enrollment Guide and where to obtain additional information about Star Ratings.
- Advise the consumer that no-cost translation services are available.
- Cancellation, withdrawal, and disenrollment processes and time frames.
- Appeals and grievance process.

Enrollment Application

You may proceed with enrollment only after thoroughly explaining all Plan benefits and rules to the consumer and receiving consent to enroll from the consumer. The following materials are required to be included with an enrollment form or made available electronically: Star Ratings document, Summary of Benefits, and the Multi-Language Insert. You must:

- Ensure that all required information is provided on the enrollment application.
- If the enrollment application contains Name and ID fields for a Primary Care Physician (PCP), then a PCP is required and both fields must be populated. Otherwise, if there is not a PCP field on the enrollment application, a PCP does not need to be designated.
- Determine and enter the proposed effective date, election period, and election period reason code (if applicable).
- Explain that the consumer will receive several mailings, including a letter confirming CMS approval into the plan, a copy of their enrollment application, a membership identification card, and a post-enrollment guide.
- Explain the Outbound Enrollment and Verification (OEV) process for all plans and set the expectation with the consumer that they will receive a letter within 15 calendar days verifying their enrollment in the plan and their understanding of its benefits.
- Ensure that the enrollment application is signed and dated by the consumer once all required information has been entered on to the election form and upon confirmation that the consumer fully understands all the details of the Plan and has read the Statement of Understanding.
 - ~ If the consumer is unable to sign their name due to physical limitations, blindness or illiteracy, the consumer may sign with a mark (e.g., "X") if it is the consumer's intent that the mark be their signature
 - ~ If an authorized representative (e.g., Power of Attorney) signs the enrollment application, they must attest to being authorized under state law to sign on behalf of the consumer, provide contact information, and be able to provide proof that they have the authority under state law to act on behalf of the consumer.
- Leave a receipt of enrollment application. All agents using an electronic enrollment method (e.g., LEAN) must provide the confirmation number, generated upon completion of the enrollment application.
- Provide the consumer with your contact information.
- Upon receipt of a paper enrollment application, enter your agent writing number, sign and date the enrollment application after verifying all information provided by the consumer correct and that it is signed by the consumer or authorized representative.
 - ~ Only the agent that explains the plan benefits and rules and completes the enrollment application with the consumer or authorized representative may affix their writing number to and sign and date the enrollment application. "Gifting" an enrollment application (i.e. allowing another agent to affix his or her writing number to, sign, and date an enrollment application) is strictly prohibited.

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- ~ The writing number assigned to an agency may only be used by the agency's designated principal. You must not share a writing number.
- ~ When multiple agents attend a formal marketing/sales event, the agent who assists the consumer or authorized representative in completing the enrollment application is the agent who must affix their writing number to, sign, and date the enrollment application.
- Submit the enrollment application within 24 hours of receipt. Within seven calendar days of receipt of the enrollment application, UnitedHealthcare must submit the information necessary for CMS to add the consumer to its records as a member of the UnitedHealthcare plan. UnitedHealthcare is considered in receipt of the enrollment application as of the date the agent takes receipt of and signs the enrollment application.
 - ~ Agents must submit paper applications to the applicable enrollment center within 24 hours of receipt via an expedient method of submission accepted by the enrollment center (e.g., fax, overnight delivery, email). Postal mail is not considered an expedient method. Faxed applications should include a coversheet that contains a HIPAA privacy statement, emails must be sent "Secure Delivery" when emailed outside of the UnitedHealthcare firewall, and all emails should include a HIPAA privacy statement.
 - ~ Agents using an offline electronic enrollment method (e.g., LEAN) must upload the enrollment application within 24 hours of receipt.
 - ~ NMA/FMO offices using eModel Office should process a paper enrollment application the same day it is received from the agent whenever possible, but no later than 24 hours after receipt. MA and PDP enrollment applications received by the enrollment center more than three calendar days after the agent's signature are considered a late application and the agent may be subject to disciplinary action.

Enrollment applications received by Enrollment more than three calendar days (sixteen days for AARP Medicare Supplement) after the agent signature will be considered a late enrollment application and the agent may be subject to disciplinary action. (Effective 12/16/16)

Enrollment Process – AARP Medicare Supplement Insurance Plan

As with all products, you must be certified to sell the AARP Medicare Supplement Insurance Plans as of the date the enrollment application is taken and for the applicable year that the enrollment application will be effective. For example, if an enrollment application is taken in October 2016 for a January 2017 effective date, the agent must be certified for 2017 AARP Medicare Supplement Insurance Plans prior to taking the enrollment application.

It is important that you use the agent version of the AARP Medicare Supplement Insurance Plan enrollment application which can be identified by the presence of the code 2460720307 at the bottom center of the first page of the enrollment application and an agent signature line, agent ID, and specific disclaimer language located at the end of the enrollment application. (Note: All enrollment applications for the state of New York contain fields for the agent signature and agent ID so it is especially important that the code 246070307 appear on page one.) Agent versions of the enrollment applications are included in the Enrollment Materials kits available through the agent website in the “Product Information and Materials” section. Agents will not be commissioned, nor will commission appeals be considered, if page 1 of the enrollment application does not contain the code 2460720307.

Incomplete, incorrect, or illegible enrollment applications delay or prevent processing and/or the inability to pay you commission for the sale.

Confirm Eligibility

- Consumers must be enrolled in Medicare Part A and Part B at the time of the plan effective date.
- Consumers must be residents of the state in which they are applying for coverage.
- The consumer must be an AARP member or a member’s spouse or partner living in the same household in order to enroll in an AARP Medicare Supplement Insurance plan. If the consumer is not a member, you may assist the consumer in setting up a new membership by calling 1-866-331-1964 or logging in to www.MyAARPconnection.com to enroll using a credit card. Alternatively, you can mail the AARP membership application and dues (with a *separate* check payable to AARP) with the insurance enrollment application. (AARP membership dues are not deductible for income tax purposes.) Additionally, if utilizing the Online

Enrollment tool for AARP Medicare Supplement Plans, membership verification renewal and new enrollment can be done within the tool.

Explain Benefits, Rules, and Member Rights

- Review the plan options with the consumer and guide them to the plan that best fits their needs.
- The consumer’s plan selection must be indicated on the enrollment application.
- If the consumer has current health coverage, it must be noted on the enrollment application.

Enrollment Application

- The enrollment application should be completed only after you have thoroughly explained to the consumer the plan benefits and rules, confirmed eligibility, disclosed

Section 7: How do I take an Enrollment Application?

agent and product specific disclaimers, and the consumer agrees to proceed with enrollment.

- Immediately sign and date the enrollment application after verifying all information provided by the consumer is correct and the enrollment application is signed by the consumer or authorized representative.
 - ~ Include your agent writing number on each enrollment application you write.
 - ~ Only the agent that completes the enrollment application with the consumer or his/her responsible party may affix their writing number to, sign, and date the enrollment application.

“Gifting” an enrollment application (i.e. allowing another agent to affix his/her writing number to, sign, and/or date an enrollment application) is strictly prohibited.

- Incomplete, incorrect, or illegible enrollment applications delay or prevent processing and/or the inability to pay you commission for the sale.

All enrollment applications must be submitted promptly to UnitedHealthcare. Enrollment applications received by Enrollment more than three calendar days (sixteen days for AARP Medicare Supplement) after the agent signature will be considered a late enrollment application and the agent may be subject to disciplinary action. (Effective 12/16/16)

Post-Sale Requirements

The following items must be left with the consumer at the time of enrollment:

- Outlines of Coverage and Rate Sheet
- *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*
- Copy of the completed and signed Replacement Notice (where applicable)
- Copy of the Automatic Payment Authorization form (where applicable)

- Additional state-specific documents may also need to be completed and submitted with the enrollment application, and/or copies left with the consumer. Directions are on the form. It is your responsibility to adhere to all federal and state regulations.

Replacement Business

- Agents must submit the *Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage* (Replacement Notice) with an enrollment application when the consumer is replacing or losing a Medicare supplement or Medicare Advantage plan. Note: requirements may vary by state.
- A Replacement Notice is included with each state-specific Enrollment Materials kit. Consumers who are replacing their existing Medicare Supplement coverage should not cancel their coverage until the new policy's effective date. When replacing an existing policy, request an effective date (always the first of the month) to coincide with the date the existing coverage ends.
- If the consumer is changing from one AARP Medicare Supplement Insurance Plan to another AARP Medicare Supplement Insurance Plan, the Replacement Notice is not required.
- If the consumer currently has a Medicare Advantage plan and would like to enroll in an AARP Medicare Supplement Insurance plan, their coverage under the Medicare Advantage plan must end by the effective date of the AARP Medicare Supplement Insurance Plan.

Enrollment in Medicare Supplement Insurance does not automatically disenroll a consumer from Medicare Advantage. The consumer should contact their current insurer or 1-800-MEDICARE to see if they are eligible to disenroll, and to disenroll if they are able

Pre-Enrollment Verification Process

Chronic Condition Special Needs Plan

Only enroll those consumers who have one of the qualifying conditions into the UnitedHealthcare Chronic Complete. Consumers are only enrolled in the plan *after their chronic condition is verified by a physician's office.*

- If the qualifying illness is not verified at the time of enrollment, it is UnitedHealthcare Medicare Solutions policy to not enroll the consumer into the Plan.

Prior to taking an enrollment application, complete a review of the chronic illness plan and determine the consumer's eligibility. If the consumer is eligible for the chronic condition plan and chooses to enroll, complete the enrollment application and submit it along with the required chronic condition authorization form.

Dual Special Needs Plan (DSNP)

Only those consumers who have Medicaid may be enrolled into a Dual Special Needs Plan (DSNP). A pre-enrollment verification process has been implemented whereby consumers are only enrolled in the plan *after their Medicaid status has been verified by Enrollment.*

- If the Medicaid status is not verified at the time of enrollment, it is UnitedHealthcare Medicare Solutions policy to not enroll the consumer into the Plan.

Prior to taking an enrollment application, complete a review of the DSNP and determine the consumer's eligibility. If the consumer is eligible for the DSNP and chooses to enroll, complete the enrollment application including the consumer's Medicaid number (from their Medicaid card). In addition, the consumer's social security number can be entered in the appropriate, but optional, field on the enrollment application

Post-Enrollment Consumer Experience for Medicare Advantage Plans

After Completing the Enrollment Application

Review the following next steps with the consumer.

- Confirm the consumer's effective date (typically the first day of the following month).
- For applications taken on October 1, 2014 or after, a member-friendly letter will be sent to the member in place of conducting Outbound and Enrollment Verification (OEV) calls.

Issuing Coverage

Coverage is approved as applied if:

- A fully completed enrollment application is submitted.
- The consumer meets the Medicare Advantage requirements.

Enrollment Denials

If CMS is unable to approve the Medicare Advantage enrollment application, a letter of denial is sent to the consumer.

Premium Refunds

Allow ample time for premium refunds to be processed. A refund check cannot be issued until UnitedHealthcare first receives confirmation that the consumer's initial premium payment has cleared successfully.

New Member Welcome Call

You are encouraged to follow-up with new members after enrollment by placing a welcome call. This provides you with an opportunity to help prevent rapid disenrollment and continue to provide exceptional service to members. It also provides you with an opportunity to ask your new members to provide your contact information to their friends and relatives, an excellent way to help build your book of business.

- Make an outbound call to all new UnitedHealthcare members within two to three weeks after the member's effective date.
- Confirm that the member received a member ID card and Welcome Kit.
- Allow the new member to ask any additional questions and address any key satisfaction drivers.
- Provide the member with customer service numbers and contact information as needed.
- Ask the new member to give your contact information to their friends and relatives so you can help them the same way you helped the new member.

This call cannot be used to sell products. If the member wishes to discuss alternative plan options, another call would have to be made. If the member states they wish to disenroll during the call, instruct them to call the customer service number on the back of their member ID card. In a professional manner, close the call.

Section 7: How do I take an Enrollment Application?

General Medicare Advantage and Prescription Drug Plan Enrollment Application Elements

What to review prior to submitting an Enrollment Application

What should match the Medicare card?

- Name
- Medicare Number
- Part A/B/D Eligibility Date

Ensure the following is marked correctly:

- Plan Selection
- Election Period
- Effective Date
- Signature dates for agent and consumer

Other information

- Date of Birth
- Physical Address and mailing address (if applicable)
- Agent name and writing number
- Primary Care Physician (PCP)
- Method of payment for the premium

What can the consumer correct on an Enrollment Application?

Typographical/Data entry errors:

- Items that can be verified on the original paper enrollment application, but were keyed incorrectly via data entry
- Items that can be easily determined were typographical errors (e.g., transposed numbers/letters – i.e., Terrace vs. Terrcae)

Items that can be verified by Medicare System:

- HICN/Medicare Claim Number
- Name
- DOB (Date of Birth)
- DOD (Date of Death)
- Gender
- Part A Eligibility Date or Part B Eligibility Date or Part D Eligibility Date
- LIS (Low Income Subsidy) Status

Items not answered on the enrollment application:

- Plan not selected, consumer must attest to plan selection
- Multiple plan selection, consumer must attest to plan selection
- Address – physical or mailing
- Signature of consumer
- Phone number
- Email address
- Emergency contact

Section 7: How do I take an Enrollment Application?

- Election Period not provided/invalid election period
- Secondary Medical Coverage Values
- Medicaid Number
- Language Preference
- Materials Format
- SPAP Eligibility (State Pharmaceutical Assistance Plan)
- Proposed effective date (must meet requirements of election period)
- PCP (Primary Care Physician/Provider)
- ESRD- status not answered or answer differs from CMS/SMS

How does the consumer make a correction on an Enrollment Application?

- Monday through Friday 7am – 8 pm CST: Contact Pre enrollment at 866-479-0059
- Saturday, Sunday, and Holidays: Contact Member Services for the appropriate plan:
 - ~ MA/PD:
 - East Coast 800-643-4845
 - West Coast 800-950-9355
 - ~ PDP: 888-867-5575

What corrections can be made on an Enrollment Application?

Any corrections made on a paper enrollment application must be initialed by the consumer.

Typographical/Data entry errors:

- Items that can be verified on the original paper enrollment application, but were keyed incorrectly via data entry
- Items that can be easily determined were typographical errors (e.g., transposed numbers/letters – i.e., Terrace vs. Terrcae)

Items that can be verified by Medicare System (Note: UnitedHealthcare can verify the information from the agent however cannot provide the information to the agent).

- HICN/Medicare Claim Number
- Name
- DOB (Date of Birth)
- DOD (Date of Death)
- Gender
- Part A Eligibility Date or Part B Eligibility Date or Part D Eligibility Date
- LIS (Low Income Subsidy) Status

Items not answered on the enrollment application:

- Election Period not provided/invalid election period
- Medicaid Number
- SPAP Eligibility (State Pharmaceutical Assistance Plan)

How are corrections made on an Enrollment Application?

- Complete the Missing/Incomplete Application Update Request Form found on *Jarvis*.
 - ~ Submit the form via email to icssupport@uhc.com or print and fax to 866-802-6062
- Contact PHD Pre-Enrollment Monday through Friday 7 am – 8 pm CST at 888-381-8581
 - ~ Option 1 [Pre-Enrollment]

Section 7: How do I take an Enrollment Application?

When is a new Enrollment Application required?

A new enrollment application is required in the following scenarios:

- Incorrect Plan Selection
- Plan selection not available in region
- Incorrect selection of county/region
- Missing information not provided within required time frame

Time Frames to Supply Missing Information

The Additional Information Letter (AIL) is sent to the consumer for missing information or verification that is needed to complete processing of their application. The Additional Information Letter (AIL) will be sent to the consumer with date by which the missing information is needed.

You will receive a daily email communication that contains the missing information needed to process the consumer's application. You can contact the Producer Help Desk and provide the missing information to UnitedHealthcare.

If you are able to provide the missing information/verification needed for a pending enrollment application, please fill out the Missing/Incomplete Application Update Request form.

Pending Reason	Time frame to Supply Information
Blank	No action required
Missing Election Period	Up to 7 days from received date [agent's received date or submittal received date]
Pending Parts A/B Effective date	IEP/ICEP: Up until the day before the eligibility date to respond. If after the eligibility date, 21 days or EOM [whichever is longer] Other Election Periods: 21 days or EOM [whichever is longer]
Medicaid	21 days from the date of the letter or the end of the month [whichever is longer]
ESRD	IEP/ICEP: Up until the eligibility date to respond. If after the eligibility date, 21 days or EOM [whichever is longer] Other Election Periods: 21 days or EOM [whichever is longer]
Intent to Enroll	30 days from the date of the letter
Other pending reasons	IEP/ICEP: Up until the day before the eligibility date to respond. If after the eligibility date, 21 days or EOM [whichever is longer] Other Election Periods: 21 days or EOM [whichever is longer]

Section 7: How do I take an Enrollment Application?

Late Enrollment Penalty (LEP)

Who incurs a Late Enrollment Penalty?

- A consumer may incur an LEP if, at any time after they become eligible for Part D coverage, there is a period of 63 or more continuous days without creditable prescription drug coverage. Creditable prescription drug coverage is defined as coverage that meets Medicare's minimum standards or pays on average at least as much as Medicare's standard prescription drug coverage.

Who determines the Late Enrollment Penalty?

- UnitedHealthcare is responsible for determining, at the time of enrollment, whether a consumer was previously enrolled in a Medicare prescription drug plan or had other creditable coverage and whether there are any lapses in coverage of 63 days or more. UnitedHealthcare will then notify CMS of the lapses and CMS will determine the LEP amount to be applied to the consumer's account. Any consumer eligible for low income subsidy (LIS) is not subject to a LEP.

Once a Late Enrollment Penalty has been determined what are the next steps for the consumer?

- UnitedHealthcare will inform the consumer via letter about the LEP as well as what the next steps are. The consumer will receive an attestation form with instructions to either fill out the form and resubmit to UnitedHealthcare or the consumer can contact UnitedHealthcare's Customer Service department and attest to the creditable coverage. The consumer will need to attest to the exact dates they had creditable coverage as well as with whom they had creditable coverage (e.g., VA benefits). The consumer will have 30 days to respond to UnitedHealthcare with this information. UnitedHealthcare may send the consumer a reminder notice as the end of the 30 days are approaching.
 - ~ Example: I had coverage through my employer Boeing from August 1, 1995 – January 31, 2014
 - ~ Example: I had VA coverage from November 1, 1997 – December 31, 2013
- If UnitedHealthcare receives an incomplete attestation (the start and end dates are missing or the type of coverage is missing) or an attestation is not received, UnitedHealthcare will follow up with the consumer via letter to obtain the missing information. The consumer will have up to 60 days after the 30 day deadline stated in the initial notice to provide UnitedHealthcare with an attestation.
- If UnitedHealthcare receives a response after 60 days from the initial deadline, UnitedHealthcare will be unable to accept the attestation and will inform the consumer of this via letter. UnitedHealthcare will inform the consumer of the LEP that will be placed on their household as well as the steps to take for reconsideration through Maximus. Maximus is CMS' independent review entity: they will notify UnitedHealthcare of the final decision upholding, reducing or eliminating the LEP amount. UnitedHealthcare will make the adjustments and send the notification to the consumer of the final outcome.

What causes a LEP Attestation to be deemed incomplete?

- Consumer does not state the full time period (start and end date of coverage)
- Consumer does not sign a submitted attestation form
- Consumer does not state what type of coverage they had (VA, Employer etc.,)

Primary Care Physician (PCP)

Discussions regarding a PCP should occur at the point-of-sale to set expectations and ensure the consumer has a provider to coordinate their care. If the consumer does not have a PCP or does not have a PCP in the plan's network, they must select one from the plan's provider network. Agents may assist the consumer in selecting a PCP, but must not refer a consumer to a particular provider or medical group.

Section 7: How do I take an Enrollment Application?

PCP's play an important role in helping members:

- Make smart, healthy lifestyle choices
- Manage prescription drugs and make sure they work well together
- Manage specialist care and help avoid extra costs and unnecessary tests
- Understand the health care system

PCP ID numbers are located in the provider directory and must be recorded on the enrollment application (paper or LEAN):

- Online directory tool located on *Jarvis*.
- Valid PCP IDs must be copied on the enrollment application exactly as displayed
- PHD support is available if online tool is not accessible

Four different ways that PCP ID numbers are processed:

- **Valid** – In-network PCP with a correct PCP ID
- **Missing** – No PCP information is listed on the enrollment application
- **Invalid** – Out-of-Network PCP name or ID
- **Incorrect** – Either the PCP name or ID for an in-network PCP was entered incorrectly on the enrollment application

Best Practices to Avoid PCP Auto-Assignment:

- Use the **online provider search directory** because it is the most up-to-date. The online provider directory is on *Jarvis*. Do not use any other online directory.
- If you cannot access the tool when meeting with a consumer, **contact the PHD**.
- **Do not contact a provider's office** because they may not be able to confirm network status for the specific Medicare Advantage plan.
- Printed provider directories are a **higher risk** for outdated/inaccurate information.
- Confirm the provider is in-network and accepting UnitedHealthcare membership for the plan in which the consumer is enrolling. A provider can be in-network for one plan, multiple plans, or all plans in a market.
- Copy the provider ID and name **exactly** as it appears in the directory. **Do not add or omit digits**.
- **Closed panel** providers will not accept any new members of the plan. Therefore, a consumer must not select a closed panel provider as their PCP, even if they are a current patient.

Physician Status

The best practice is to look up every consumer's Primary Care Physician in the Provider Directory to determine network status **and the PCP's Physician Status**.

There are three physician statuses and it is important that you understand what each status means to the consumer you are enrolling.

- **Accepting New Patients** - Physician is accepting any UnitedHealthcare enrollees. Auto-assignment only occurs if there was an error when filling the application out and the PCP information was missing, invalid or inaccurate.
- **Existing Patients** - Physician is only accepting enrollees who are current patients. It is important to answer the existing patient question in the PCP section on the application. Auto-assignment of a new physician will occur if the existing patient question is no answered or there is missing, invalid, or incorrect PCP information on the application.
- **Not Accepting New Patients** - Physician is not accepting any UnitedHealthcare enrollees, new or existing patients. Consumers must pick a new physician when filling out the application. Auto-assignment will occur with the selection of a closed panel PCP on the application.

Section 7: How do I take an Enrollment Application?

Medicare Advantage and Prescription Drug Plan Enrollment Application Cancellation, Withdrawal, or Disenrollment Requests for CMS Regulated Plans

A consumer or legal representative may request, for any reason, to cancel, after submission to the Centers for Medicare & Medicaid Services (CMS), or withdraw, prior to submission to CMS, their enrollment application prior to the effective date of coverage. A consumer's enrollment can only be cancelled or withdrawn if the request is made (based on the date the telephone call or written notification is received by UnitedHealthcare or representative) prior to the effective date of the enrollment. A Request to cancel an enrollment application occurs prior to the effective date, but after UnitedHealthcare has submitted the enrollment data to CMS.

In addition, the member or legal representative may request to terminate their enrollment in a plan after the effective date.

If a consumer requests to withdraw their enrollment application prior to the agent submitting the enrollment application, the agent must return the enrollment application to the consumer.

An NMA/FMO, agency, or agent is not permitted to accept any requests to cancel or withdraw an enrollment application or terminate enrollment in a plan once the enrollment application has been submitted. EDC agents must direct all requests to cancel or withdraw enrollment applications or terminate enrollment to the plan's Customer Service.

You may neither verbally nor in writing, nor by any action or inaction, request or encourage a member to disenroll. You are not permitted to make additional contact with a member or legal representative who request cancellation or withdrawal of their enrollment application or voluntary disenrollment with the plan. You must cease all contact with the member or their legal representative once it is known that the member has requested voluntary disenrollment. UnitedHealthcare Member Relations Department is authorized to contact disenrolling consumers within the guidelines provided under the privacy regulations and policies.

Withdrawal of Enrollment Application

Requests to withdraw an enrollment application occur prior to the effective date and prior to UnitedHealthcare submission of the enrollment data to CMS.

- If a paper enrollment application was signed by the consumer and the agent has not submitted it to UnitedHealthcare, the agent is required to return the paper enrollment application to the consumer. The agent is prohibited from submitting to the plan, retaining, or destroying the enrollment application once the consumer has requested the withdrawal.
- If the paper enrollment application has been submitted to the plan or if an electronic method of enrollment was used, the agent must direct the consumer to Customer Service to facilitate the withdrawal request. The Customer Service number is located in the consumer's Enrollment Guide.

Cancellation of Enrollment Application

A request to cancel an enrollment application occurs prior to the effective date, but after UnitedHealthcare has submitted the enrollment data to CMS. You must direct the consumer to Customer Service to facilitate the cancellation request. The Customer Service number is located in the Enrollment Guide.

Section 7: How do I take an Enrollment Application?

Request to Disenroll

A voluntary disenrollment occurs after the effective date.

- A member may request disenrollment only during a valid election period.
- The member may disenroll by:
 - ~ Enrolling in another plan (during a valid election period)
 - ~ Providing a written (signed) notice to UnitedHealthcare
 - ~ Calling 1-800-MEDICARE.
 - ~ Completing an online disenrollment request via the consumer portal.
- If the member verbally request disenrollment, you must instruct the member to make the request in one of the ways described above.

Denial

An enrollment application is denied if the consumer does not meet CMS eligibility guidelines (e.g., does not have Parts A and B eligibility or does not live in the plan's service area) or the consumer does not respond to the additional information letter within the required time frame.

Involuntary Disenrollments

A member may be involuntarily disenrolled after their enrollment application has been approved. UnitedHealthcare defines these disenrollments as involuntary because the member does not elect the disenrollment but rather that CMS determines the member to be ineligible for the coverage they have elected.

Involuntary Disenrollment Reasons:

Special Needs Plans

- Move out of contracted skilled nursing facility (ISNP)
- Loss of Medicaid eligibility (DSNP)
- Loss of qualifying chronic condition (CSNP)

General Plans

- Non-payment of plan premium
- Death of member
- Termination of plan
- Incarcerated or moved out of plan's service area
- Fraud or abuse by member
- Disruptive behavior by member

See the Enrollment Handbook for additional details.

Customer Service Resources

For customer service needs of the member, you can refer the member to the contact information on the back of their membership identification (ID) card as telephone numbers and hours of service availability differ by plan.

Below is a listing of the customer service hours of availability and telephone numbers for various plans. Because information may change, it is advised that the member refer to the back of their ID card.

Customer Service – PFFS

8 a.m. to 8 p.m. local time, 7 days a week

Telephone: Please refer to the telephone number on the back of the member's ID card.

Customer Service – HMO/PPO/RPPO/POS

8 a.m. to 8 p.m. local time, 7 days a week

Telephone: Please refer to the telephone number on the back of the member's ID card.

Customer Service – AARP Medicare Supplement Insurance Plans

7 a.m. to 11 p.m. Eastern Standard Time Monday - Friday

9 a.m. to 5 p.m. Eastern Standard Time - Sunday

Telephone: 1-800-523-5800

TTY: 1-800-232-7773

Section 8: How am I Paid?

Compensation Overview

Credential Validation Rules

Commission Payment Schedule and Payment Calculations

Agent of Record Retention

Assignment of Commission

Electronic Funds Transfer (EFT)

Commission Payment Audit

Pended Commission Process

Plan Changes

Debt Repayment Plan

**SecureHorizons Medicare Supplement Renewal
Commissions**

Compensation Overview

A writing agent who submits an enrollment application is only eligible for a commission if he/she is properly credentialed (i.e. contracted, certified in the product in which the consumer enrolled, and licensed and appointed, if applicable, in the state in which the consumer resides) at the time of sale, irrespective of the credentialing status of any up-line entity.

If the writing agent is eligible for a commission on the sale, then any up-line entity to the writing agent that is properly credentialed at the time of sale will be compensated. Entities that are not properly credentialed at the time of sale are not eligible to be compensated and their commission will be paid to their direct up-line, since the direct up-line is stepping into the shoes of the down-line who was not properly credentialed at the time of sale. If a writing agent is not properly credentialed, no commissions will be paid to the writing agent or their respective up-line. In the event the writing agent is a solicitor and their direct up-line is not properly credentialed at the time of the sale, the solicitor commission and the override commissions of their direct up-line will be paid to the level above the direct up-line. It is the responsibility of the level that receives payment to administer commissions to the solicitor who made the sale.

Agent Compensation

Compensation is defined by the Centers for Medicare & Medicaid Services (CMS) as monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commission, bonuses, gifts, prizes, awards, and finder's fees. (Medicare Managed Care Manual, Chapter 3, "Medicare Marketing Guidelines")

Commission

Commission is a form of compensation given to an agent for new enrollments of consumers in the plan that best meets such consumers' health care needs and membership renewals. Plan sponsors are not required to compensate agents or brokers for selling Medicare products. However, if plan sponsors do compensate agents or brokers, such compensation must comply with CMS and other regulatory guidance.

- Plans must establish a compensation structure for new enrollments and renewals effective in a given plan year. The compensation structure:
 - ~ Must be reasonable and reflect fair market value for services performed.
 - ~ Must comply with fraud and abuse laws, including the anti-kickback statute.
 - ~ Must be in place by the beginning of the plan year marketing period, October 1.
 - ~ Must be available upon CMS request for audits, investigations, and to resolve complaints.
- If plans pay commissions they must abide by CMS guidance by paying commissions for initial year (i.e. new to Medicare) enrollments as well as renewal compensation. CMS determines if an enrollment qualifies as an initial year or renewal year enrollment and directs the plan sponsor on which compensation level should be paid. The following rules pertain to the compensation cycle:
 - ~ The commission amount paid to an agent or broker for enrollment of a Medicare consumer into an Medicare Advantage (MA) or Prescription Drug Plan (PDP) plan is as follows:
 - After CMS publishes rate guidance for the upcoming plan benefit year, UnitedHealthcare will determine commission rates by contract-plan benefit package (PBP) and state based on market specific objectives.

Section 8: How am I Paid?

- Upon receipt of a CMS-approved enrollment application and validation of the writing agent's credentials, commission for a new enrollment will be paid at the renewal rate based on the number of months the member is enrolled for the plan benefit year.
- Upon notification from CMS that a member qualifies for the initial rate, the commission for the new enrollment paid at the renewal rate will be reversed and repaid at the initial rate. Commission will be calculated based on the number of months the member is enrolled for the plan benefit year, except when the member has no plan history per CMS then these will be paid at the full initial rate regardless of effective date of enrollment.
- CMS guidelines state a plan year ends on December 31 regardless of effective date of the enrollment.
- Renewal commissions to the writing agent are paid so long as the writing agent is in good standing according to the terms of the agent's contract and the member is still enrolled. Renewal commissions will begin in January of the following plan benefit year. For example, renewal commissions for a July 2015 effective date will begin January 2016 on a per member per month basis. CMS requires that any renewal payment be no more than fifty percent of the current year fair market value.
- ~ If the member leaves the plan:
 - Voluntarily within the first three months (i.e. a rapid disenrollment), the full amount of the commission paid is charged back.
 - Voluntarily in months 4 to 11, commission paid is charged back on a pro-rated basis based on the number of months the member was in the plan.
 - If a member terminates coverage involuntarily in months 1 to 11 (for example due to a plan exit), commission paid is charged back on a pro-rated basis based on the number of months the member was a member of the plan.
 - Charge backs will be recovered from both new and renewal commissions in the next available commission cycle. If there is not enough new or renewal commissions to offset the charge back, the balance of the charge back is rolled into the next commission cycle. This continues until the charge back is repaid in full.
 - All terminations that result in a full or prorated charge back will be processed regardless of the date the termination is received.

Credential Validation Rules

First-year commissions

To be eligible to receive first-year commissions, as of the consumer's application signature date, the writing agent must be properly credentialed as outlined below:

- Must be actively contracted with UnitedHealthcare.
- Must be actively licensed in the state of sale.
- Must be actively appointed in the state of sale (if applicable).
- Must be certified in the product in which the consumer enrolled for the applicable effective year.

Monthly Renewals (Year Two and Subsequent Years)

- For MA/PDP applications effective prior to 01/01/2014 and for AARP Medicare Supplement applications with all effective dates, to receive renewal commissions, the agent must not be termed for-cause or deceased (Exception: For AARP Medicare Supplement Insurance plans issued in the state of Washington, in the case of death, agent commissions will continue to be paid to a successor agent.)
- For MA/PDP applications effective 01/01/2014 and later for agents to be eligible to receive monthly renewals, the writing agent and solicitors must be properly credentialed as noted below. For solicitors who are terminated not –for-cause, their immediate up-line must be properly credentialed. For solicitors that are terminated for-cause or upon death, monthly renewals to their up-lines cease. Credentialing requirements for writing agents and solicitors include:
 - ~ First Year commission was processed and paid.
 - ~ Must be actively contracted (including servicing status contract) or in suspended status with UnitedHealthcare as of renewal processing date.
 - ~ Must be actively licensed in the state of sale (or agent's resident state for servicing status contract) as of the renewal processing date.
 - ~ Must be actively appointed (if applicable) in the state of sale (or agent's resident state for servicing status contract) as of the renewal processing date.
 - ~ Active status agents must be certified in the product of sale for the renewal year as of the renewal processing date and the servicing status agent must be properly certified according to the terms of servicing agreement.

Credential Validation Rules for the Up-line

- First-year commissions
 - To be eligible to receive first-year commissions, as of the consumer's application signature date, the up-line or override entity must be properly credentialed as outlined below:
 - ~ Must be actively contracted with UnitedHealthcare.
 - ~ Must be actively licensed in the state of sale.
 - ~ Must be actively appointed (if applicable) in the state of sale.
 - ~ Writing agent must have successfully passed credential validation for first-year commissions.
- Monthly renewals (Year Two and Subsequent Years)
 - ~ For MA/PDP applications effective prior to 01/01/2014 and for AARP Medicare Supplement applications with all effective dates, to receive renewal commissions, the up-line entity or agent must not be termed-for-cause or deceased (Exception: For AARP Medicare Supplement Insurance plans issued in the state of Washington, up-line entity or agent commissions will continue to be paid to a successor agent.
 - ~ For MA/PDP applications effective as of 01/01/2014 and later for up-line entity to be eligible to receive monthly renewals, the up-line or override entity must be properly credentialed as noted below:

Section 8: How am I Paid?

- First Year commission was processed and paid.
- Must be actively contracted (including servicing status contract) or in suspended status with UnitedHealthcare as of the renewal commission processing date.
- Must be actively licensed in the state of sale (or resident state for servicing status contract) as of the renewal processing date.
- Must be actively appointed in the state of sale (or resident state for servicing status contract) as of the renewal processing date.
- Writing agent must have successfully passed credential validation for renewals.

Commission Payment Schedule and Payment Calculation

Commission Payment Schedule

- Medicare Advantage (MA) and Prescriptions Drug Plans (PDP)
 - ~ New Business – paid twice weekly
 - ~ Renewals – paid monthly, Per Member Per Month, MA renewals are processed the third weekend of the month and PDP renewals are processed the fourth weekend of the month
- AARP Medicare Supplement Insurance Plans
 - ~ New business advances and updates to current book of business – process weekly
AARP Medicare Supplement Insurance products are paid a nine-month advance in most states (as noted here or in the contract). The advance is not considered fully earned until the member has been enrolled nine months. As the member remains enrolled in months one through nine, a portion of the advance is considered earned. As premium is paid by the member for months one through nine, a portion of the advance is considered earned. Example: If the member terminates in month seven, two months of the advance are considered unearned and will be charged back to the agent. Note: An exception to this rule is when a member pays their premium for the full year from January 1 through December 31 in advance (by the end of January). Then the commission advance is considered fully earned in the month of February. However, if the plan terminates during the first year, the agent will be charged back for commissions paid for months plan is not in force.
 - ~ Premiums and Renewals – processed monthly
Monthly premiums and renewals begin in month two, however typically recover against Unearned Advance Debt through month nine and processed the first weekend after the first full week of a month.

Tax Information

- Commissions paid are reported on the 1099 in the year they are paid. Payments issued in one year and then voided and reissued in the next year will be reported on the 1099 for the year in which the original payment was issued.
- The assignee receives the 1099 for any payments received on behalf of the assignor.
- Garnished payments are reported on the 1099 of the garnished agent in the year the payment was originally processed.

Garnishment

When a formal notification of garnishment is received commissions will be withheld based on the terms of the levy. Garnishment amounts will be paid to the appropriate agency or organization on a monthly basis unless otherwise specified. Garnishment of commission payments will continue until the total amount of the garnishment is satisfied or a notice of satisfaction is received from the garnishing agency.

Section 8: How am I Paid?

AARP Medicare Supplement Insurance plans – Charge backs

Commissions are earned on the duration of a member's enrollment. Any unearned commission paid on an AARP Medicare Supplement policy will be charged back to all levels that were paid for that policy.

- Charge backs will be recovered from the next available commission payment of any UnitedHealthcare product.
- If there is not enough new or renewal commissions to offset the charge back, the balance of the charge back is rolled to the next commission statement. This continues until the charge back is repaid in full.

Miscellaneous Forms of Compensation

Commissions, bonuses, gifts, prizes, awards, and referral/finder's fees are examples of compensation. The value of all forms of compensation must be included in the total compensation amount paid to agents for an enrollment and may not exceed the limits set forth in the CMS agent compensation regulations and implementing guidance.

Reimbursement of Costs Associated with Selling

The following are not considered compensation according to CMS:

- Payment of fees to comply with state appointment laws, training and testing, and certification.
- Reimbursement for mileage to and from appointments with consumers.
- Reimbursement for actual costs associated with consumer sales appointments such as venue rent, materials, and snacks.

Agent of Record Retention

In the two circumstances below, a renewal-eligible agent's status as AOR and associated entitlement to renewal payments will be retained for a qualifying enrollment when eligibility requirements have been met. The AOR remains responsible for servicing the member. UnitedHealthcare reserves the right to deny an agent AOR retention or remove an agent as AOR.

- Service Area Reduction (SAR) Impacted Medicare Advantage Member Enrolls in a Qualifying Medicare Advantage Plan

The original agent will retain AOR status for SAR plan changes if all of the following requirements are met:

- ~ A member's current UnitedHealthcare Medicare Advantage plan is closing and the member is able to make a new plan election (i.e. the member is not automatically mapped to an existing plan);
- ~ The member must enroll in a new UnitedHealthcare Medicare Advantage plan during the Annual Election Period (AEP) or a Special Election Period (SEP) with an effective date of January 1, February 1, or March 1;
- ~ The plan must be a UnitedHealthcare Medicare & Retirement managed MA, MAPD, DSNP, or CSNP. (Note: Any other type of plan switch does not qualify for AOR retention, including Medicare Supplement Insurance, Institutional SNP, Medicare – Medicaid Plan (MMP), and individual PDP.);

Section 8: How am I Paid?

- ~ A non-renewal eligible Telesales agent must conduct the enrollment in the new qualifying UnitedHealthcare Medicare Advantage plan or the impacted member may self-enroll via Web or paper enrollment application without involvement of a renewal-eligible agent; and
 - ~ The original agent must be a renewal-eligible agent and appropriately licensed, appointed, and product certified for the new plan.
- **Non-SAR Medicare Advantage Members Enrolls in a Qualifying MA Plan**
The original agent will retain AOR status for non-SAR plan changes if all of the following requirements are met:
- ~ The current member must be currently enrolled in a UnitedHealthcare Medicare & Retirement managed Medicare Advantage plan with or without integrated Part D benefits;
 - ~ Effective August 1, 2016, the member may use any available election period (i.e. AEP or SEP).
 - ~ The current member must switch from the current plan to another qualifying UnitedHealthcare Medicare & Retirement managed Medicare Advantage plan. Qualifying plan changes are as follows: from an MA, MAPD, DSNP, or CSNP to an MA, MAPD, DSNP, or CSNP. (Note: Any other type of plan switch does not qualify for AOR retention, including Medicare Supplement Insurance, Institutional SNP, Medicare – Medicaid Plan (MMP), and individual PDP.)
 - ~ A non-renewal eligible Telesales agent must conduct the enrollment in the new qualifying UnitedHealthcare Medicare Advantage plan or the member may self-enroll via Web or paper enrollment application without involvement of a renewal-eligible agent; and
 - ~ The original agent must be a renewal-eligible agent and appropriately licensed, appointed, and product certified for the new plan.
- **Commission Payment**
- ~ For qualifying enrollments, the retained AOR (and the AOR's up-line, if applicable) will receive a new commission at the renewal year rate for the new enrollment. Effective August 1, 2016, commissions for SAR and non-SAR plan changes will be paid on a monthly basis the month following the plan effective month (except for plans effective December 1, which must pay by December 31).
 - ~ For non-qualifying enrollments, such as a member switching from an MA Plan to Medicare Supplement Insurance and/or a Part D plan, the agent facilitating the plan switch will become the new AOR and, if eligible, will receive any commission/incentive payments per standard procedures.

Assignment of Commission

Agent Assignment to an Individual or Entity

- The assignor must be contracted, licensed, certified, and appointed (if applicable) in the state in which the consumer resides by UnitedHealthcare.
- The assignee, an individual or entity represented by a principal, must also be actively contracted.
- The assignor and the assignee must belong to the same distribution channel. For example, an Independent Career Agent (ICA) cannot assign commissions to an External Distribution Channel (EDC) agent and an EDC agent cannot assign to an ICA agent.
- Assignment to an estate, widow(er), or heir: Under the Agent Agreement, death of the agent is an automatic termination. The company shall cease paying compensation to the agent and no further payment shall be due.
- Assignment of commissions can only occur to one individual or entity at 100%.

Section 8: How am I Paid?

Assignment of Commission Process

Agents can request to assign commissions by submitting a properly executed Assignment of Commissions form to SH.Commissions.Administration@uhc.com or faxing it to 1-866-761-9162, Attn: Commissions Department. Forms are available through *Jarvis* under the **Resources section under the “Commission Search” tab**. Assignment is effective on the date the Assignment of Commissions form is signed by an authorized officer of UnitedHealthcare.

Termination of Authorization to Assign Commissions

The authorization to assign commissions will be terminated if any of the following conditions exist:

- Termination of the assignee.
- Termination for cause or death of the assignor.
- Assignor’s failure to maintain proper credentialing.
- The assignor submits a written request to terminate authorization to assign commissions. Note: The assignee has no right to revoke a request to terminate an authorization provided by the assignor.

Electronic Funds Transfer

To submit an Electronic Funds Transfer (EFT) request:

- Access *Jarvis*.
- Access “Commission Search” tab
- Access “Resources”
- Access the EFT Form link, complete, and submit the form according to the instructions.
- An email confirmation is sent to email address on file.
- The updated EFT change may take up to two commission cycles to take effect.
- For any issues associated with self-service, email the PHD at phd@uhc.com.

Commission Payment Audit

An agent or up-line may submit an audit or appeal request when he/she disagrees with a payment amount, including instances when the agent has not been paid, but feels he/she should have been. Audit/appeal requests related to commissions for new enrollments may be submitted **for policies effective in the current plan year or prior plan year. Appeals related to renewal commissions may be filed for transactions in question from the current plan year or prior plan year. However, appeals for the prior plan year payments must be filed by November 30 of the current plan year.** Audit/appeal requests related to renewal payments are not reviewed if a corresponding new transaction was not paid. The request must be in writing and must detail the specific applications the agent is questioning. If an issue with the commission payment system is identified, it will be corrected and the commission will be processed systematically. A follow-up communication will be sent to the agent. Decisions made by the Commissions Audit department are final. Note: This rule will be waived if required due to a CMS audit, DOI audit, or legal proceeding.

Audits/appeals can be submitted for UnitedHealthcare MA/MA-PD, SNP, and PFFS; AARP MA/MA-PD, PDP, and Medicare Supplement; SecureHorizons Medicare Supplement; Care Improvement Plus, Medica and Sierra products.

Section 8: How am I Paid?

- The agent must email PHD at phd@uhc.com and include supporting documentation to open a Service Request to process a commission payment audit request.
- PHD will verify if the member is actively enrolled in a UnitedHealthcare plan and that the agent requesting payment is active at the time of sale. If the preceding criteria is met, the Service Request will be escalated to the Commissions Audit department for additional research.
- Results of the audit of each enrollment application will be communicated to the agent by the Commissions Audit department.
- Responses will be stored within the PHD Service Request.
- Follow-up calls associated with the request from the agent or up-line should be directed to the PHD at phd@uhc.com with reference to the Service Request provided.

Pended Commission Process

Commissions are paid to eligible, non-employee agents for enrollment applications that are complete, legible, and accurate. A non-employee agent is eligible to receive commission if at the time of sale, as indicated by the date of consumer signature on the enrollment application, they were fully credentialed (i.e. contracted with UnitedHealthcare, licensed and appointed, if applicable, in the state in which the consumer resides, and certified in the product in which the consumer enrolled). Commission will be pended (withheld) if the writing agent fails any of the credential validation checks, as well as if an invalid writing number is entered on the enrollment application. If an agent is not licensed at the time of sale, the agent will be terminated and the member will be notified of the sale involving an unqualified agent. (Refer to appointment and contract termination section for details related to termination due to an unqualified sale.)

Reporting and Communication Process

- Weekly No Pay Agent Communication
 - ~ A weekly communication (each Friday) of pending sales and/or payments is sent to the affected agent and his/her NMA/FMO/SMA .
 - Communication is sent primarily via email.
 - An exception process is in place for an instance where the agent has no email on file or the email is invalid.
 - As part of this process, updated email information is gathered from the agent so the no pay communication can be sent to the agent.
 - In cases where email communication is not possible, a letter will be sent to the agent via postal delivery.
 - A summary of all weekly communications is provided to the following teams: EDC leadership and Insurance Solutions.
- Pended Commission Status Reporting
 - ~ The agent and their up-line or manager/supervisor can review commission status and statements under the “**Commission Statements**” tab on *Jarvis*. If a commission is pended, the reason(s) for payment ineligibility is provided. In addition, the Pended Sales Report is provided to EDC on a weekly basis.

Review and Resolution Process

The primary goal of the review process is to determine whether a pended commission is eligible for payment or is legitimately pending due to an issue with agent credentialing and/or enrollment application quality. The agent and his/her up-line (EDC), can review commission status and statements under the

Section 8: How am I Paid?

“Commission Statement” tab on *Jarvis*. If a commission is pended, the reason(s) for payment ineligibility is provided. The process for pended commission review and resolution includes the following steps:

Appeals Process:

- The communication outlines a clear appeal process that agents may use if they feel a transaction has been pended inappropriately.
 - ~ The agent has 30 days from receipt of the communication to submit an appeal to the PHD at PHD@uhc.com.
 - ~ The Agent On-Boarding, Certification, and/or Commissions team reviews the appeal and approves or denies it.
 - ~ For appeals that are specifically related to agent certification, the following requirements must be met:
 - An agent may request exception process review under one of the following circumstances:
 - Agent knew, in good faith, that they were certified in the product and can provide documentary evidence, but UnitedHealthcare Medicare Solutions internal business process or technical error did not reflect that the agent had passed the test in that product.
 - Agent was told they were certified, and can provide evidence, but due to internal business process errors, was not provided with the appropriate certification requirements or online development plan.
 - In order for an exception to apply, all of the following criteria must be met:
 - Agents must have taken the appropriate certification tests by the time the exception is being considered.
 - A UnitedHealthcare Medicare Solutions/UnitedHealth Group system or process created the certification error.
 - Agent was acting in good faith.
 - ~ For appeals that specifically relate to agent licensing, information available through the Department of Insurance or National Insurance Producer Registry (NIPR) will be used to validate licensing claims.

Analyst Review:

- Appeals are forwarded to an Agent On-Boarding and/or Certification analyst for review. Results of analyst review, on a per application basis, will fall into one of three categories:
 - ~ System(s) will be updated to reflect the necessary change(s) for the agent and the commission will be paid systematically.
 - ~ Commission payment remains ineligible due to reason(s) stated.
 - ~ Appeal could not be evaluated based on currently approved rules, i.e. guidelines or published rules do not exist for the scenario under evaluation.
- The transaction record and the Producer Contact Log (PCL) will be updated to reflect the final decision.
 - ~ Approved appeals: System records are corrected and payment will be systematically processed during the next commission cycle.
 - ~ Denied appeals: The transaction record will be updated to reflect a “permanent pend” status indicating no further appeal is available.
- The appeals process can take up to 14 business days, and the agent is contacted via email, phone, or letter with the final decision on the appeal.

Plan Changes

- Any MA/MA-PD or PDP plan and/or plan benefit package change is a commissionable event and may result in a new commission paid on a Per Member, Per Year (PMPY) basis. (See the Agent of Record (AOR) Retention above).
- If the effective date of the plan change is within the rapid disenrollment period of the original/prior effective date, the prior agent will be subject to full or prorated charge back depending on if the termination was voluntary or involuntary.
- If the effective date of the plan change is in month four through eleven of the original/prior effective date, the prior agent will receive a prorated charge back per CMS guidelines unless the member was enrolled in the prior plan through 12/31, in which case the commission is considered fully earned.
- If the effective date of the plan change is in benefit plan year two, the prior agent will not receive renewals on the original/prior policy.

Debt Repayment Plan

UnitedHealthcare Medicare Solutions routinely conducts commission administration audits using the Medicare Membership Report from CMS to validate that charge backs have been appropriately processed due to members that rapidly disenroll or otherwise disenroll within the first plan benefit year or to validate agents no longer receive renewal commissions following a member's disenrollment from a Medicare Advantage or Prescription Drug Plan. When an audit process reveals an overpayment, the impacted agent is charged back accordingly. Charge backs may be applied against future payments to an agent or may be recovered by any other means allowed by law.

- In order to minimize the impact of large charge backs, an agent may request a debt repayment plan by submitting an appeal to the PHD via email at PHD@uhc.com. Debt repayment options are only available for charge backs for the sale of Medicare Advantage and Prescription Drug plans and in situations where large debt is created due to audits of commission payments. Debt repayment options are not available for charge back debt created as a result of day-to-day commissions processing. To request a debt repayment plan:
 - ~ The agent must be in good standing (i.e. agent is not the subject of an open complaint investigation and/or open corrective and/or disciplinary action outreach),
 - ~ The agent must have an existing renewal book of business, **and**
 - ~ The amount of debt must exceed 2 months of renewal payments.

SecureHorizons Medicare Supplement Renewal Commissions

SecureHorizons Medicare Supplement is no longer sold through external channels. Renewal commissions are paid monthly.

Renewal Commission Processing Schedule:

- UnitedHealthcare pays all agents for all business either by check or through Electronic Funds Transfer into the agent's bank account. Commission for SecureHorizons Medicare Supplement products are administered by CHCS Inc.
- Renewals – All
 - ~ Paid monthly
 - ~ Cycle closes the last business day of the month
 - ~ Direct deposit – funds are available 24-48 business hours after the payment file is sent to the bank.
 - ~ Statements and checks are mailed within 24-48 business hours after last day of the month.

Section 9: What are Expected Performance Standards?

Compliance and Ethics

Agent Performance Standards

Performance that may result in Immediate Termination

Agent Outreach

Sales Agent Oversight

Complaints and Allegations of Agent Misconduct

Revocation of Authority to Sell

Suspension of Marketing and Sales Activities

Termination – Non-Producing Agency or Agent

Termination – Disciplinary Action

Termination – Administrative

Termination – Due to Unqualified Sale

Discretionary Termination without Cause

Termination Process

Request for Reconsideration

Section 9: What are Expected Performance Standards?

Compliance and Ethics

Code of Conduct

Overview

Our Code of Conduct provides essential guidelines that help us achieve the highest standards of ethical and compliant behavior. At UnitedHealthcare and UnitedHealth Group, we hold ourselves to the highest standards of personal and organizational integrity in our interactions with consumers, employees, contractors and other stakeholders, including the Centers for Medicare & Medicaid Services (CMS).

Act with integrity

- Recognize and address conflicts of interest.

Be Accountable

- Hold yourself accountable for your decisions and actions. Remember, we are all responsible for compliance.

Protect Privacy. Ensure Security

- Fulfill the privacy and security obligations of your job. When accessing or using protected information, take care of it!

Your Role and Responsibilities

- To fulfill your Compliance Responsibilities.

Stop. Think. Ask.

- Speak up about your concerns
- Address any mistakes, especially when a consumer may be effected
- Do the right thing – the first time and every time

If you encounter what you believe to be a potential Code of Conduct or policy violation, speak up! Speaking up is not only the right thing to do, it is required by Company policy.

UnitedHealth Group expressly prohibits retaliation against employees and agents who, in good faith, report or participate in the investigation of compliance concerns.

Compliance Reporting Resources

- Compliance
Question compliance_questions@uhc.com
- Privacy & Security
incidents UHC_Privacy_Office@uhc.com
- The UnitedHealth Group Compliance & Ethics HelpCenter 800-455-4521
or www.uhghelpcenter.ethicspoint.com
(available 24 hours a day, 7 days a week.)

The complete Code of Conduct can be accessed on *Jarvis*.

Conflict of Interest

A conflict of interest can occur when your interests or those of your immediate family could affect or appear to affect your decision making on behalf of UnitedHealthcare or where your objectivity could be questioned because of these interests or activities. All employees, contractor, and agents contracted with UnitedHealthcare attest that they have read, understand, and will abide by UnitedHealth Group's Code of Conduct.

Types of Conflict of Interest

There are several situations that create the potential for a conflict of interest when acting as a representative UnitedHealthcare. They include, but are not limited to:

Employment with UnitedHealth Group or its Affiliate

- An employee of UnitedHealth Group or its affiliate is simultaneously in a non-employee contractual relationship with UnitedHealthcare. For example, an employee is contracted as an ICA or EDC agent.

Section 9: What are Expected Performance Standards?

Ownership Interest in a Provider or other Business Partner

- An employee, contractor, or agent has a direct or indirect ownership interest in a health care provider or UnitedHealthcare business partner, including, but not limited to health care service and/or equipment provider, vendor, supplier, or manufacturer. For example, a UnitedHealthcare appointed agent has an ownership interest in, holds a position as an employee or consultant, or serves on the Board of Directors with a chiropractic practice, dental clinic, or Durable Medical Equipment (DME) company.

Relationship with a Provider or other Business Partner

- An employee, contractor, or agent has an employment or other type of relationship or position of influence with a health care service or UnitedHealthcare business partner, including, but not limited to, an equipment provider, vendor, supplier, or manufacturer. For example, a family member of an ISR or sales leader owns and/or operates a business contracted with UnitedHealthcare to provide services.

Relationship with Competitor

- An EDC is contracted and appointed with multiple carriers, including direct competitors of UnitedHealthcare.

Relationship with Agent/Agency and their Up-line or Down-line in their Structural Organization

- A UnitedHealthcare employee manages or is managed by a family member within their sales organization reporting structure. For example, an ICA's agent manager is the agent's mother.

Sale of Outside Insurance Products by any UnitedHealthcare Employee

- Outside sales of insurance products that compete with UnitedHealthcare insurance products requiring a state license (e.g., health, life, financial services, and property/casualty) by a full-time

UnitedHealthcare employee is prohibited. For example, an ISR sells life insurance outside of their normal working hours.

Disclosure of a Conflict of Interest

- You must disclose any real or potential conflicts of interest at the time of contracting and as they arise while contracted with UnitedHealthcare. The contracting process will suspend until the conflict has been removed or it is determined that it can be compliantly managed. If the conflict is discovered after contracting, the contractor/agent must notify AgentOversightAdmin@uhc.com within three business days of discovery.
- Once an employee has discovered or been notified of a real or potential conflict of interest between an employee and a non-employee, they must submit a disclosure using the Conflict of Interest Agent Disclosure Form, along with any supporting documentation, to AgentOversightAdmin@uhc.com and the employee's manager via email within three business days of discovery.
- For purposes of this section and Management of Conflict of Interest Subsection, an EDC agent whose conflict is limited to "Relationship with Competitor" is not required to submit a Disclosure of Conflict of Interest Form or have the conflict managed.

Management of Conflict of Interest

If it is determined a conflict of interest exists, UnitedHealthcare will take one or more of the following actions:

Require the employee or contractor to divest of the conflict.

- A full time UnitedHealth Group sales employee, regardless of their role, may not engage in any outside sales activity for any licensed insurance products. Such activity is deemed a conflict of interest, is prohibited, and is deemed inconsistent with

Section 9: What are Expected Performance Standards?

the purpose and requirements of the UnitedHealth Group Code of Conduct and the Avoiding Conflicts of Interest Policy.

Develop a conflict resolution and management plan approved by the Distribution Compliance Officer and Vice President of Operational Support and Forecasting.

- If it is determined that a conflict of interest exists between an employee and a non-employee, the conflict will be managed with the employee. The non-employee will receive written communication stating the nature of the conflict with a reminder of their obligations per their contract. Failure by the non-employee to comply with their written contract could result in termination.

Terminate the employee, contractor, or agent

- Refer to the Agent Termination Process.

Privacy and Security Incidents

You are required to act in compliance with all of the Centers for Medicare & Medicaid Services (CMS) regulations and guidelines and other applicable federal and state laws.

UnitedHealthcare expects agents to act with the highest degree of ethics and integrity and in the best interest of its consumers and members.

UnitedHealthcare does not tolerate unethical behavior and our policies and procedures strictly prohibit activities that are not in the best interest of those we serve. Federal law requires Medicare plan sponsors to implement and maintain a Compliance Program that incorporates measures to detect, prevent, and correct compliance related issues that include fraud, waste, and/or abuse.

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides requirements for the protection of health information. There are two pertinent provisions that guide the use of member/consumer information:

- Privacy Provisions

~ The HIPAA Privacy Rule outlines specific protections for the use and sharing of Protected Health Information (PHI).

- Security Provisions

~ The HIPAA Security Rule defines how PHI should be maintained, used, transmitted, and disclosed electronically.

Under HIPAA, if member information is disclosed to an unintended recipient, the UnitedHealthcare Privacy Office may have to:

- Notify the member
- Post the disclosure on the Health and Human Services (HHS) website
- Notify the Centers for Medicare and Medicaid Services (CMS)
- Notify state Attorney General (AG) or Department of Insurance (DOI) and/or other state agency as required by state law
- Notify the media
- In addition, individuals, including employees and business associates, may be criminally liable for intentional disclosures, privacy, and/or security incidents involving a potential or actual disclosure of member/consumer information

If you become aware of an inappropriate HIPAA/PHI disclosure, it **must** be reported within 24 hours of discovery.

You are responsible for protecting our consumers, members, our brand, and our company. Failure to protect PHI/PII may result in corrective and/or disciplinary action up to and including termination. You can report suspected privacy or security incidents through:

- Incidents should be reported to one of the following:
 - ~ The UnitedHealthcare Program Privacy Office at UHC_Privacy_Office@uhc.com
 - ~ Your supervisor or manager
 - ~ The Segment Compliance Officer/Compliance Lead
 - ~ The UnitedHealth Group Compliance & Ethics HelpCenter 800-455-4521 or www.uhghelpcenter.ethicspoint.com (available 24 hours a day, 7 days a week.)

Section 9: What are Expected Performance Standards?

- Security incidents (unauthorized access of UHG data/systems, laptop theft) must be *immediately* reported to the UHG Support Center at 888-848-3375 (24 hours a day, 7 days a week)
- UnitedHealthcare prohibits retaliatory action against any individual for raising concerns or questions regarding ethics and compliance matters or for reporting suspected violations in good faith.

Privacy and Security

You must protect the privacy and security of consumer/member Protected Health Information (PHI) and/or Personally Identifiable Information (PII) at all times. When conducting educational and/or marketing/sales activities and events, agents must remember the safeguards below to ensure proper handling of PHI/PII and maintenance of consumer privacy. Agents who fail to protect consumer/member PHI/PII may be subject to corrective and/or disciplinary action up to and including termination.

Protected Health Information (PHI)

PHI is individually identifiable information (including demographics) that relates to health condition, the provision of care, or payment of such care.

- Individual + Health Information = PHI
~ For Example: John Doe has diabetes = PHI
- The fact that someone is applying for coverage or is enrolled in a UnitedHealthcare plan is considered health information

Personally Identifiable Information (PII)

PII is a person's first name or first initial and last name in combination with, including but not limited to, one or more of the following data elements:

- Social Security Number
- Driver's License Number or State Identification Card Number

- Credit card number or debit card number
- Unique biometric data (e.g., fingerprint, retina, or iris image)
- Tax information
- Account Number in combination with any required security code, access code or password that would permit access to an individual's financial account.

PHI and PII can be in any form or medium, including oral, written or electronic communications.

Examples of disclosures include:

- Leaving hard copy documents behind at a sales/marketing activity
- Faxing documents with PHI to an incorrect fax number
- Mailing documents with PHI to an incorrect address
- Lost or stolen hard copy documents (e.g., enrollment applications)
- Stolen unencrypted computers
- Sending an email with PHI to an incorrect email address (outside of UnitedHealthcare walls)
- Sharing login/passwords to bConnected with others

Agents Must:

- Carry only the minimum amount of hard copy documents with consumer/member PHI or PII necessary to complete the day's activities.
- Double check information you have entered on applications is correct (e.g., did you transpose digits in the house number or Medicare Claim Number)
- Keep document containing PHI/PII with them at all times while on marketing/sales activities, placing document in a folder or locked briefcase.
- Keep documents in a secure locked area (e.g., file cabinet).
- Ensure that agents take all documents containing member/consumer PHI or PII with them when they leave a sales activity.

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- Keep their laptop or documents with them at all times – never leave their laptop or hard copy documents in their car.
- Encrypt all laptops, computers, smart phones, mobile phones, or other portable electronic devices in a manner so PHI/PII contained on laptops, computers, or other portable electronic devices is unreadable, undecipherable, or unusable.
- Position monitors or laptops to minimize viewing PHI/PII by unauthorized personnel or the general public.
- Double check the fax number or email address to ensure the intended recipient receives the document. Email PHI/PII using secure-encrypted program.
- Use a fax cover sheet containing the HIPAA Privacy Statement when faxing or emailing PHI or PII.
- Include the HIPAA Privacy Statement when emailing PHI or PII.
- Dispose of documents containing PHI/PII in a secure manner (e.g., shred).
- Report suspected privacy incidents to UnitedHealthcare Privacy Office at uhc_privacy_office@uhc.com, agent manager/leadership, Segment Compliance Lead, UnitedHealth Group Ethics & Compliance Help Center at 1-800-455-4521, or compliance_questions@uhc.com.

Agents must not:

- Leave hard copy documents unattended in an area where the documents could be viewed or accessed by others (e.g., desk, vehicle, table, or booth)
- Discuss consumer/member information in public spaces (e.g., halls, elevators, lobbies, lunchrooms, cafeterias, restaurants, lavatories, parking lots) or other unsecured public places where the conversation could be overheard. Be cognizant of eavesdroppers and others who may appear to be interested in your business.
- Leave laptops and/or documents containing PHI/PII unattended or unsecured outside the workplace (e.g., at home, at a hotel, while traveling, unattended in a vehicle).

- Share, store, or use consumer/member information inappropriately.
- Store PHI/PII in virtual (cloud) storage.
- Share user ID's/passwords to UnitedHealthcare systems with others.
- Put consumer/member information on a jump drive (or similar portable storage device).
- Scan or store paper enrollment applications or business reply cards (BRC) electronically, except when appropriate encryption software is in place to ensure the protection of private data transmission.
- Throw hard copy documents containing PHI/PII in the garbage, unless they have been shredded.

Fraud, Waste, and Abuse

You are accountable for complying with all applicable laws, rules, regulations, policies, and procedures regarding fraud, waste, and abuse. UnitedHealthcare relies on your integrity, good judgment, and values to ensure we remain compliant.

Fraud is intentionally obtaining something of value through misrepresentation or concealment of facts. The complete definition of fraud has many components including:

- Intentional dishonest actions or misrepresentation of fact,
- Committed by a person or entity, and
- With knowledge the dishonest action of misrepresentation could result in an inappropriate gain or benefit.

This definition applies to all persons and all entities.

Waste and abuse are generally broader concepts than fraud. Waste includes inaccurate payments for services, such as unintentional duplicate payments, and can include inappropriate utilization and/or inefficient use of resources. Abuse describes practices that, either directly or indirectly, result in unnecessary costs to health care benefit programs. This includes any practice that is not consistent with the goals of providing services that:

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- Are medically necessary
- Meet professional recognized standards for health care, and
- Are fairly priced

Generally speaking, waste and abuse can be identified by the following concepts:

- Over-use of services
- Practices or activities – whether by providers, members, vendors, employees or contractors – that are inconsistent with sound business, financial, or medical practices
- Practices or activities that cause unnecessary costs to the health care system

In most cases, waste and abuse are not considered to be caused by careless actions but rather the misuse of resources.

You can report suspected fraud, waste, and abuse to the UnitedHealthcare Fraud Tip Line at 866-242-7727 (Monday – Friday from 8:00 a.m. – 6:00 p.m. or 24 hours a day, 7 days a week for recorded messages.

Ethics and Integrity

Being ethical is much more than knowing the difference between right and wrong. It is being able to recognize and find your way through an ethical dilemma.

Merriam-Webster's Dictionary defines ethics as:

- The discipline dealing with what is good and bad and with moral duty and obligation.
- A theory or system of moral values
- A guiding philosophy.
- A set of moral issues or aspects.

Promoting an ethical and honest environment involves all agents embracing the values of honesty and integrity.

The following are several tips that should aid you in your daily activities:

- Understand the Centers for Medicare & Medicaid Services (CMS) regulations and UnitedHealthcare rules, policies, and procedures
- Report misconduct

- Ask if you don't know the answer. Remember there are plenty of resources to help you make ethical decisions, so don't feel reluctant about asking advice.
- Take responsibility for your actions.
- Remember the 3Bs of Ethics and Integrity:
 - ~ Be Informed
 - ~ Be Aware
 - ~ Be Vocal

Ethical issues arise in most aspects of marketing and selling and encompass three main components disclosure, competency, and suitability.

Disclosure

- You must disclose to consumer all information needed to make an informed decision
- You must inform consumers of the advantages, as well as, the limitations of the products you present
- You must disclose the interest you have in the transaction (e.g., any commissions received for a successful sale)
- Disclose all true out-of-pocket costs including, but not limited to, the fact that the consumer must keep paying their Medicare Part B premium
- Disclose the annual maximum out-of-pocket limit
- Take the time to answer the consumer's questions

Competency

- You have an obligation to fully comprehend the products you are selling
- Product comprehension protects against placing a consumer into a non-suitable product

Suitability

- You have an obligation to recommend a product that best meets the consumer's needs, goals, and financial resources
- Selling the right product, to the right consumer, at the right time should be your goal

Section 9: What are Expected Performance Standards?

You can report potential misconduct or policy violations to:

- Your Manager, Supervisor, or Sales Director
- Compliance.Question@uhc.com
- The UnitedHealth Group Compliance & Ethics HelpCenter 800-455-4521 or www.uhghelpcenter.ethicspoint.com (available 24 hours a day, 7 days a week.)

UnitedHealthcare expressly prohibits retaliation against employees or contractors who, in good faith, report or participate in the investigation of compliance concerns.

Agent Performance Standards

All agents are expected to comply with CMS regulations and guidelines, federal and state laws, and UnitedHealthcare rules, policies and procedures.

- External Distribution Channel (EDC) and company sales management personnel provide ongoing monitoring of your sales activities, performance against business objectives, and compliance to all applicable CMS regulations and guidelines, federal and state laws and UnitedHealthcare rules, policies, and procedures and document any performance or compliance issues and take corrective and disciplinary action when necessary.
- Sales management uses monitoring tools and processes to review your compliance, quality, and performance against minimum required performance thresholds.
- You will receive coaching, required corrective action, and/or other progressive discipline if you fail to meet defined performance thresholds.
- You must complete and pass all required UnitedHealthcare training.

- You must participate in any required remedial training.

One-on-One Evaluations - UnitedHealthcare Senior Care Options - Massachusetts

UnitedHealthcare Senior Care Options sales management is responsible for ensuring that agents authorized to sell UnitedHealthcare Senior Care Options – Massachusetts product complete required product specific training, attend periodic meetings, and complete ongoing monitoring activities.

Agent training and monitoring includes:

- You will receive 30, 60, 90 day follow-up for continuing education, training, and case review upon certification in the UnitedHealthcare Senior Care Options Plan – Massachusetts product.
- You must attend quarterly meetings with UnitedHealthcare sales management for continuing education, training, and case reviews, and best practices.
- UnitedHealthcare sales management will perform periodic ride-alongs to observe the non-employee agent at a face-to-face personal/individual marketing appointment.

Performance that may result in Immediate Termination

In some circumstances a recommendation for immediate termination (for-cause or not-for-cause) may occur. An agent terminated “For-Cause” will be reported to the applicable state Department of Insurance and CMS and will not be eligible for sales commissions in compliance with state regulatory requirements. Refer to the Agent Termination section for details related to agent termination and state/CMS notification.

Engaging in the following activities may result in a recommendation for immediate termination:

- Any occurrence of fraud, forgery, payments, inducements, deception, or coercion

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- Sale of a UnitedHealthcare product when not appropriately licensed
- Violation of terms and conditions of Agent/Agency Agreement
- Gross violation of UnitedHealthcare policy and procedures or CMS regulations or guidelines
- Failure to divest or manage a conflict of interest as agreed upon by the Vice President of Operational Support and Forecasting and the Compliance Officer (see Conflict of Interest section)
- Any other applicable situations deemed appropriate by UnitedHealthcare

Agent Outreach

You will be contacted if your compliance, quality, and/or performance data is of an unacceptable level according to defined thresholds. Outreach is generally conducted by your manager/supervisor or BDE, who will use systems, tools, and resources to help determine the appropriate level of outreach and corrective or disciplinary action. These tools will help ensure consistency in assignment of corrective and/or disciplinary action. The Agent Oversight team will monitor appropriate and timely completion of action by managers/supervisors, BDEs, and agents.

Agent Outreach

- The BDE or manager/supervisor assigned the CR is responsible for meeting with or contacting you and communicating the appropriate improvement plan. Agent outreach is document in PCL.
- Through the Corrective Action Referral (CAR) or Disciplinary Action Committee (DAC) process, you may receive an assigned action to complete.
- For EDC agents, their up-line may also implement corrective action based on its internal business policy.

Sales Agent Oversight

Compliance Monitoring and Thresholds

UnitedHealthcare Medicare Solutions has implemented a variety of compliance monitoring programs to ensure all agents are conducting sales, marketing, and enrollment activity in accordance with federal regulations and UnitedHealthcare rules, policies, and procedures. Compliance monitoring programs that are reported in the SMRT Compliance include:

- Cancelled Enrollment Applications
- Complaints
- Late Enrollment Applications
- Rapid Disenrollment
- Secret Shopper - CMS Surveillance
- Secret Shopper – Vendor (Event Observation Program)

Late event reporting, unqualified sales, and suspicious sales, and agent use of public web enrollment portals are additional monitoring programs that are not reported through SMRT Compliance, but may result in the assignment of a CR that requires agent outreach. UnitedHealthcare reserves the authority to monitor additional issues and circumstances as deemed warranted.

While monitoring programs are inherently designed to identify weaknesses, the goal is to use the information to consistently and constantly improve future behavior and outcomes, thus increasing the mutual success of the agent, manager, and business.

Calculation methods and thresholds have been established for all compliance monitoring programs and are periodically reviewed. For easy identification, threshold status results within SMRT Compliance are identified as Yellow and Red to correspond with results trending toward becoming unacceptable and unacceptable evaluation or results, respectively. Each of the monitoring programs, along with the calculation method and thresholds, are described later in this section.

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For additional questions regarding the compliance monitoring thresholds, contact your manager.

Cancelled Applications

The Cancelled Applications threshold monitors consumer cancellation of an enrollment application, prior to the effective date.

Note: The key difference between the Cancelled Application program and the Rapid Disenrollment program is that cancelled applications take place *prior* to the effective date, whereas rapid disenrollments take place *after* the effective date.

Complaints

Complaints and allegations of agent misconduct/misrepresentation originate from internal and external sources. The Agent Complaint Tracking (ACT) team receives and reviews agent-related complaints, except for those received by the Compliance and Ethics Help Center, which the Ethics Investigations Unit (EIU) reviews. The ACT team uses a criteria grid to determine if the complaint is referred to the Complaint Education Contact (CEC) process or the Compliance Investigations Unit (CIU) for investigation. At the conclusion of an EIU or CIU investigation, each allegation within a complaint receives an outcome of Substantiated, Unsubstantiated, Inconclusive, Insufficient Information, No Allegation, or Non-Response. The ACT team determines the final disposition of a complaint, which includes No Action Required, Corrective Action Referral (CAR) process, or Disciplinary Action Committee (DAC) process. Agents referred to the CAR process must successfully complete the assigned sales remediation training course(s) and corresponding assessment, with a minimum score of 80% within three attempts, within five calendar days of availability. The individual assigned the CR must complete agent outreach and documentation in PCL within 14 calendar days of receipt. The typical turnaround time for DAC corrective action is 30 calendar days.

The determination of the threshold in SMRT Compliance is based upon the investigation outcome or process to which the agent was referred. Agent outreach is conducted by the manager or BDE at the time the CEC, CAR, or DAC action is assigned. Results are reported through SMRT Compliance. The outreach and prescribed training or corrective action will be documented in PCL.

Cumulative Complaint Point Remediation Outreach (Effective 09-12-2016)

Agents who have accumulated five or more complaint points will be actively managed by their agent manager/supervisors until their complaint points drop below five points. Monthly Complaint Points Remediation CRs will be automatically generated for agents who have five or more complaint points and agent manager/supervisors will have 30 calendar days from the CR date to conduct and document the “Complaint Points Remediation Ride-Along” for field agents or the “Complaint Points Remediation Coaching Session”.

Late Enrollment Applications (Effective 12/16/16)

Late enrollment applications is a compliance program that monitors the timely submission of enrollment applications. Medicare Advantage or Prescription Drug Plan enrollment application is late when the received date by Enrollment is greater than four calendar days from the agent signature date. For AARP Medicare Supplement enrollment applications, an enrollment application is late when the received date is greater than 16 calendar days from the agent signature date.

*At its discretion, based upon seasonal volume UnitedHealthcare may modify the threshold (i.e. calendar days) applied to determine a Late Enrollment Application from agent signature date.

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Rapid Disenrollment

Rapid Disenrollment is a compliance program that monitors consumer voluntary disenrollment from a plan within three months of the effective date.

You should strive to enroll each consumer in the plan that best meets the consumer's health care needs. In addition, you must meet company and regulatory guidelines during the presentation to ensure the consumer understands the benefits and requirements of the plan in which they are enrolling. By enrolling the consumer in the plan that best meets their needs and ensuring consumer understanding, you are reducing the risk of a rapid disenrollment.

Secret Shopper - CMS Surveillance

CMS Surveillance (Secret Shopper - CMS) is a compliance program that identifies an agent's improper marketing and sales practices during marketing/sales or educational events. The outcome of the secret shopper observations are only shared with UnitedHealthcare if you fail the review. Reviews are scored on a Pass/Fail basis. UnitedHealthcare has 48 hours after notification of a failed observation to respond to CMS regarding the allegation(s). An infraction occurs when an event has one or more findings where the finding is labeled "Does Not Contest", "Agree", or "Dispute". If disputed, the CMS final outcome must state "Deficiency Stands". Compliance validates all CMS secret shopper reviews. For validated infractions, the ACT team will generate a CR.

CMS monitors agent behavior in order to protect the interests of the Medicare consumer. Agents are expected to comply with all Medicare marketing guidelines including rules related to reporting marketing/sales events, using CMS approved marketing materials, and conducting promotional activities.

Secret Shopper – Vendor (Event Observation Program)

The Event Observation Program (Secret Shopper – Vendor) is a compliance program that evaluates agent marketing and sales practices at reported marketing/sales events. UnitedHealthcare uses a contracted vendor to perform the agent evaluations. Completed evaluations are reviewed by the Event Observation Program manager and forwarded to the ACT team for validation. A passing evaluation threshold is 85%. Any composite score below 84% is considered a failing score. Agents who received a deficiency related to any of the evaluation's compliance questions will be considered auto fail (below 85%). There are two categories of Secret Shopping results for which the ACT team facilitates agent outreach: Unsuccessful Events (No Shows), and Failed Events (Scores less than 85%). For validated infractions for Failed and Unsuccessful Events, the ACT team will generate a CR.

The program uses both random and target sampling techniques to select marketing/sales events to secret shop. Marketing/Sales events are selected from those reported each month and include both scheduled formal (i.e. presenter audience format) and informal (e.g. retail booth). The evaluator may participate in the marketing/sales event by asking specific questions pertaining to the plan such as eligibility, provider network, and benefit features. At the conclusion of their visit, the evaluator completes an agent evaluation form provided by Distribution Compliance. A score of 85% or higher is considered a passing evaluation score.

Unqualified Sales and Corrective/Disciplinary Action

You must be appropriately licensed, appointed (if applicable), and certified at the time of the sale in order to be eligible for a commission or incentive on the sale.

- If you are appropriately licensed, but not appointed (if applicable) in the state in which the consumer resides and/or certified in the product in which the consumer enrolled will

Section 9: What are Expected Performance Standards?

be assigned a CAR and two complaint points for the first instance in a rolling 12-month period. A CR will be generated and assigned to a manager/supervisor or BDE to conduct agent outreach.

- You will be terminated not-for-cause if at the time of sale they were not licensed in the state in which the consumer resides, including if the license lapsed or expired or if a subsequent incident of an unqualified sale due to appointment or certification occurs in a rolling 12-month period after having received prior outreach.

Suspicious Sales Monitoring

Two reports are used to monitor enrollment activity that is potentially fraudulent. The suspicious agent report looks for enrollment trends based on agent over time. The deceased enrollee report compares enrollment application receipt date to the consumer's reported death date. Potential incidents of suspected agent fraud are analyzed and forwarded for investigation as appropriate.

Event-Related Infraction and Corrective/Disciplinary Action

All events must be reported to UnitedHealthcare. The presenting agent must pass with a score of 85% or better, within six attempts the Events Basics assessment prior to reporting and/or conducting an educational or marketing/sales event. The presenting agent is responsible for the timely entry, changing, and/or cancelling of the event in bConnected as well as the accuracy of the information reported.

- **Late Reported, Changed, or Cancelled Event**

- ~ A report is generated that identifies events entered in UnitedHealthcare's event reporting application less than 14 calendar days prior to the date of the event and events that are changed or cancelled in the reporting application within three business days of the date of the event.

- **Failure to Report**

- ~ A failure to report infraction, as reported by CMS through their clipping service audit or UnitedHealthcare Compliance or discovered during a complaint investigation, results in a formal Operational Issues complaint against the presenting agent and a CAR. You will be assessed two complaint points and must complete assigned corrective action, which includes completing the on-line Operational Issues remediation module and a second session of the Events Basics module, receiving manager/supervisor/BDE coaching, and completing an attestation of understanding that a second offense within the 12-month period following coaching will result in a DAC referral and may result in termination.

- **Failure to Complete Events Basics Module**

- ~ Upon receipt of event evaluation results, Compliance validates that the presenting agent indicated on the scorecard successfully completed the applicable Events Basics module (i.e. passed the assessment with a minimum score of 85% or better within six attempts). A presenting agent who does not successfully complete the applicable Events Basics module prior to conducting the evaluated event will receive coaching and will be assigned an Operational Issues complaint, two complaint points, and a CAR, which includes completing the Operational Issues remediation module and Events Basics module as assigned.

- **Presenting Agent is not Contracted with UnitedHealthcare**

- ~ If during the event evaluation scorecard validation process, Compliance determines that a non-contracted agent conducted a marketing/sales event on behalf of UnitedHealthcare, they will look up the reported event in the event reporting application to determine the intended presenting agent, determine

Section 9: What are Expected Performance Standards?

who made the decision to replace the presenting agent, and what knowledge sales management had of the situation. Corrective and/or disciplinary action may include a no-show infraction against the presenting agent listed in the event reporting application, a Do Not Re-contract flag against the non-contracted agent (if an inactive agent record is located in the UnitedHealthcare system).

▪ **Unsuccessful Event (No-Show) Infractions**

- ~ Unsuccessful Event (No-Show) infractions result when the agent did not show up for a reported event, the incorrect event type was reported, the agent arrived late and after the observer/secret shopper arrived, the reported and actual addresses of the event are not the same, the event could not be located due to inadequate signage, the time of the event was changed, or the event was cancelled but not reported. The presenting agent (indicated in the event reporting application) must complete assigned corrective action, which includes completing the Operational Issues remediation module and a second session of the Events Basics module and receiving manager coaching that includes an event observation by the manager (Note: BDEs do not conduct event observations). An agent failing a second event observations/secret shops due to Unsuccessful Event in a 12-month rolling period after having been coached will be assigned corrective actions. Agents failing a third event

observation/secret shop due to Unsuccessful Event in a 12-month rolling period after having been coached will result in a DAC referral.

- ~ Agents failing an event evaluation/secret shop for a reason other than an Unsuccessful Event (No-Show) must complete a second session of the Events Basics module and will receive manager coaching that includes an event observation by the manager (Note: BDEs do not conduct event observations).

Use of Public Web Enrollment Portal

You are not permitted to submit consumer enrollments or be physically present when a consumer is self-submitting an enrollment via a UnitedHealthcare public web portal. Enrollment activity is monitored for potentially fraudulent activity and outreach calls are made to members to identify the party who initiated, keyed, and submitted the enrollment application via a public web portal. When it is determined that an agent completed an enrollment via a UnitedHealthcare public web portal or was physically present when a consumer submitted an enrollment via a UnitedHealthcare public web portal, a formal Operational Issues complaint is substantiated and two complaint points and a CAR are assigned. An agent completing a second enrollment in the same manner in a 12-month rolling period, after having been coached, will be assigned corrective action. An agent submitting a third enrollment via a UnitedHealthcare public web portal, after having been coached, will result in a DAC referral.

Section 9: What are Expected Performance Standards?

SMRT Compliance Agent Thresholds

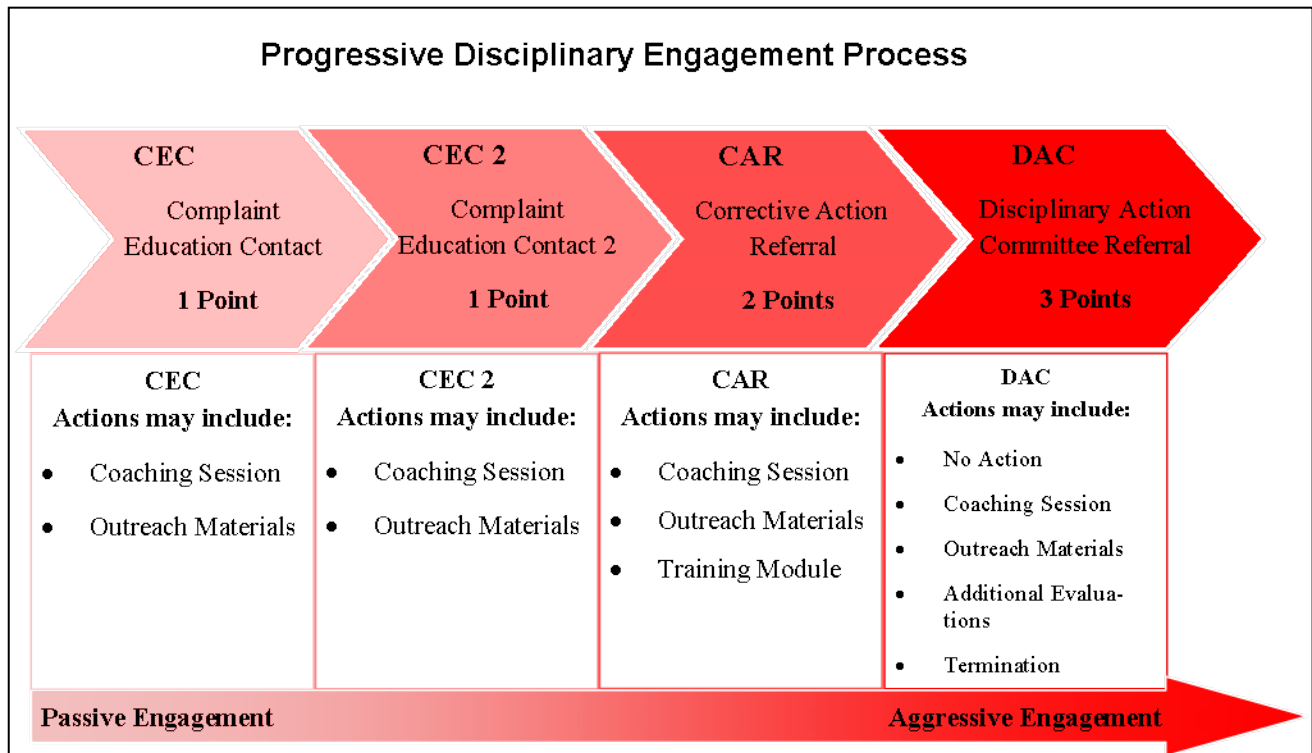
SMRT Compliance Agent Threshold Matrix v.1.6
Effective 06/01/17

Program	Complaint	Cancelled Enrollment Application	Rapid Disenrollment	Late Enrollment Application	Event Observation Program (Secret Shopper Vendor)	CMS Surveillance (Secret Shopper - CMS)
Infraction Definition	All closed complaints that are actionable. (Does not include complaints with a final action of: No Current Action Required, Non-Complaint, or Operational Issue/No Action Required) For DAC, all items referred to DAC.	A consumer cancels the enrollment application before the effective date.	Member disenrolls from MA or PDP within 3 months from plan effective date.	Enrollment received date for MA/PDP applications is greater than 4 calendar days from agent signature date and greater than 16 calendar days for AARP Medicare Supplement applications.	Any evaluation score less than 85%.	An event has 1 or more valid findings where the finding is labeled as "Does Not Contest", "Agree", or "Dispute". If disputed, the CMS final outcome must state "Deficiency Stands".
Threshold	Agent Threshold	Agent Threshold	Agent Threshold	Agent Threshold	Agent Threshold	Agent Threshold
Minimum Requirement	N/A	Minimum of 10 enrollment applications	Minimum of 10 enrollment applications	N/A	N/A	N/A
Timeframe	Daily	Future 3 effective dates (Evaluated independently)	Most recent 6 completed effective dates (Evaluated independently)	Trailing time period	Daily	Daily
Limitations on CR Creation	N/A	1 red per effective date	1 red per effective date	Must wait 7 calendar days before creating another CR	N/A	N/A
Yellow CR	A closed complaint has been referred to CEC or CEC2.	N/A	NA	NA	NA	N/A
Red CR	A closed complaint has been referred to the CAR or DAC	Greater than 25% Cancellation Rate	Greater than 10% Rapid Disenrollment Rate	Greater than or equal to 4 late enrollment applications in the last 7 calendar days	Less than 85% evaluation score	Greater than or equal to 1 Failed Events
Threshold Calculations	Looks at complaints referred to CEC, CAR, or DAC.	Calculates the percentage of cancelled enrollment applications by effective date for the nearest 3 future effective months. Total number of cancelled applications divided by total number of submitted enrollment applications for each effective date, independently.	Calculates the overall percentage of Rapid Disenrollments for an agent for the last 6 completed months. Total number of rapid disenrollments divided by total accreted enrollment applications for each effective date, independently.	Number of late enrollment applications in a trailing time period.	Overall composite score of the Secret Shopper event.	Number of Pass or Fail Infractions.
Incident Date	Application Date; If not available, Receipt date	Application Date	Application Date	Agent Signature Date; If not available, Application Date	Event Date	Event Date
Infraction Date	For all programs, the date the infraction is identified and created in SMRT Compliance					

Section 9: What are Expected Performance Standards?

Complaints and Allegations of Agent Misconduct

Agents are expected to conduct themselves in a manner required by the Centers for Medicare & Medicaid Services (CMS) regulations, state and federal laws, guidelines, and UnitedHealthcare rules, policies, and procedures. Complaints and allegations of misconduct against agents are considered serious matters that require prompt attention.



Progressive Disciplinary Engagement Process

The Progressive Disciplinary Engagement Process is designed to take timely, appropriate, and effective corrective and disciplinary action against offending agents and escalated actions against reoffending agents.

The overall goal of the process is to lead to better educated and more effective agents representing UnitedHealthcare.

In the Progressive Disciplinary Engagement Process there are four levels of complaints.

- Complaint Education Contact (CEC) *
- Complaint Education Contact 2 (CEC2) *
- Corrective Action Referral (CAR)

- Disciplinary Action Committee Referral (DAC)

* Only the Plan and Product Knowledge Issue and the Point-of-Sale and Post-Sale Issues allegation families are CEC and CEC2 eligible.

There are six allegation families that group related complaints together.

- Lead-Contact Issues
- Prohibited Activities
- Risk to Consumers and/or Organization
- Operational Issues
- Plan and Product Knowledge Issues
- Point-of-Sale and Post-Sale Issues

Section 9: What are Expected Performance Standards?

Point System

Actionable complaints (i.e. Inconclusive or Substantiated outcomes) will be assessed points based on the outcome of the complaint. Points will accumulate over a rolling 12 months. When a point threshold is met or exceeded, you will receive training/outreach or escalated disciplinary action.

The point breakdown is as follows:

- CEC = 1 point
- CEC2 = 1 point
- CAR = 2 points
- DAC = 3 points

Source of Complaints

Complaints can originate from both internal and external sources. All complaints against agents will be immediately provided to the Agent Complaint Tracking (ACT) team.

Sources of Complaints and Allegations of Agent Misconduct:

- Internal sources may include UnitedHealthcare Medicare Solutions Service Center (OSC), UnitedHealthcare Medicare Solutions National Service Center for Government Programs (NSC), and Appeals and Grievances, but could also arise in sales and marketing, service integrity and member support, provider services, care coordination, Producer Help Desk (PHD), Ethics Point, or compliance as examples.
- External sources may include the Centers for Medicare & Medicaid Services (CMS), state Departments of Insurance (DOI) or Departments of Health or Public Welfare, state Attorneys General, providers, state or federal law enforcement, and other state or federal regulatory agencies, as examples.

The ACT team will conduct an initial review of the complaint and will create a record of every complaint. The ACT team will determine the appropriate action for the complaint through the

Progressive Disciplinary Engagement Process and/or further investigation of the complaint.

Under no circumstance may the agent referenced in the complaint contact the consumer or member who filed the complaint regarding the allegations in the complaint during the investigative process.

Initial Review and Pre-Disposition

Review Process

The ACT team will complete the entry of each complaint as needed into the agent complaint tracking tool and a case number is assigned. Each complaint is reviewed to validate that it is within the scope of the agent complaint process.

- A complaint is closed, the case documented accordingly, and the submitter notified if the following conditions exist:
 - ~ No UnitedHealthcare sales agent is involved in the complaint
 - ~ The product identified in the complaint is not a UnitedHealthcare Medicare Solutions product
 - ~ The basis for the complaint is due to an internal business operational issue and submitted through the agent complaint tracking tool
- If the complaint is in scope of the agent complaint process, it moves to the pre-disposition stage

Pre-Disposition

The ACT team reviews each complaint using the Complaint Education Contact (CEC) – Corrective Action Referral (CAR) – Disciplinary Action Committee Referral (DAC) criteria grid to determine if the complaint is referred to the CEC process or the Compliance Investigations Unit (CIU) for investigation. The status of the complaint is updated in the agent complaint tracking tool.

Section 9: What are Expected Performance Standards?

The Progressive Disciplinary Engagement Process

Complaint Education Contact (CEC) or (CEC2)

If the complaint is determined to fall within the criteria to be a CEC or CEC2 complaint, the complaint may not be further investigated. If a CEC is assigned, you will be assigned a pre-defined outreach per applicable allegation. A CEC2 will be assigned if an agent receives more than one complaint in any of the two applicable family allegations or receives two complaints that are similar in nature. In addition to addressing the specific issue, the entire allegation family must be addressed when a CEC2 is assigned.

The manager/coach is responsible for completing the assigned coaching session with you.

- The ACT team uses the CEC Outreach Tool to determine appropriate outreach.
- For active agents, a Coaching Request (CR) is created in PCL and is assigned to the appropriate Broker Development and Education Specialist (BDE) or agent manager/supervisor.
- For inactive agents, a CR is not created. The status of the complaint is updated in the agent complaint tracking tool and Agent On-Boarding is notified to flag the agent DNR in the event the agent wants to re-contract. If you on-board with a vendor or eAlliance that is different from where the original outstanding complaint/error occurred, your current vendor or eAlliance will be provided with the description of the complaint/error without any PHI or PII unless there is a clear business purpose. In the event there is a clear business purpose requiring disclosure of PHI or PII related to the complaint/error, the minimally necessary amount of PHI or PII shall be provided to the current vendor or eAlliance with such information sent via secure transmission (e.g. if the agent committed the infraction while under vendor ABC and then on-boards the next AEP with XYZ)

- When an agent is re-appointed and active, they have access to the required tools and systems in order to complete coaching and begin marketing activities.
- The BDE or agent manager/supervisor has 14 calendar days from the date the CR was created to complete and document agent outreach and close the CR unless an extension has been requested by the agent manager/supervisor or BDE and approved by the ACT team. The CR is managed according to the amended due date.
- The ACT team monitors the completion of CEC CRs and implements an escalation process for CRs not completed within the required timeframe.

Corrective Action Referral (CAR)

If the complaint is determined to not be eligible for a CEC or CEC2 or requires escalated review, the complaint will be additionally investigated. If the complaint is assigned as a CAR you will be assigned a module for the applicable allegation family the complaint falls into. The assignment of a CAR following the investigation means that there were findings that warranted escalated outreach. Please note: it is not necessary that a complaint be investigated, in order to assign a CAR.

See the Corrective Action Referral process section.

Disciplinary Action Committee Referral (DAC)

If the complaint is assigned to the DAC, it will be reviewed by a committee of select senior management. The committee will review you comprehensively and determine the appropriate action based on the review.

Possible actions may include, but are not limited to:

- Assignment of applicable module(s)
- Assignment of outreach materials or trainings
- Additional evaluations or ride-a-longs

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- Requirement of a formal acknowledgement of the complaint/issue
- Termination
- If the requirements are not met within the allotted timeframe, the agent may be referred for administrative termination.

See the Disciplinary Action Committee Referral process section for additional details.

Investigation of Complaints or Allegations of Agent Misconduct by the Compliance Investigations Unit (CIU)

Repeated or severe allegations of misconduct requiring additional investigation are forwarded to the Compliance Investigations Unit (CIU).

Upon receipt of complaint referral from the ACT team, CIU makes a preliminary assessment of the case that includes assigning the case to an investigator. The CIU will initiate an investigation as quickly as possible. At any point during the investigation, CIU may determine, by using a severity grid, that a recommendation to suspend an agent's ability to market and sell UnitedHealthcare products is justified. The CIU will forward the suspension recommendation to the Director of Agent Complaint Tracking.

Investigation Process

The investigation process consists of obtaining information, documenting findings, and determining allegation outcomes.

- Generally, a Request for Agent Response (RAR) is prepared and sent directly to you and to your sales or NMA/FMO management hierarchy. The RAR requests specific detailed responses to each allegation as well as other pertinent questions, facts, and circumstances. An agent must submit their own RAR statements with an Agent Attestation of Signature. A written response to the RAR is required within five business days. If a response is not received by the date requested, you, along with your sales or NMA/FMO management hierarchy, is sent a Non-Response Letter (NRL) stating that a response must be received within two

business days. If no response is received within the prescribed timeframe, an administrative termination is initiated.

- Members or their authorized representatives may be interviewed during an investigation to gather required details regarding the complaint or to confirm identity of the agent and/or other pertinent facts. All contact with members is made in accordance with CMS guidance.
- The investigator may also conduct a telephone interview of you. These interviews may occur prior to or as a follow-up to the RAR or NRL when the investigator needs more information or clarification of details. Interviews of other witnesses relevant to the investigation are also conducted as determined appropriate.
- System research is conducted to obtain information regarding claims, customer service notes, lead generation, and other details as determined in reviewing the case (CIU investigator, CIU management) to assist investigators resolve allegation outcomes.

Under no circumstance may you contact the consumer or member who filed the complaint regarding the allegations in the complaint during the investigative process.

Allegation Outcome

A complaint may contain one or more separate allegations as determined by the investigation. Each allegation is investigated and an outcome determined on its own merits. Therefore, different allegation outcomes may result from one complaint. Following the review of an allegation, investigation, and consideration of the findings, one of the following allegation outcomes is assigned:

- The CIU will determine an allegation outcome of Substantiated, Unsubstantiated, Inconclusive, Insufficient Information, No Allegation, or Non-Response. The allegation outcome is considered in the recommendation for a final action which is assigned at the conclusion of the investigation.

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- **Substantiated:** Based on the evidence and facts that existed at the time the investigation was conducted and applicable CMS Medicare Marketing Guidelines, internal policy, or other authority, a reasonable person would conclude that the allegation is true.
- **Unsubstantiated:** Based on the evidence and facts that existed at the time the investigation was conducted and applicable CMS Medicare Marketing Guidelines, internal policy, or other authority, a reasonable person would conclude that the allegation is unfounded.
- **Inconclusive:** There was insufficient evidence, facts, or corroborating evidence that existed at the time the investigation was conducted that would lead a reasonable person to conclude the allegation is neither substantiated nor unsubstantiated.
- **Insufficient Information:** The complaint lacked the minimum amount of information necessary to determine the identity of the agent, member, or other information necessary to conduct a complex investigation.
- **No Allegation:** The complaint is determined not to have been a complaint against you for sales or marketing misconduct in accordance with CMS guidelines and company policy.
- **Non-Response:** You failed to respond within the required timeframes to the RAR and NRL.

Refer for Disposition

Upon completion of the investigation, the Investigative Report, Investigative Findings, and Allegation Outcomes are generally documented in the agent complaint tracking tool. The case is updated as 'Refer for Disposition' in the tracking tool and is referred back to the ACT team. Supporting documentation, including exhibits, are provided to the ACT team within the tracking tool.

- Final action recommendations may include No Action Required, Training/Corrective Action, or Termination. Terminations may be either For Cause or Not for Cause based

on the circumstances of the case. If the recommendation is for training or counseling, the matter is sent through the Corrective Action Referral (CAR) process. Recommendations for termination or suspension are referred to the Disciplinary Action Committee (DAC).

- Sales management will review the allegation, investigation outcome, and final action determination with you. The investigation and outcome documentation will be placed in your performance file. The Agent Complaint Tracking (ACT) team will track completion of training and/or corrective action assigned to you as a result of the complaint investigation. Sales management will oversee your completion of training, corrective action and/or disciplinary action resulting from the complaint investigation. Corrective action plans will be documented in your performance file.

Assignment of Final Disposition

The ACT team considers each allegation outcome assigned by the CIU at the completion of an investigation to determine the final disposition of a complaint. The following final dispositions are available:

No Action Required

The following situations result in no required action and the case is closed in the agent complaint tracking tool:

- The allegation outcome is Insufficient Information, No Allegation, or Unsubstantiated. If the investigation results in unsubstantiated outcomes for all allegations, the Agent Closure Letter is emailed to you, thanking you for your cooperation and notifying you of the investigative results.
- The allegation outcome is Inconclusive or Substantiated, you had received outreach for the same allegation or the same allegation family within the past twelve months, and the event/enrollment application for the current allegation took place before the outreach occurred. You are notified via email that no further action is required.

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Referral to the Corrective Action Referral Process

For allegation outcomes of Inconclusive or Substantiated, the ACT team uses the CEC-CEC 2-CAR-DAC Referral Criteria Grid to determine if a referral to the Corrective Action Referral (CAR) process is appropriate. The following situations result in a CAR process referral:

- You have not had outreach for the same allegation(s) within the past twelve months and the CEC-CEC 2-CAR-DAC Referral Criteria Grid recommends referral to the CAR process.
- You have exhausted all CEC/CEC2 opportunities for the same allegation family (-ies) within the past twelve months and the event/enrollment application for the current allegation took place after the CEC/CEC 2 outreach occurred.

Referral to the Disciplinary Action Committee

For allegation outcomes of Inconclusive or Substantiated, the ACT team will use the CEC-CEC 2-CAR-DAC Referral Criteria Grid to determine if a referral to the Disciplinary Action Committee (DAC) is appropriate. The following situations result in a DAC referral:

- You have not had outreach for the same allegation(s) in the past twelve-months and the CEC-CEC 2-CAR-DAC Referral Criteria Grid recommends referral to the DAC.
- You have had outreach for a non-CEC eligible allegation (i.e. high-risk) through either the CAR or DAC within the past twelve months and the event/enrollment application for the current allegation took place after the previous CAR or DAC outreach occurred.
- You have had repeated instances of lower severity complaints.
- Your behavior posed a continuing risk to company reputation or harm to members.

Corrective Action Referral Process

The Corrective Action Referral (CAR) process supports the progressive disciplinary process and is a proactive measure intended to address egregious agent behavior with retraining efforts delivered in a prompt manner intending to correct the underlying problem that resulted in program violation and to prevent future noncompliance. The following steps are taken when a referral is made to the CAR process:

- The ACT team uses the CEC Outreach Tool to determine appropriate outreach.
- For active agents, a Coaching Request (CR) is generated in PCL and assigned to the appropriate BDE or agent manager/supervisor.
- For inactive agents, a CR is not created. The status of the complaint is updated in the agent complaint tracking tool and Agent On-Boarding is notified to flag the agent DNR in the event the agent re-contracts. When an agent is re-appointed and active, the agent will have access to the required tools and systems for the coaching requirements to be completed for the previous complaint and to begin marketing activities. If you on-board with a vendor or eAlliance that is different from where the original outstanding complaint/error occurred, your current vendor or eAlliance will be provided with the description of the complaint/error without any PHI or PII unless there is a clear business purpose. In the event there is a clear business purpose requiring disclosure of PHI or PII related to the complaint/error, the minimum necessary amount of PHI or PII shall be provided to the current vendor or eAlliance with such information sent via secure transmission (e.g. if the agent committed the infraction while under vendor ABC and then on-boards the next AEP with XYZ).
- The applicable Sales Remediation Web-Based Training Course(s) is assigned to you.
- You must successfully complete the course(s) within five calendar days of availability. Successful completion is

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defined as completing the course in its entirety and passing the corresponding assessment with a minimum score of 80% within six attempts. UnitedHealthcare has the discretion to reset the module to three additional attempts for you to complete and pass the course (e.g., system issue caused one or more failure, or your manager/supervisor or BDE requested a reset).

- The BDE or agent manager/supervisor has fourteen calendar days from receipt to complete and document agent outreach and close the CR, unless an extension has been requested by the BDE or agent manager/supervisor and approved by the ACT team. The CR is managed according to the amended due date.
- You will be required to complete any and all assigned modules and/or materials.
- The ACT team monitors the completion of CAR Coaching Requests and implements an escalation process for Coaching Requests not completed within the required fourteen calendar days. See Escalation Process for details.
- A monthly report is available that details key metrics of the CAR process including the percent of CAR outreaches completed.
- If the findings of the investigation relate to Substantiated outcomes for Unreported Sales Events or Unauthorized Marketing Materials, you are also required to review, complete, sign and return a mandatory CMS Attestation acknowledging understanding of the issue.
- If the requirements are not met within the allotted timeframe, you may be referred for administrative termination.

Disciplinary Action Committee

The Disciplinary Action Committee (DAC) is responsible for determining appropriate disciplinary and/or corrective action up to and including agent termination.

Committee Membership and Mechanics

- The DAC, chaired by the Director of Agent Complaint Tracking, is comprised of six management-level representatives from Compliance, sales, and sales operations.
- A representative of the Legal Department serves as a legal advisor to the committee.

DAC Proceedings

- At the completion of a complaint investigation, the ACT team will refer an agent to the DAC if the allegation outcome, along with other defined criteria, indicates DAC Referral as the prescribed final disposition or if an agent has recurring instances of lower severity complaints.

DAC Outcomes

The following outcomes are available to the DAC:

- No Action Required
 - The DAC determines you do not require additional training to address the issue presented.
- Corrective Action
 - The DAC recommends appropriate corrective action tailored to address the complaint or issue of noncompliance and timelines for completion. In such cases, the ACT team opens a Coaching Request in PCL, in addition to drafting a formal corrective action letter that is sent to you and your applicable up-line notifying the appropriate manager to facilitate appropriate outreach and training to you. Typically, DAC recommended corrective action (e.g., training and/or manager ride-along/sit-beside) must be completed within 30 calendar days, unless an extension has been requested by the BDE or agent manager/supervisor and approved by the ACT team. The CR is managed according to the amended due date.
- Deauthorization of Sales and Marketing Activity
 - The DAC deauthorizes you from performing sales and marketing activity of a particular product until assigned corrective action is completed. The DAC

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chairperson is responsible for notifying the agent's manager of the deauthorization and required training. Your manager is responsible for monitoring the completion of the assigned training.

- Termination
 - The DAC terminates you. In addition to the decision to terminate the agent, the DAC must determine if the termination is for-cause or not-for-cause. Agent On-Boarding is notified to flag the agent DNR. (Refer to the Agent Termination Process section for termination process details.)

Coaching Request Extension Process

Under certain circumstances, a BDE or agent manager/supervisor may request from ACT an extension to the required CR completion date. Contact your BDE or agent manager/supervisor for process details.

Revocation of Authority to Sell

Your performance is monitored in a variety of areas including rapid disenrollment rates and complaint ratios. Performance in each area is measured against established thresholds. If your performance fails to meet defined performance thresholds, coaching, corrective action, and/or disciplinary action may be imposed. Refer to the Agent Performance section for detailed information on performance standards, oversight, and development.

If you fail to comply with or maintain acceptable complaint ratios and/or rapid disenrollment rates is limited to a specific product and efforts to remediate do not achieve the desired change in the agent's performance against monitoring program threshold(s), UnitedHealthcare may process a termination of your authority to sell the identified product.

Revocation of Your Authority to Sell Specific Medicare Advantage Products Process

Authority to sell specific products is defined within your agent agreement. If your authority to sell a specific product is revoked; you will receive a contract amendment.

- You will receive a notification letter detailing the authority revocation, the product, and the effective date. Note: the effective date is thirty days or the based on the terms of your agent agreement.
- Commissions will not be paid on any enrollment applications written for a product after the revocation of authority effective date.
- You will continue to receive commission renewals, if eligible, for business written prior to the revocation effective date.
- Contact your sales leadership for additional process details.

Appealing Revocation of Authority to Sell a Specific Medicare Advantage Product Process

You may appeal the revocation of your authority to sell a specific product.

- The notification letter will provide your appeal rights and instructions.
- All appeals must be in writing and must include your name and address and be submitted via email to business_monitoring@uhc.com.
- In the written appeal, you must clarify and provide detail, or explain mitigating circumstances, regarding the complaint and/or rapid disenrollment findings, including correction of errors or share extenuating circumstances.
- You must wait a minimum of six months after a denial notification before submitting a new appeal.
- Contact your sales leadership for additional appeal process details.

Suspension of Marketing and Sales Activities

UnitedHealthcare Medicare Solutions expects you to comply with all Centers for Medicare & Medicaid Services (CMS) regulations, state and federal laws, guidelines, and UnitedHealthcare rules, policies, and procedures.

- If at any time your performance or action damages or threatens to damage the reputation of UnitedHealthcare or does not meet compliance standards, UnitedHealthcare can initiate the suspension of your sales and marketing activities.
- A determination to suspend can also be based on the severity of an allegation(s), the threat of additional harm, the number of pending complaints or investigations, the nature and credibility of information initially provided, and/or the number of members or consumers affected and can be based on other oversight criteria.
- Contact your sales leadership for additional suspension of marketing and sales activities.

Suspension Process

- When a recommendation to suspend your sales and marketing activities is made, you will be mailed a suspension notification letter from the Vice President of External Distribution (EDC Channel) with a copy sent to your NMA/FMO.
- The suspension is effective immediately upon notice and continues until the investigation is complete and a final disposition is recommended and completed or as indicated in the notification.
- You are not to market or sell UnitedHealthcare products while on a suspension status.
- New business written during the suspension period will not be eligible for commission. Renewals, if eligible, will be paid while on a suspension status.

Termination – Non-Producing Agency or Agent

UnitedHealthcare Medicare Solutions contracts, certifies, and appoints agents whose intent it is to represent and sell UnitedHealthcare Medicare Solutions products. Intent to sell is demonstrated by the submission of a contract packet and timely certification.

Agents/agencies that have not maintained certification and/or written UnitedHealthcare business over a reasonable period (usually 12 months or more) are considered dormant. On a periodic basis, action will be taken to terminate dormant agents/agencies.

- You will receive a notification letter detailing the reason for termination, the effective date of termination, and instructions for submitting appeals to the Producer Help Desk (PHD).
- Any appeal may be submitted within the notification period (usually 30 days or based on the terms of the agent agreement) if one of the following conditions can be met:
 - ~ Proof of sales (e.g., a copy of a commission statement or screen shot from *Jarvis*)
 - ~ Proof that your role was that of a sales trainer and not an EDC sales agent (e.g., a signed letter from the NMA/FMO verifying the agent as a trainer)
 - ~ Proof you use the writing number of an agency (e.g., a copy of the agency commission statement)
- If an appeal is not filed or the appeal is denied, a not-for-cause termination will be processed on the termination effective date
- You are eligible to apply to re-contract immediately following the termination effective date.

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Termination – Disciplinary Action

Refer to the Complaints and Allegations of Agent Misconduct section for disciplinary action termination determination details.

Termination – Administrative

Administrative terminations are disciplinary, not-for-cause terminations initiated in two circumstances.

- If you fail to respond within the prescribed timeframes to Request for Agent Response (RAR) and Non-Response Letters (NRL) sent by an investigator during a complaint investigation.
 - ~ You will receive a notification letter detailing the reason for termination, the termination effective date, and the appeal process.
 - ~ If you do not respond within the thirty-day termination notification period, your termination process will begin and a Do Not Re-Contract flag to your file.
 - If you respond within the thirty-day termination notification period, you provide a sufficient RAR/NRL response to the investigator, a retraction to the notification of termination letter will be sent by mail to you.
 - You may request a reconsideration of an administrative termination
 - See your sales leadership for additional details
- If you fail to complete the required training/coaching resulting from a Complaint Education Contact (CEC/CEC2), Corrective Action Referral (CAR), or DAC referral or any required compliance monitoring program coaching.
 - ~ You will receive a notification letter detailing the reason for termination, the

termination effective date, and the appeal process.

- ~ The termination will process 30 days from the termination notification letter and a Do Not Re-Contract flag will be added to your file.
 - If the training is completed within the thirty day timeframe, a retraction to the notification of termination letter will be sent by mail.
 - You may request a reconsideration of an administrative termination
 - See your sales leadership for additional details

Termination – Due to Unqualified Sale

You are prohibited from making an unqualified sale. An unqualified sale is a sale by an agent who, at the time the enrollment application was written, was not appropriately licensed, or appointed (if applicable) in the state in which the consumer resided or certified in the product in which the consumer enrolled.

UnitedHealthcare will send a letter of notification to the member stating that you were not qualified to sell at the time the enrollment application was completed.

The member may request to make a plan change. However, an unqualified sale does not necessarily affect the consumer/member's enrollment in the plan.

Commissions will not be paid on any unqualified sale.

Termination due to License Issue

A not-for-cause termination will be initiated if at the time of sale you were not licensed in the state in which the consumer resides, including if the license lapsed or expired.

- You can appeal during the termination notification period (usually 30 days or based on the terms of the agent agreement) by

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providing documentation that includes proof of an active license at the time of the sale.

- You are eligible to re-contract after a minimum of 12 months following the date of the unqualified sale.

Termination due to Certification or Appointment Issue

A not-for-cause termination will be initiated if there are two incidents of an unqualified sale due to certification or appointment in a rolling 12-month period.

- You can appeal during the termination notification period (usually 30 days or based on the terms of the agent agreement) by providing documentation that includes proof of the proper state appointment/product certification.
- You are eligible to re-contract after a minimum of 12 months following the date of the unqualified sale.

Discretionary Termination without Cause

You may be discretionary terminated at will and without cause by UnitedHealthcare sales management upon 30 days prior written notice.

Termination Process

All contract and appointment terminations are classified Not-for-Cause or For-Cause.

Termination of appointment may be recommended by UnitedHealthcare, an NMA/FMO, a regulatory agency, state Department of Insurance, or an agent may request a voluntary termination or an alteration to the EDC hierarchy.

Not-for-Cause Termination

A not-for-cause termination may be initiated for agents by UnitedHealthcare, or requested for any reason by an agent or the agent's NMA/FMO. The termination notification period for not-for-cause termination is thirty-days or per the agent

agreement. Depending on the reason for termination, the agent may be flagged Do Not Re-Contract in the contracting system.

Not-for-Cause Termination Process

1. UnitedHealthcare-initiated, not-for-cause terminations
 - a. You will receive a not-for-cause termination letter, detailing the reason for termination, the termination effective date, and the appeal process (if applicable).
2. Disciplinary Action Committee (DAC)-initiated and disciplinary action, not-for-cause agent terminations,
 - a. You will receive a not-for-cause termination letter, detailing the reason for termination, the termination effective date, and the appeal process (if applicable).
3. Agent and/or NMA/FMO not-for-cause termination
 - a. Requests are submitted to Agent On-Boarding via email to UHPCred@uhc.com with the subject "Termination"
 - Upon receipt of a not-for-cause termination request, Agent On-Boarding updates the contracting system with the appropriate termination effective date.
 - The appointment termination is processed by Agent On-Boarding based on the termination effective date.
 - If you have down-line agents and the termination is requested by UnitedHealthcare or is due to an unqualified sale, the entire down-line is reassigned to the next hierarchy as of the termination effective date. Any solicitors in the down-line are terminated as of the termination effective date.
 - If you have down-line agents and the termination is requested by the NMA/FMO, the entire down-line is terminated or reassigned to the next hierarchy.

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- You are flagged Do Not Re-Contract in the contracting system if directed by the DAC, Legal, ACT (for administrative terminations), field sales leadership, or as the result of an unqualified sale due to no license or repeated appointment or certification failures.
- You may request a reconsideration of termination. (See Request for Reconsideration section)

For-Cause Termination

UnitedHealthcare may initiate for agents a for-cause termination. Agents terminated for-cause will be flagged Do Not Re-Contract in the contracting system. UnitedHealthcare will report for-cause terminations to the appropriate state Department of Insurance (DOI) and the Center for Medicare and Medicaid Services (CMS).

For-Cause Termination Process

- You will receive a for-cause termination letter, detailing the reason for termination, the termination effective date, and the appeal process.
- Agent On-Boarding is notified of the termination request by the ACT team.
- Agent On-Boarding processes the for-cause state appointment termination with the same termination date as indicated in the termination notification letter.
- If you have down-line agents, the entire down-line is reassigned to the next hierarchy as of the termination effective date. Any solicitors in the down-line are terminated as of the terminated termination effective date.
- You are flagged Do Not Re-Contract in the contracting system.
- You may request a reconsideration of a termination. (See Agent Request for Reconsideration section)

State and CMS Notification Process

UnitedHealthcare will comply with all regulatory requirements regarding state and CMS notification of appointment termination of agents.

- If the appointment termination is for-cause, Agent On-Boarding is responsible for completing and mailing a state notification packet, including a cover letter, to the DOI for each state in which you are appointed, or licensed to sell if the state does not require appointment. Agent On-Boarding will copy CMS on your resident state notification.
- If the appointment termination is not-for-cause, Agent On-Boarding will electronically notify the DOI for each state in which you are appointed, or licensed to sell if the state does not require appointment, that you were terminated not-for-cause. Agent On-boarding will copy CMS on the agent's resident state notification when the termination is due to unqualified sale due to license.
- A copy of each state notification will be uploaded to your electronic file, archived, and maintained according to regulatory requirements by Agent On-Boarding.

Request for Reconsideration

If you are flagged "Do Not Re-Contract", you may not contract with any UnitedHealth Group company, including commercial products.

Agent Request for Reconsideration – Non Employee Agents

If your contract and/or appointment were terminated as a result of a DAC decision or an effective administrative termination, you may request a reconsideration of that decision.

- You must complete and email a Request for Reconsideration of Appointment form and all supporting documentation to business_monitoring@uhc.com within 90 days of the termination effective date. If an initial request is received after 90 days of the termination effective date, the request will be addressed on a case-by-case basis by Sales Policy and Oversight Senior Leadership.

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- The DAC will review the reconsideration request at a future DAC meeting.
 - ~ If there are open complaints against you, the committee will review them in order to determine whether to proceed with considering your reinstatement request.
 - ~ The DAC will review the reconsideration request, along with any pertinent information, and render a decision. The decision is documented in the DAC minutes and written notification of the DAC's decision is sent to you via carrier and by email (with a read receipt) to your address in DCM. A copy of the notification is sent to your NMA/FMO and/or manager/supervisor.
- If you are approved for reinstatement, you must begin the re-contracting process by submitting a new contracting packet. All contracting requirements apply, including a background check and certification application. Any open complaints or previously incomplete corrective action must be processed and completed by you upon on-boarding.
- If you are denied reinstatement, the Do Not Re-Contract status remains indefinitely.
- The ACT team will review your complaint history. If you have unaddressed complaints received after termination, which have substantiated allegation outcomes for allegations within the Risk to Consumers/Organization or Prohibited Activities allegation families, you will be denied a re-contracting request.
- The DAC reviews the re-contracting request, sales behavior changes made by you, and a future action plan.
- If the DAC approves the re-contracting request, the DNR flag will be removed and you must address any outstanding member complaints, and participate in required monthly sales evaluations for six months following the reappointment.
- If the DAC denies the re-contracting request, the DNR flag will remain and you are prohibited from future contracting opportunities.

Agent Request to Re-contract after Denial – Non-Employee Agents (Effective May 1, 2016)

Under certain circumstances, an agent denied reinstatement through the process outline in this guide, is permitted to re-contract. Agents terminated for-cause by the DAC are prohibited from re-contracting. The following guidelines apply to DAC and Administrative not-for-cause terminations:

DAC Not-for-Cause Termination

- A minimum waiting period of 24 months from your termination effective date is required.
- A UnitedHealthcare sales leader must approve and support your request to re-contract.
- You and a UnitedHealthcare sales leader must request, complete, and email a Request for Reconsideration of Appointment form and all supporting documentation to the ACT team via business_monitoring@uhc.com.

Administrative Termination - CIU

- A minimum waiting period of 12 months from your termination effective date is required.
- A UnitedHealthcare sales leader must approve and support your request to re-contract.
- You and a UnitedHealthcare sales leader must request, complete, and email a Request for Reconsideration of Appointment form and all supporting documentation to the ACT team via business_monitoring@uhc.com.
- The ACT team will review your complaint history and open a request to address an outstanding investigation.
- The agent must respond and cooperate with the CIU until the outstanding investigation is completed. If the initial complaint receipt date exceeds 24 months prior to the request for reconsideration, the reconsideration request must be heard by the DAC prior to completion of the investigation.
 - ~ If you fail to respond and cooperate with the investigation a second time, the re-contracting request will be denied and you will be prohibited from future contracting opportunities.
 - ~ If unaddressed complaints received after termination have substantiated

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allegation outcomes for allegations within the Risk to Consumers/Organization or Prohibited Activities allegation families, the re-contracting request will be denied.

- The DAC reviews the re-contracting request, sales behavior changes made by you, and a future action plan.
- If the DAC approves the re-contracting request, the DNR flag will be removed, the ACT team will disposition the investigation findings, and you must participate in required monthly sales evaluations for six months following the reappointment.
- If the DAC denies the re-contracting request, the DNR flag will remain and you are prohibited from future contracting opportunities.

Administrative Termination - BDE

- A minimum waiting period of 12 months from your termination date is required.
- A UnitedHealthcare sales leader must approve and support your request to re-contract and receive prior coaching.
- You and a UnitedHealthcare sales leader must request, complete, and email a Request for Reconsideration of Appointment form and all supporting documentation to the ACT team via business_monitoring@uhc.com.

- You and a UnitedHealthcare sales leader must request, complete, and email a Request for Reconsideration of Appointment form and all supporting documentation to the ACT team via business_monitoring@uhc.com.
- The ACT team will review your complaint history. If you have unaddressed complaints received after termination, which have substantiated allegation outcomes for allegations within the Risk to Consumers/Organization or Prohibited Activities allegation families will be denied a re-contracting request.
- The DAC reviews the re-contracting request, sales behavior changes made by you, and a future action plan.
- If the DAC approves the re-contracting request, the DNR flag will be removed, previous corrective action will be re-opened and referred for completion, and you must participate in required monthly sales evaluations for six months following the reappointment. If you fail to complete the previous corrective action, you will be terminated and you are prohibited from future contracting opportunities.
- If the DAC denies the re-contracting request, the DNR flag will remain and you are prohibited from future contracting opportunities.

Section 10: Glossary of Terms

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Glossary of Terms

This glossary is not a complete glossary of terms and should not be copied, used for other documents, distributed and/or reproduced.

Term	Definition
5	
5-Star Special Election Period (SEP)	<p>A special election period that allows an eligible consumer to enroll in an MA plan or PDP with a Plan Performance Rating of five (5) stars during the year in which that plan has the 5-star overall rating, provided the consumer meets the other requirements to enroll in that plan (e.g., living within the service area as well as requirements regarding end-stage renal disease).</p> <p>As overall ratings are assigned for the plan contract year (January through December), possible enrollment effective dates are the first of the month from January 1 to December 1 during the year for which the plan has been assigned an overall rating of 5 stars. A consumer may use this SEP only one time from December 8 through November 30 of the following year in which the plan has been granted a 5-star overall rating. The enrollment effective date is the first of the month following the month in which the plan receives the enrollment application.</p> <p>Eligible consumers can switch from an MA plan, a PDP, or Original Medicare to an MA-only plan, an MA-PD plan, or a PDP that has a 5-star overall rating.</p> <p>A consumer using this SEP can enroll in an MA-only plan, an MA-PD plan, or a PDP with a 5-star overall rating even if coming from Original Medicare (with or without concurrent enrollment in a PDP). Consumers enrolled in a plan with a 5-star overall rating may also switch to a different plan with a 5-star overall rating. A consumer in an MA-only or MA-PD coordinated care plan who switches to a PDP with a 5-star overall rating will lose MA coverage and will revert to Original Medicare for basic medical coverage.</p> <p>Regardless of whether the consumer has Part D coverage prior to the use of this SEP, any consumer who enrolls in a 5-star PFFS MA-only plan is eligible for a coordinating Part D SEP to enroll in a PDP. This SEP does not guarantee Part D coverage. If a consumer in either an MA-PD plan or a PDP chooses to enroll in an MA-only coordinated care plan with a 5-star overall rating, that consumer would lose Part D coverage and must wait for a subsequent enrollment period to obtain Part D coverage under the normal enrollment rules. Late enrollment penalties might also apply.</p>
A	
AARP[®]	<p>AARP (formerly known as the American Association of Retired Persons) is a membership organization leading positive social change and delivering value to people age 50 and over through information, advocacy and service.</p>
ACT (Agent Complaint Tracking) Team	<p>The team that manages the intake, review and pre- and post-disposition of complaints. Monitors the completion of related Coaching Requests within Producer Contact Log (PCL) and creates monthly reports that detail key complaint metrics.</p>
Administrative Termination	<p>A not-for-cause appointment termination that results when an agent fails to respond in the prescribed time to a Request for Agent Response or fails to complete corrective and/or disciplinary action within the prescribed time frame.</p>
Advertising Materials	<p>Advertising materials are intended to attract or appeal to a plan sponsor consumer. Advertising materials contain less detail than other marketing materials and may provide benefit information at a level to entice a consumer to request additional information. Some examples include television, radio</p>

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	advertisements, print advertisements, billboards, and direct mail.
Agency Manager	A UnitedHealthcare employee who is responsible for the relationship between a contracted agency in the External Distribution Channel (EDC) and UnitedHealthcare.
Agent	A global term to refer to any licensed, certified, and appointed individual soliciting and selling UnitedHealthcare products, including, but not limited to, FMO, SGA, MGA, GA, ICA, ISR, Broker, Solicitor, or Telesales agent. See also Solicitor and Producer.
Agent ID	<i>See Writing Number.</i>
Agent Manager	A UnitedHealthcare employee responsible for the relationship between the agent and UnitedHealthcare.
Agent of Record	The agent that presented the plan information to the consumer, signed the enrollment application, and continues to service the member once enrolled. The agent of record is the agent that is eligible for commission.
Agent On-Boarding	The functional area within UnitedHealthcare that manages the centralized contracting and appointment data required to ensure sales agent file information is compliant with CMS and applicable state Department of Insurance (DOI) guidelines.
Allegation	A claim or assertion that an agent violated CMS Medicare Marketing Guidelines, Company policy, or engaged in other inappropriate sales activities.
Annual Election Period –AEP	An annual period (October 15 through December 7) when consumers and members can make new plan choices. Consumers may elect to join a Medicare Advantage (MA) or Prescription Drug (Medicare Part D) Plan for the first time. Members can change or add Medicare Part D, change MA Plans or return to Original Medicare. Elections made during this period will become effective January 1st of the following year.
Annual Notice of Change -ANOC	Notification to active members of plan premium, benefits and cost sharing changes for the next calendar year. Also, the name used to describe the process of generating the plan information for the next calendar year notifications.
Anti-Kickback Statute	<p>The primary purpose of the federal anti-kickback statutes or laws is to restrict the corrupting influence of money on health care decisions – including knowingly and willingly offering payment or gifts to induce referrals of items or services covered by Medicare, Medicaid, or other federally funded program. (<i>See 42 U.S.C. 1320a-7b</i>)</p> <p>Examples of activities that may be prohibited under the statute:</p> <ul style="list-style-type: none"> • Offering cash reimbursement in exchange for an enrollment or referral. • Offering gifts or services greater than a nominal amount permitted by federal guidelines. • Offering gifts or services dependent on enrollment or referral. <p>A violation of the federal anti-kickback law is a felony offense that carries criminal fines of up to \$25,000 per violation, imprisonment for up to five years and exclusion from government health care programs.</p>
Appointment (Agent)	A procedure required by most states that grants limited authority to an individual to market and sell a company’s insurance products within that state.
Appointment – Sales Presentation	<i>See In-Home Appointment and Out-of-Home Appointment.</i>
ASI	AARP Services, Inc.

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ASL Interpreter	American Sign Language – interpreter service for the hearing or speech impaired.
Authorized Representative	A person who is authorized under State law to complete the Enrollment Application and make health care decisions on behalf of the consumer/member and is authorized to receive health care related information on his/her behalf. Documentation of this authority must be available upon request by the plan or by CMS.
B	
Background Investigation	The investigation of criminal records, credit history, insurance licensing history, Office of Inspector General records, and General Service Administration excluded party records and other factors that UnitedHealthcare reviews regarding an agent applicant’s history during the agent contracting and on-boarding process. Also known as background check.
bConnected	A software application designed to drive sales effectiveness in both the field and telesales environments. From within one integrated system, bConnected enables agents to efficiently create contact and opportunity records, qualify consumers, select plans, send fulfillment information, and schedule consumers for appointments and marketing/sales events. <i>See also Lead.</i>
Book of Business	The collection of leads, contacts, and/or members assigned to a particular agent.
Brand	A name that identifies and distinguishes a product and Company and any associated logos, service marks, images, etc. Brand elements are defined for each of the UnitedHealthcare Medicare Solutions brands, via a set of brand guidelines that address logos, legal marks and requirements, brand colors, typography, layout requirements and other topics in detail. Complete graphics usage guidelines may also be included.
Broker Development and Education Specialist (BDE)	UnitedHealthcare staff that reach out to educate agents in the External Distribution Channel (EDC) on specific monitoring program issues such as complaints, rapid disenrollment, and Secret Shopper results. Proactive positive reinforcement contacts are also conducted.
Business Reply Card - BRC	A paper or electronic document returned to UnitedHealthcare or a UnitedHealthcare agent as a response/request for either more information, permission to be called or contacted by an agent, or be removed from a mailing list, etc.
C	
Call Monitoring	A quality assurance function used to evaluate inbound and outbound calls either side-by-side or remotely for the purposes of compliance and training (to identify areas of opportunity), while ensuring an agent’s or other plan representative’s accountability as a representative of the UnitedHealthcare Group brand is compliant as it pertains to CMS guidelines.
Captive Agent	An agent, who by virtue of employment or contract, must solicit and sell exclusively a UnitedHealthcare Medicare Solutions product or products. For example, all employee agents are captive to UnitedHealthcare Medicare Solutions and ICA agents are for Medicare Advantage products only.
Catastrophic Coverage	A level of coverage in a Medicare Part D Plan that starts for members after they reach the plan’s out-of-pocket limit for covered drugs during the coverage gap. In the catastrophic coverage stage, the member only pays a small coinsurance amount or a copayment for the rest of the year. <i>Note: If a member gets “Extra Help” paying their drug costs, they will not have a coverage gap and will either continue to pay a small copayment or no copayment once they reach catastrophic coverage.</i>
Certified/Certification	The process required by CMS that all agents selling Medicare products are annually trained and tested on Medicare rules and regulations and company rules, policies and procedures specific to the company’s products the agent intends to sell.

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The Centers for Medicare & Medicaid Services - CMS	The federal government agency that oversees the Medicare and Medicaid Programs by establishing regulations and guidance for health care providers, assessing quality of care in facilities and services, and ensuring that both programs are run properly by contractors and state agencies. CMS communicates guidance and regulatory requirements and provides oversight to Medicare Advantage Organizations and Prescription Drug Plans.
CMS Data Use Agreement	<p>As part of the Medicare contracts UnitedHealthcare maintains with CMS, the company is required to attest annually that it will only use CMS data and their systems for the administration the Medicare managed care and/or outpatient prescription drug benefit programs.</p> <p>Anyone supporting or performing work on behalf of UnitedHealthcare Medicare programs and who has access to CMS systems is obligated to follow UnitedHealth Group privacy and security policies and practices such as not sharing passwords, using the minimum necessary information and systems access to complete our jobs, and ensure confidential data is protected and secure at all times.</p>
Coaching Request	The documentation in PCL of all coaching interaction between the manager/supervisor or BDE and an agent/agency. <i>See also Service Request.</i>
Co-Branding	The relationship between two or more separate legal entities, one of which is an organization that sponsors a Medicare plan.
Code of Conduct	<p>The UnitedHealth Group Code of Conduct provides essential guidelines that help the organization achieve the highest standards of ethical and compliant behavior in its work every day.</p> <p>The Code of Conduct applies to all employees, directors, and contractors and represents a core element of the Company's compliance program.</p> <p>UnitedHealthcare and UnitedHealth Group hold themselves to the highest standards of personal and organizational integrity in its interactions with consumers, employees, contractors, and other stakeholders like CMS.</p> <ul style="list-style-type: none"> • Act with Integrity: Recognize and address conflicts of interest. • Be Accountable: Hold yourself accountable for your decisions and actions. Remember, we are all responsible for Compliance. • Protect Privacy. Ensure Security: Fulfill the privacy and security obligations of your job. When accessing or using protected information, take care of it.
Cognitive Ability	The consumer's capacity to understand, assemble and reason based on the information provided. <i>See Diminished Mental Capacity (Cognitive Impairment)</i>
Coinsurance	An amount member may be required to pay as their share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%). Coinsurance for in-network services is based upon contractually negotiated rates (when available for the specific covered service to which the coinsurance applies) or Medicare Allowable Cost, depending on the contractual arrangements for the service.
Cold Calling	The act of cold calling, including, but not limited to, telephone calls, emailing, text messaging and leaving voice mail, are all prohibited. CMS has specific regulations in relation to marketing through unsolicited contacts. Agents may not engage in any direct unsolicited contact with consumers, including consumers who are aging-in. <i>(See also Unsolicited Contact and Door-to-Door Solicitation)</i>
Commission	<i>Refer to Compensation.</i>
Community Event/Meeting	See Sales Event. All Community Events. Meetings are "Formal Marketing/Sales Events"
Community Rating	All members in the same rating class pay the same rate (excludes discounts and surcharges). <i>See also Issue Age Rating and Attained Age Rating.</i>
Compensation	CMS defines compensation as monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commission, bonuses, gifts, prizes, awards, and referral/finder's fees. Compensation does not include the payment of fees to comply with state appointment laws; costs related to training, certification, and testing requirements; reimbursement for mileage to and from educational and marketing/sales events

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	<p>or marketing appointments with consumers; and reimbursement for actual costs associated with educational and marketing/sales events and marketing appointments such as venue rent, snacks, and materials.</p>
<p>Compensation: EDC and ICA</p>	<p><i>The compensation guidance contained in this section apply to independent agents. Employed and captive agents who only sell for one Plan/Part D Sponsor are exempt from compensation requirements, except where noted.</i></p> <p>UnitedHealthcare pays non-employee agents in the External Distribution Channel (EDC) and Independent Career Agent (ICA) channel a commission for enrollment of a consumer into a UnitedHealthcare Medicare Solutions Medicare Advantage Plan, Prescription Drug Plan, or Medicare supplement insurance policy according to the terms of their Agent Agreement. Commission payments for sales written by a solicitor are paid to the solicitor's up-line. The remainder of this section applies to Medicare plans regulated by CMS. Refer to your Agent Agreement and/or Agent Guide for details.</p> <p><u>Compensation Types and Amounts</u></p> <p>There are two types of compensation for MA/MA-PD and PDP enrollments:</p> <p>Initial Compensation: Initial compensation is paid at an amount at or below the fair market value (FMV) cut-off amounts published by CMS annually.</p> <p>Initial Compensation is paid for the member's first year of enrollment in a plan (e.g., MA-PD) regardless of the plan sponsor. Initial compensation is also paid when a consumer enrolls in an "unlike plan type."</p> <ul style="list-style-type: none"> • When a member enrolls in a plan and has no prior plan history, the plan sponsor may pay the full year initial compensation amount or a pro-rated amount based on the number of months the member is enrolled. • When a member changes plans during the initial year, the plan sponsor must pay the agent at a pro-rated initial year rate, based on the number of months the member is enrolled in the plan. <p>Renewal Compensation: Renewal compensation is paid in any amount up to fifty (50) percent of the current FMV, published by CMS annually. Renewal compensation is paid in the member's second and subsequent enrollment years. Renewal compensation is also paid when a beneficiary enrolls in a new "like plan type" as described below.</p> <p>When a member enrolls in a plan mid-year, the plan sponsor must pro-rate the commission paid to the agent based on the number of months the member is enrolled in the plan.</p> <p>For each MA, MA-PD, and the PDP enrollment, CMS determines if the enrollment qualifies for initial compensation or renewal compensation and the plan sponsor must comply with CMS' determination. Therefore, if a member disenrolls from one plan and enrolls in another, CMS determines the compensation type for the new enrollment</p> <ul style="list-style-type: none"> • Like Plan Type Enrollment – The member is enrolled in a PDP, MA, MA-PD, MMP, or section 1876 cost plan and enrolls in another PDP, MA, MA-PD, MMP, or section 1876 cost plan respectively. The compensation type would be renewal in these instances. • Unlike Plan Type Enrollment - The member is enrolled in a PDP, MA, MA-PD, MMP or section 1876 cost plan and enrolls in a different plan type. For example, a member enrolled in a PDP enrolls in a MA-PD. Note that if a member is enrolled in two separate plans such as a MA-only plan and a stand-alone PDP, the compensation rules apply independently to each plan. However, when a member is enrolled in two separate plans such as a MA-only and PDP, and then enrolls in a single plan, such as an MA-PD, compensation is paid based on the MA plan movement.

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	<p>Compensation Cycle Compensation paid for plan enrollment is based on the enrollment year, which runs from January 1 through December 1. Payments may not be based on enrollment years (rolling basis) other than January through December. For example, if a member’s enrollment is effective on September 1, then the initial year for that member ends on December 31, even though the member has only been in the plan for four months. In January of the next year, the plan would begin paying renewal payments to the agent, who assisted the member.</p> <p>Plan sponsors may only pay compensation for the current year enrollment. Payments must not be paid until January 1 and must be paid in full by December 31 of the enrollment year. Plan sponsors may pay compensation annually, quarterly, monthly, or utilizing other schedules.</p> <p>Referral/Finder’s Fees UnitedHealthcare does not pay non-employee agents referral/finder’s fees for the recommendation of a Medicare consumer into a UnitedHealthcare plan that meets the Medicare consumer’s healthcare needs. However, CMS guidelines prohibit the payment of a referral/finder’s fee to an agent in excess of \$100 per referral or enrollment in a MA/MA-PD plan or in excess of \$25 per referral or enrollment in a stand-alone PDP. The referral/finder’s fee must be included as part of total compensation and must not exceed the fair market value for that contract year.</p> <p>Marketing Fees Agents are prohibited from charging a consumer or member any type of fee for the marketing of a Medicare insurance product including, but not limited to entrance fees to attend educational or marketing/sales events, fees to conduct a personal/individual marketing appointment (e.g., in-home), or to cover the cost of materials.</p> <p>Compensation Recovery (Charge Backs) Plan sponsors must recover compensation payments from agents under two circumstances:</p> <ol style="list-style-type: none"> 1. The member disenrolls from the plan within the first three months of enrollment (rapid disenrollment), and 2. Any other time a member is not enrolled in a plan. <p>Rapid disenrollment applies when a member moves from one plan sponsor to another or when the member moves from one plan to another plan offered by the same plan sponsor. It does not apply when the member enrolls in a plan effective October 1, November 1, or December 1, and subsequently changes plan effective January 1 of the following year. Rapid disenrollment compensation recovery does not apply in certain circumstances defined by CMS. In some cases, only a pro-rated amount of compensation must be recovered. When a member disenrolls after they have been enrolled in the plan at least three continuous months, only the amount the agent was paid for months the member was no longer enrolled in the plan is recovered.</p> <p>Effective Date of Change for New Compensation Guidance Compensation rules are applied based on the effective date of the member’s enrollment. Therefore, MA, MA-PD, PDP, MMP, and section 1876 cost plan enrollments with an effective date of January 1, 2015, or after are subject to the compensation guidance released by CMS in Chapter 3 Medicare Marketing Guidelines (MMG) on June 17, 2014. Enrollments effective prior to January 1, 2015, are subject to the compensation requirements found in the 2014 MMG.</p>
<p>Complaint</p>	<p>A grievance received from a consumer or member, or any person or organization acting on a consumer or member’s behalf, including written grievances from any Department of Insurance or other regulatory or governmental agency.</p>
<p>Complaint Education Contact (CEC)</p>	<p>A process to address agent behavior to prevent repeat complaint infractions through training and coaching.</p>

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Compliance Investigations Unit (CIU)	A unit within UnitedHealthcare Government Programs responsible for the investigation of complaints regarding agents selling UnitedHealthcare Medicare products. Complaints referred to the CIU are severe allegations of misconduct or repeated complaints of lower severity.
Compliance Program	<p>Federal law requires Medicare plan sponsors to implement and maintain an effective Compliance Program that incorporates measures to detect, prevent, and correct noncompliance and fraud, waste, and abuse. The 7 key elements of a compliance program are:</p> <ol style="list-style-type: none"> 1. Written Standards of Conduct 2. High Level Oversight 3. Training & Education 4. Effective Lines of Communication / Reporting Mechanisms 5. Enforcement & Disciplinary Guidelines 6. Monitoring & Auditing 7. Response to Identified Issues <p>The program reflects a company's good faith effort to reduce non-compliance with legal, regulatory, and business requirements.</p>
Compliance Reporting Resources	<ul style="list-style-type: none"> • Compliance Questions – compliance_questions@uhc.com • Privacy & Security Incidents – uhc_privacy_office@uhc.com • The UnitedHealth Group Compliance & Ethics HelpCenter at 800-455-4521
Compliance Requirements	A series of directives established by regulatory bodies and UnitedHealth Group that must be adhered to.
Conflict of Interest	A situation in which an individual's personal, financial, social, or political interests or activities, or those of their immediate family, could affect or appear to affect their decision making on behalf of UnitedHealthcare or where their objectivity could be questioned because of these interests or activities.
Consumer	The customer, Medicare beneficiary, lead, or prospect for all products who is not currently enrolled in particular a UnitedHealthcare Medicare Solutions plan.
Coordinated Care	In Medicare Part C, the health care plans that coordinate a consumer's care by the physicians and hospitals visited. These plans may have some restrictions on the physicians and hospitals used for care. These plans are also referred to as "managed care" plans. PFFS and MSA Plans are not coordinated care plans.
Copayment	An amount the member may be required to pay as their share of the cost for a medical service or supply, like a physician's visit or a prescription. A copayment is usually a set or fixed amount, rather than a percentage.
Corrective Action Plan (CAP)	When it is determined that an organization or business area is not complying with Medicare program requirements, the organization or business area is directed by CMS or the internal stakeholders to take all actions necessary to correct the behavior, issue or process that was identified as noncompliant with Medicare program requirements. A step-by-step plan of corrective action is developed to achieve targeted outcomes for resolution of the identified issues.
Corrective Action Referral (CAR)	A process that supports the progressive disciplinary process and is a measure to address egregious agent behavior with retraining efforts delivered in a timely manner.
Cost Sharing	The amount a member pays for services or drugs received and includes any combination of a deductible, copayment or any coinsurance.
Coverage Determination	Decision to cover (or not cover) prescription drugs within the plan's benefit design that is associated with utilization management programs for Medicare Prescription Drug Plans.

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Coverage Gap	Most Medicare <i>prescription</i> drug plans have a coverage gap. This means that after the member and plan have spent a certain amount of money for covered drugs, the member has to pay all costs out-of-pocket for their drugs up to a limit. The member's yearly deductible, coinsurance or copayments, and what they pay in the coverage gap all count toward this out-of-pocket limit. The limit does not include the drug plan's premium. There are plans that offer some coverage in the gap. However, plans with coverage in the gap may charge a higher monthly premium.
Credentialing	Process of contracting, appointment, certification, and approval for an agent to sell any UnitedHealthcare Medicare Solutions products.
Creditable Coverage (Prescription Drug)	Prescription drug coverage, for a plan other than a Medicare Part D Plan, which meets certain Medicare standards. For consumers currently enrolled in a drug plan that gives prescription medication coverage, their plan will tell them if it meets the Medicare standards for creditable coverage. (<i>See also Late-Enrollment Penalty</i>).
Creditable Coverage (Medical)	Certain kinds of previous health insurance coverage that can be used to shorten a pre-existing condition waiting period under a Medigap plan. Note: This is not the same as creditable prescription medication coverage.
Cross-Selling	CMS regulations and guidelines prohibit marketing non-health related products (e.g., annuities, life insurance, and disability) to consumers during any Medicare Advantage or Medicare Part D sales activity or presentation. This activity is <u>prohibited</u> .
D	
Deductible	The amount a member must pay for health care services or prescriptions, before Original Medicare, their prescription drug plan, or other insurance coverage begins to pay.
Deemed Provider	<p>A Medicare-participating provider who agrees to accept the plan's terms and conditions of payment for a specific member visit by virtue of the fact that the provider is aware, in advance, that the patient is a PFFS member and the provider has reasonable access to the plan's terms and conditions of payment. Members must inform providers of PFFS Plan membership and present their ID card prior to receiving covered services at each visit. If the provider does not agree to be deemed, the PFFS member must find another provider. Providers agree to bill the plan and will not balance bill the member.</p> <p>A provider must agree to be deemed each time a member seeks covered medical services. The provider can decide whether or not to accept the plan's terms and conditions of payment each time they see a PFFS member. A decision to treat one plan member does not obligate the provider to treat other PFFS members, nor does it obligate providers to accept the same member for treatment at a subsequent visit.</p>
Deeming	<p>A provider is deemed by law to have a contract with the plan when all of the following four criteria are met:</p> <ol style="list-style-type: none"> 1) The provider is aware, in advance of furnishing health care services, that the patient is a member of the plan. (All members receive a member ID card that includes the plan logo that clearly identifies them as PFFS members.) 2) The provider has a copy of, or has reasonable access to, the plan's terms and conditions of payment rates. 3) The provider furnishes covered services to a plan member. 4) The provider agrees to submit the bill for covered services directly to the plan. <p>If all of these conditions are met, the provider is deemed to have agreed to the plan's terms and conditions of payment for that member specific to that visit.</p> <p><i>Note: The provider can decide whether or not to accept the plan's terms and conditions of payment each time they see a member. A decision to treat one plan member does not obligate them to treat other plan members, nor does it obligate them to accept the same member for treatment at a subsequent visit.</i></p>
Diminished Mental Capacity (Cognitive Impairment)	A condition caused by dementia or other disability that affects how clearly a person thinks, learns new tasks, and remembers events that just happened or happened a long time ago. <i>See Cognitive Ability</i>
Disciplinary Action	Committee responsible for determining appropriate disciplinary and/or correction action up

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Committee (DAC)	to and including agent termination.
Distribution Channel (Sales)	Categories of individuals or organizations that market and sell the Company's products. UnitedHealthcare Medicare Solutions utilizes four distribution channels: Telesales, Internal Sales Representative (ISR), Independent Career Agent (ICA), and External Distribution Channel (EDC).
Door-to-Door Solicitation	<p>The practice of <i>Unsolicited Direct Contact</i> for the purposes of marketing/selling any product in the UnitedHealthcare Medicare Solutions portfolio and is strictly prohibited. The consumer must first initiate or solicit contact. These guidelines apply to contact made in person, contact made by telephone, and contact made by e-mail.</p> <p>In-home and personal/individual marketing appointments <i>are allowed</i> if the following conditions are met:</p> <ul style="list-style-type: none"> • The consumer initiated and scheduled an appointment prior to the visit • A documented Scope of Appointment (SOA) has been recorded or completed as well as signed by the consumer prior to the visit. <p>Direct, unsolicited, in-person contact with a consumer. May include actual door-to-door solicitation or unauthorized in-person contact with a consumer in any public place, e.g. parking lot, senior center, etc. <i>See also Cold-Calling and Unsolicited Contact.</i></p>
Doughnut Hole	Name for the step in a Medicare Part D Plan in which members pay all expenses for eligible medications up to a specific amount (determined by CMS each year). <i>See Coverage Gap.</i> (Note: Doughnut Hole is not a CMS Preferred term – Coverage Gap is the term of choice.)
Down-Line	A term used to describe agents within an NMA or FMO hierarchy that are below the management/reporting level of a specific entity/agency.
Dual-eligible	<p>Consumers and/or members receiving benefits from both Medicare and Medicaid. With the assistance of Medicaid, some Dual-eligibles do not have to pay for certain Medicare costs. The Medicaid benefit categories and type of assistance are listed below:</p> <ul style="list-style-type: none"> • Full Benefit Dual Eligible (FBDE): Full-benefit dual eligibles have no cost sharing in Medicare Part A or Part B. Medicaid pays for their Medicare Part A hospital deductible, Medicare Part A coinsurance, Medicare Part B monthly premium, and Medicare Part B deductible and 20 percent co-payments. For Part D, full-benefit dual eligibles are exempt from any monthly premium, annual deductible, costs under the doughnut hole, and only nominal co-payments on drugs if they live at home. • Qualified Disabled and Working Individual (QDWI): Payment of the consumer's Medicare Part A premiums. • Qualifying Individual (QI): Payment of the consumer's Medicare Part B premiums. • Specified Low Income Medicare Beneficiary (SLMB): Payment of the consumer's Medicare Part B premiums. • SLMB-Plus: Payment of the consumer's Medicare Part B premiums and full Medicaid benefits. • Qualified Medicare Beneficiary (QMB Only): Payment of the consumer's Medicare premiums, deductibles and cost-sharing (excluding Part D). • QMB-Plus: Payment of the consumer's Medicare premiums, deductibles, cost-sharing (excluding Part D) and full Medicaid benefits. <p><i>Note: QMBs, SLMBs, and QIs are automatically enrolled in the low-income subsidy program which provides assistance with prescription drug costs.</i></p>
E	
Educational Event	An event designed to inform Medicare consumers about MA, Prescription Drug or other Medicare programs but do not steer, or attempt to steer consumers toward a specific plan or limited number of plans. Educational events may not include any sales or marketing activities such as the distribution of marketing materials or the distribution or collection of enrollment applications. When advertised, educational events must be advertised as educational; otherwise they are considered marketing/sales events. Educational events are held in public venues, do not extend to personal/individual appointments, and cannot include lead-generation activities.

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Educational Information	Communications free of plan specific information or marketing toward a specific plan.
eModel Office	An electronic enrollment method used by approved NMA, FMO, and SGA offices and some internal sales offices to convert a consumer's paper enrollment application to an electronic format for direct entry into UnitedHealthcare's enrollment system. When a paper application is converted to an electronic format, the paper application must be scanned and the image submitted to UnitedHealthcare as a record of the consumer's wet signature.
End Stage Renal Disease - ESRD	Permanent kidney failure. The stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.
Enrollment Application	Refers to the form used by consumers to request to enroll in a Medicare Advantage Plan, Prescription Drug Plan or Medicare Supplement Plan.
Errors and Omissions (E&O) Insurance	Errors and Omissions insurance covers UnitedHealthcare contracted agents and solicitors in the event they misrepresent a plan and its benefits to a consumer.
Evidence of Coverage (EOC)	Evidence of Coverage is the legal, detailed description of plan benefits. It explains what the Plan must do, member's rights and the rules they need to follow to get covered services and prescription drugs.
Exception	A type of coverage determination that, if approved, allows the member to get a drug that is not on the Plan sponsor's formulary (a formulary exception) or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). The member may also request an exception if the Plan sponsor requires the member to try another drug before receiving the drug the member is requesting or the plan limits the quantity or dosage of the drug the member is requesting (a formulary exception).
Excluded Medications	Medications that are not housed within the benefit. These medications may be excluded due to a plan sponsor's business or clinical decision to not cover the medication or they could be excluded because the Medicare Modernization Act (MMA) excludes the medications under the Medicare Part D program.
Executive Distribution Oversight Committee (EDOC)	<p>A UnitedHealthcare Government Programs Senior Leadership cross-functional team established to drive overall direction of the Sales and Distribution Oversight activities and to establish an infrastructure that is both receptive and participatory to the Oversight requirements.</p> <p>The EDOC assists the Medicare Compliance Oversight Committee (MCOC) and PSMG Corporate Responsibility & Compliance Program Oversight Committee (PSMG Committee) in ensuring the organization is consistently and fully complying with all laws and regulations pertaining to the services provided to beneficiaries of Medicare.</p>
External Distribution Channel (EDC)	One of four sales distribution channels that market and sell UnitedHealthcare Medicare Solutions products. The channel consists of contracted entities, including NMAs, FMOs, agencies (SGA, MGA, GA), agents, and solicitors (not contracted with UnitedHealthcare, but through their up-line). EDC entities, agencies, agents, and solicitors are not employees of UnitedHealth Group and are not exclusive (captive) to UnitedHealthcare.
Extra Help	A Medicare term used to describe the financial help available to consumers with limited income and resources. "Extra Help" is the common reference used by the Social Security Administration in reference to the federal LIS program.
F	
False Claim Act	<p>The Federal False Claims Act prohibits any person from submitting or causing the submission of a false claim or dishonest record to the federal government that he or she knows (<i>or should know</i>) is false.</p> <p>A claim, broadly defined, includes any record or submission that results or could result in payment.</p> <p>In general, the Federal False Claims Act covers fraud involving any federally funded contract or program, with the exception of tax fraud.</p> <p>Violations of the False Claims Act can result in liability for repayment of up to three times the original dollar amount that the government was defrauded and potential civil penalties of \$5,500 to \$11,000 for each false claim.</p>

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Federal Do not Call List (FDNC)	A national registry for consumers to advise certain entities of their request to not be contacted via telephone. The Federal Trade Commission manages this national registration.
Field Marketing Organization (FMO)	An independent marketing organization that is licensed, appointed, and directly contracted with UnitedHealthcare Insurance Company to solicit and sell the UnitedHealthcare Medicare Solutions portfolio of products through its network of down-line contracted and appointed agents. The FMO is the top level in its hierarchy structure.
For-Cause Termination	A termination of an agent's contract and/or appointment that is the result of specified misconduct that violates the agreement.
Formulary	A list of prescription drugs covered by the plan. The list includes both brand-name and generic drugs. The formulary is often published to the web or in a written document. However, the document may only reference the preferred medications. (Often referred to as Preferred Drug List or PDL).
Fraud, Waste, & Abuse	<p>Fraud is intentionally obtaining something of value through misrepresentation or concealment of facts. The complete definition has three primary components:</p> <ul style="list-style-type: none"> • Intentional dishonest actions or misrepresentation of fact, • Committed by a person or entity, and • With knowledge the dishonest action or misrepresentation could result in an inappropriate gain or benefit. <p>This definition applies to all persons and entities. However, it is important to know that there are special rules around false statements to government programs such as Medicare and Medicaid. (See examples of 'Anti-Kickback Statute' and 'False Claims Act')</p> <p>Waste includes inaccurate payments for services, such as unintentional duplicate payments, and can include inappropriate utilization and/or inefficient use of resources.</p> <p>Abuse describes practices that, either directly or indirectly, result in unnecessary costs to health care benefit programs. This includes any practice that is not consistent with the goals of providing services that:</p> <ul style="list-style-type: none"> • Are medically necessary • Meet professionally recognized standards for health care, and • Are fairly priced.
G	
General Agent (GA)	An independent contractor with a direct contract with UnitedHealthcare at the GA level. May refer agents and solicitors for certification and appointment to solicit and sell any of the UnitedHealthcare Medicare Solutions products.
Generic Drugs	A prescription drug that has the same active ingredients as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs. Also known as Generic Medications.
Geographic Area	A specific region, state, county, or zip code.
Grandfathering	Allows for continued coverage of specific therapies that may have been covered previously, but are no longer being covered after a formulary or benefit change.
Grievance	A type of member complaint. Informal verbal complaints are handled by a call center that processes verbal complaints for Medicare consumers. Written complaints are the responsibility of the Appeals and Grievances National Service Center. Grievances may include complaints regarding the timeliness, appropriateness, access to and/or setting of a provided item.
Group Retiree	A consumer who is Medicare eligible, retired from his/her previous employer, and is looking to continue health care and/or prescription coverage with their previous employer. Employer Groups contract with health plans, which allow them the opportunity to offer products and administer benefits through contractual agreements and arrangements. With subsidized plans, the employer contributes to the premium, but with endorsed plans, the employer does not.
Guaranteed Issue	When insurance companies are required by law to sell or offer consumers a Medigap policy. In these situations, an insurance company cannot deny consumers a Medigap policy or place conditions on a Medigap policy, such as exclusions for pre-existing conditions, and cannot

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	charge consumers more for a Medigap policy because of past or present health problems.
H	
Health Fair/Expo	An informal educational or marketing/sales event.
Health Insurance Claim Number - HICN	Consumer's Medicare identification number.
Health Maintenance Organization - HMO	A type of Medicare Advantage Plan in which members select a primary care physician (PCP) to help coordinate their care and go to providers in the Plan's contracted network, except in the event of an emergency or for renal dialysis. Members will need referrals from their PCP to see specialists in some plans.
Hierarchy	The structure of an NMA or FMO down-line that is defined as part of the NMA/FMO/agent contracting process.
HIPAA	Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA is a federal law that provides requirements for the protection of health information as well as provisions to combat fraud, waste, and abuse.
HIPAA Privacy Statement	<p>A HIPAA Privacy Statement must always be included on a fax cover sheet when sending PHI/PII via fax machine or electronic/desktop fax.</p> <p>Sample HIPAA Privacy Statement:</p> <p><i>This facsimile transmission contains confidential information intended for the parties identified above. If you have received this transmission in error, please immediately notify me by telephone and return the original message to me at the address listed above. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.</i></p>
HPMS Complaint Tracking Module (CTM)	A CMS database and communication tool used to capture beneficiary complaints received by Medicare and transmit to the appropriate plan sponsor.
I	
Incentive	<i>Refer to Compensation: ISR, sales management, Telesales.</i>
Inconclusive Allegation	Following review of the allegations against an agent, appropriate investigation, consideration of the evidence and pertinent circumstances, there is insufficient information to determine the truth or falsity of the allegation(s).
Inconclusive Complaint	Following review of the allegations against an agent, appropriate investigation, consideration of the evidence and pertinent circumstances, there is insufficient information to determine the true or falsity of the complaint.
Independent Career Agent (ICA)	A non-employee agent licensed, appointed, and contracted with UnitedHealthcare Insurance Company to solicit and sell the UnitedHealthcare Medicare Solutions portfolio of products. The ICA contract provides that they are exclusive for UnitedHealthcare Medicare Advantage products.
In-Home Appointment	A personal/individual marketing appointment that takes place in a consumer's residence. Includes a nursing home/facility resident's room. Requires a Scope of Appointment form. <i>See also Out-of-Home Appointment and Personal/Individual Marketing Appointment.</i>
Initial Coverage Election Period (ICEP)	A period during which an individual newly eligible for MA may make an initial enrollment request to enroll in an MA plan. This period begins three months immediately before the individual's first entitlement to both Medicare

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	<p>Part A and Medicare Part B and ends on the later of:</p> <ol style="list-style-type: none"> 1. The last day of the month preceding entitlement to both Medicare Part A and Medicare Part B, or; 2. The last day of the consumer's Medicare Part B initial enrollment period. <p>The initial enrollment period for Medicare Part B is the seven (7) month period that begins 3 months before the month an individual meets the eligibility requirements for Medicare Part B and ends 3 months after the month of eligibility.</p>
Initial Coverage Limit -ICL	The period after a PDP member has met their deductible and before their total medication expenses have reached a specific amount including amounts the member has paid and what the plan has paid on their behalf.
Internal Sales Representative (ISR) Agent	A UnitedHealthcare employee who is appointed (if applicable) to solicit and sell UnitedHealthcare Medicare Solutions products in the field.
L	
Late-Enrollment Penalty -LEP	An amount added to the plan premium when a consumer does not obtain creditable prescription drug coverage when first eligible for Medicare Part D or who had a break in creditable prescription drug coverage of at least 63 consecutive days. The LEP is considered a part of the plan premium.
Lead	A consumer who, by their actions, has demonstrated an interest in a UnitedHealthcare product (includes current members). Company-generated leads are documented and managed in bConnected.
Learning Management System (LMS)	Online training and certification portal. UnitedHealthcare's LMS is LearnSource (formerly ULearn).
License	A certificate giving proof of formal permission from a governmental authority to an agent to sell insurance products within a state.
Logo	A mark or symbol that identifies or represents a company, business, product, and/or brand.
Long-Term Care Pharmacy - LTC	A pharmacy owned by or under contract with a long-term care facility to provide prescription medications to the facility's residents.
Low Income Copayment -LIC	Reduced prescription copayment level for the member.
Low Income Subsidy - LIS	A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.
M	
Marketing Materials	Includes any informational materials that perform one or more of the following actions: promotes an organization, provides enrollment information for an organization, describes the rules that apply to enrollees in an organization, explains how Medicare and Medicaid (Fully Integrated Dual SNPs, MME product(s) as applicable) services are covered under an organization (including conditions that apply to such coverage), and/or communicates with the individual on the various membership operational policies, rules, and procedures.
Marketing/Sales Events - Formal and Informal	<p>Are defined both by the range of information provided and the way in which the content is presented. In addition, marketing/sales events are defined by the Plan's ability to collect Enrollment Applications and enroll Medicare consumers during the event. A marketing/sales event is designed to steer, or attempt to steer, consumers toward a plan or limited set of plans.</p> <ul style="list-style-type: none"> • A formal marketing/sales event is structured in an audience/presenter style with sales personal or plan representative formally providing specific sponsor information via a presentation on the products being offered.

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	<ul style="list-style-type: none"> An informal marketing/sales event is conducted with a less structured presentation or in a less formal environment like a retail booth, kiosk, table, recreational vehicle, or food banks where an agent can discuss plan information when approached by a consumer.
Master General Agent (MGA)	An independent contractor with a direct contract with UnitedHealthcare at the MGA level. May refer agents and solicitors for certification and appointment to solicit and sell any of the UnitedHealthcare products.
Medicaid	A program that pays for medical assistance for certain individuals and families with low incomes and resources. Medicaid is jointly funded by the federal and state governments to assist states in providing assistance to people who meet certain eligibility criteria. A Medicare Supplement Insurance policy cannot be sold to consumers who receive assistance from Medicaid unless assistance is limited to help with Medicare Part B premiums or Medicaid buys the Medicare Supplement Insurance policy for the consumer.
Medicare	A federal government health insurance program for: <ul style="list-style-type: none"> People age 65 and older People of all ages with certain disabilities People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or kidney transplant)
Medicare Advantage Disenrollment Period -MADP	January 1 – February 14 The 45-day period when Medicare Advantage members have an annual opportunity to prospectively disenroll from any MA plan and return to Original Medicare (they may also select a PDP for Medicare Part D coverage).
Medicare Advantage “Medical Only” Plan – MA Only	A Medicare Advantage Plan with only medical coverage. It does not have an integrated Medicare Part D prescription medication benefit.
Medicare Advantage Plans	Health plans offered by private insurance companies that contract with the federal government to provide Medicare coverage. Medicare Advantage Plans may be available both with and without Medicare Part D Plans. Medicare Advantage Plans may also be referred to as Medicare Health Plans or Medicare Part C.
Medicare Advantage Prescription Drug - MA-PD	A Medicare Advantage Plan that integrates Medicare Part D prescription drug benefits with the medical coverage.
Medicare Beneficiary	One who receives Medicare. Referred to as “consumer” or “member” (see separate definitions) throughout this document. One who is entitled to Medicare Part A and eligible for Medicare Part B.
Medicare-Medicaid Plan (MMP)	A CMS and state run test demonstration program where individuals receive both Medicare Parts A and B and full Medicaid benefits and are, generally, passively enrolled into the state’s coordinated care plan with the ability to opt-out and choose other Medicare options. MMPs are designed to manage and coordinate both Medicare and Medicaid and include Part D prescription and drug coverage through one single health plan. MMP demonstrations and eligible populations vary by state.
Medicare Part A	The part of Medicare that provides help with the cost of hospital stays, skilled nursing services following a hospital stay, and some other kinds of skilled care.
Medicare Part B	The part of Medicare that provides help with the cost of physician visits and other medical services.
Medicare Part B Premium	The premium amount deducted from a Medicare consumer's Social Security check. The Medicare Part B Premium varies from year to year.
Medicare Part C	Medicare Part C Plans are referred to as Medicare Advantage Plans.

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	<ul style="list-style-type: none"> • Include both Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) • Private insurance companies approved by Medicare provide this coverage • In most plans, members need to use plan physicians, hospitals and other providers or they will likely pay more • Members may pay a monthly premium (in addition to their Medicare Part B premium) and a copayment for covered services • Costs, extra coverage and rules vary by plan
Medicare Part D	Known as Medicare Prescription Drug Plans. The part of Medicare that provides coverage for outpatient prescription medications. These plans are offered by insurance companies and other private companies approved by Medicare. Consumers can get Medicare Part D coverage as part of a Medicare Advantage Plan (if offered where a consumer lives), or as a stand-alone Prescription Drug Plan.
Medicare Private Fee-for-Service Plan – PFFS	A type of MA Plan that allows members to go to any Medicare eligible provider who agrees to accept the PFFS Plan's terms and conditions of payment rates. PFFS Plans may or may not use networks to provide care, depending on whether the PFFS plan is a network or non-network plan. Note: UnitedHealthcare currently only offers non-network PFFS plans.
Medicare Private Fee-for-Service Plan – PFFS – Network Plans	Requires the plan to meet access standards through written provider contracts or agreements. Note: UnitedHealthcare only offers non-network PFFS plans.
Medicare Private Fee-for-Service Plan – PFFS – Non-Network Plans	Requires the use of deemed providers who agree to accept the plan's terms, conditions and payment rates. Note: UnitedHealthcare only offers non-network PFFS plans.
Medical Savings Plan - MSA	A type of MA Plan that combines a high deductible Medicare Advantage Plan and a bank account. The plan deposits money from Medicare in the account. Consumers can use it to pay their medical expenses until their deductible is met. Note: UnitedHealthcare currently does not offer a MSA plan.
Medicare Savings Programs - MSP	Many older adults have low incomes, but not low enough to qualify for Medicaid. There are several Medicare Savings Programs available under Medicaid to help lower income seniors and disabled individuals pay for some of their out-of-pocket medical expenses. They are: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individual 1 (QI-1), Qualified Disabled and Working Individual (QDWI).
Medicare Supplement Insurance	Medicare Supplement insurance sold by private insurance companies to fill “gaps” (deductibles, coinsurance and copayments) in Original Medicare. A Medicare Supplement insurance policy cannot be sold to a Medicare Advantage plan member unless the member is switching to Original Medicare. A Medicare Supplement policy can and is sold to members in Medicare Part D (not MA-PD) Plans. Also referred to as “Medigap”.
Medication Therapy Management	A type of Drug Use Review and associated interventions that look to address members' safety and cost concerns through prescriber consultation and member pharmacist counseling. The service is required by the Medicare Modernization Act and targets members with complex medication regimens and costly medication expenditures.
Medigap Policy	<i>See Medicare Supplement Insurance.</i>
Member	The enrollee, Medicare beneficiary, or customer who is currently enrolled in a UnitedHealthcare Medicare Advantage Plan, Prescription Drug Plan, and/or Medicare Supplement plan.
Member-Only Educational Event	An educational event designed to engage new and existing members to promote the understanding and use of their plan benefits, provide an opportunity to strengthen the value of UnitedHealthcare, and/or support member retention. No enrollment or marketing/sales activities are permitted.
MIPPA	Medicare Improvement for Patient and Providers Act of 2008.

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Monthly Plan Premium	The fee a member pays if enrolled in a Medicare Advantage Plan (like HMO or PPO), in addition to the Medicare Part B premium for covered services, if applicable.
N	
National Marketing Alliance (NMA)	An independent marketing organization that is licensed, appointed, and directly contracted with UnitedHealthcare Insurance Company to solicit and sell the UnitedHealthcare Medicare Solutions portfolio of products through its network of down-line licensed, certified, and appointed agents. The NMA is the top level in its hierarchy structure.
Network	Group of physicians, hospitals, and pharmacies who have contracts with a health insurance plan to provide care/services to the plan's members. The Medicare Part D prescription drug plan's network of pharmacies may help members save money on medications.
Network Pharmacy	A licensed pharmacy that is under contract with a Medicare Part D sponsor to provide covered Medicare Part D drugs at negotiated prices to its Medicare Part D Plan members.
New Agent	An agent who has never contracted with UnitedHealthcare or an agent who has not written business for any six-month period under their current name or other alias.
National Insurance Producer Registry (NIPR)	NIPR developed and implemented the Producer Database (PDB), which provides: financial/time savings, reduction in paperwork, real time information, verification of license and status in all participating states, ease of access via the internet, and single source of data versus multiple web sites.
Nominal Value	Items or services worth \$15 or less based on the retail purchase price.
Non-Captive Agent	A licensed, certified, and appointed, non-exclusive independent contractor who solicits and sells any UnitedHealthcare Medicare Solutions product.
Non-Complaint	A member's withdrawal or nullification (verbal or in writing) of an allegation against an agent or broker. Also includes circumstances where, upon review, a complaint fails to state an allegation of agent or broker misconduct.
Non-Licensed Representative	<i>See Unlicensed Representative.</i>
Non-Resident License	An agent who is licensed and appointed (if applicable) to sell in a state outside of the state where that agent holds their primary residency.
Non-Retaliation	UnitedHealth Group and UnitedHealthcare expressly prohibit retaliation against employees and agents who, in good faith, report or participate in the investigation of compliance concerns.
Not-For-Cause Termination	A type of termination of an agent's contract and/or appointment for reasons other than breach of the for-cause provision of the agent agreement.
O	
Open Enrollment Period - (for Medigap)	A one-time only, six-month period when federal law allows consumers to buy any Medigap insurance policy they want that is sold in their state. It starts in the first month that a consumer is covered under Medicare Part B and is age 65 or older. Some states may have additional open enrollment rights under state law. During this period, consumers cannot be denied a Medigap policy or charged more due to past or present health problems.
Organization Determination	Any determination made by a Medicare health plan with respect to any of the following: <ul style="list-style-type: none"> • Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services; • Payment for any other health services furnished by a provider other than the Medicare health plan that the member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan; • The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the member believes should be furnished or

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	<p>arranged for by the Medicare health plan;</p> <ul style="list-style-type: none"> • Reduction, or premature discontinuation of a previously authorized ongoing course of treatment; • Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member; or • Medicare Savings Accounts (MSA) only: Decisions regarding whether expenses, paid for with money from the MSA Bank Account or paid for out-of-pocket, constitute Medicare expenses that count towards the deductible; and, prior to satisfying the deductible, decisions as to the amount the member had to pay for a service.
Original Medicare	<p>One of the consumer's health coverage choices as part of Medicare.</p> <ul style="list-style-type: none"> • Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). • Medicare provides this coverage. • Consumers have a choice of physicians, hospitals and other providers that accept Medicare. • Generally, consumers pay deductibles and coinsurance. • Consumers usually pay a monthly premium for Medicare Part B.
Outbound Enrollment and Verification Call (OEV)	<p>Outbound calls conducted by the plan to consumers who recently enrolled in a Medicare Advantage plan to ensure consumers requesting enrollment into a plan by agents/brokers understand the plan benefits, costs, and plan rules.</p>
Out-of-Home Appointment	<p>A scheduled one-on-one sales presentation (Scope of Appointment requirements apply) that is conducted anywhere except the consumer's residence. Includes, but is not limited to, any common area/community room of a nursing home/facility. <i>See also In-Home Appointment.</i></p>
Out-of-Network Pharmacy	<p>A licensed pharmacy that is not under contract with a Medicare Part D sponsor to provide negotiated prices to Medicare Part D Plan members.</p>
Out-of-Network Provider	<p>A provider or facility with which UnitedHealthcare does not have a contract; therefore, there is no agreement for the non-participating provider to arrange, coordinate, or provide covered services to members of the UnitedHealthcare. These providers are considered out-of-network and are not under contract to deliver covered services to members of UnitedHealthcare.</p>
Out-of-Pocket Maximum – OOP Max	<p>An annual limit that some plans set on the amount of money a member will have to spend out of their own pocket for benefits. All Medicare Advantage plans are required by CMS to have an out-of-pocket maximum.</p>
P	
Party ID	<p>A number assigned by Agent On-Boarding that provides primary identification of an individual. All writing numbers assigned to the individual are tied to their Party ID.</p>
Permission to Call (PTC)	<p>Permission given by a consumer to be called or otherwise contacted. It is to be considered limited in scope, short-term, event-specific, and may not be treated as open-ended permission for future contacts. Does not apply to postal mail.</p>
Pended Commission	<p>A commission for the sale of a policy that cannot be paid as a result of one or more impedance.</p>
Personally Identifiable Information (PII)	<p>A person's first name or last name in combination with one or more of the following data elements:</p> <ul style="list-style-type: none"> • Social Security Number • Driver's License Number or State Identification Card Number • Account Number, Credit Card or Debit Card Number in combination with

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	any required security code, access code or password that would permit access to a consumer's financial account.
Personal/Individual Marketing Appointment	A scheduled face-to-face marketing presentation that typically occurs in a consumer's residence, but may also be conducted in a coffee shop, library, or other public setting. Includes a nursing home/facility resident's room. Requires a Scope of Appointment form. Also called in-home appointment.
Plan Benefit Package - PBP	The package of benefits to be offered in a specific geographic area by a sponsor under an MA plan, MA-PD plan, PDP, section 1876 cost plan, or employer group waiver plan, filed annually with CMS for approval.
Pledge of Compliance	A document signed (electronically) annually by agents pledging compliance with the CMS guidelines and regulations and UnitedHealthcare rules, policies, and procedures.
Point-of-Service - POS	A type of HMO plan that also gives members the option to use providers outside the plan's contracted network for certain benefits, generally at a higher cost. The benefits that are covered out-of-network vary by plan.
Policy Center	An internal website that contains a comprehensive inventory of UnitedHealth Group policies and procedures accessible to UnitedHealth Group employees.
Portfolio Certified	To complete and pass all prerequisite certification modules and the Medicare Advantage (includes Private Fee-for-Service Plans) Plans, Prescription Drug Plans, Chronic Condition and Dual Special Needs Plans, and AARP Medicare Supplement Insurance Plans product modules.
Preferred Provider Organization - PPO	A type of MA Plan in which the member can use either network providers or non-network providers to receive services (going outside the provider network generally costs more). The plan does not require member's to have a referral for specialist care.
Premium	The amount paid by a member to participate in a plan or program. Includes LEP, LIS reductions, Employer Subsidy reductions, and rider premiums.
Prescription Drug Plan -PDP	A stand-alone plan that offers Medicare Part D prescription medication coverage only.
Preventive Services	Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).
Primary Care Physician -PCP	A physician seen first for most health problems. The PCP may also coordinate a member's care with other physicians and health care providers. In some Medicare Advantage Plans, members must see their PCP before seeing any other health care provider.
Prior Authorization - PA	A type of utilization management program that requires that before the plan will cover certain services/prescriptions, a member and/or their physician must contact the plan. A member's physician may need to show that the service/medication is medically necessary for it to be covered.
Producer	A global term introduced in 2007 to refer to any licensed, certified, and appointed individual soliciting and selling UnitedHealthcare Products, including, but not limited to NMA, FMO, SGA, MGA, GA, ICA, ISR, Broker, Solicitor or Telesales representative.
Producer Contact Log (PCL) <i>formerly Service Gold</i>	A contact management system used to document agent/agency interactions with the PHD and/or sales managers/supervisors or BDEs.

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Producer Help Desk (PHD)	A UnitedHealthcare call center whose purpose is to provide support to all agents with issues that pertain to the agent experience.
Protected Health Information (PHI)	Individually identifiable information (including demographics) that relates to health condition, the provision of health care, or payment of such care. <ul style="list-style-type: none"> Identified individual + health information = PHI <ul style="list-style-type: none"> For example, Jon Doe + has diabetes = PHI The fact that someone is applying for coverage or is enrolled in a UnitedHealthcare plan is considered health information PHI.
Provider	Any individual who is engaged in the delivery of health care services in a state and is licensed or certified by the State to engage in that activity, and any entity that is engaged in the delivery of health care services in a state and is licensed or certified to deliver those services if such licensing or certification is required by state law or regulation.
Provider Contact Form	Consumers identify preferred physicians and hospitals on the Enrollment Application during the enrollment in a PFFS plan.
Q	
Quantity Limits - QL	A management tool designed to limit the use of selected medications for quality, safety, or utilization reasons. Limits may be on the amount of the medication that the plan covers per prescription or for a defined period of time.
R	
Rapid Disenrollment	A voluntary disenrollment by a member within three months of the plan effective date. Rapid disenrollment is a key metric that agents are measured on; a high volume may indicate problems with the sales process.
Ready to Sell	An agent has met the certification requirements for their channel in order to market/sell for the plan year.
Referral – Medical	A formal recommendation by the member’s contracting PCP or his/her contracting medical group to receive health care from a specialist, contracting medical provider, or non-contracting medical provider.
Referral – Sales	A consumer who contacts an agent directly upon the recommendation of an existing client, consumer, member, or other third party. In all cases, a referred individual needs to contact the plan or agent/broker directly.
Region	Certain plan types such as PDP and Regional PPO MA plans are offered by regions. CMS created regions based on population size so that plans within a region are able to enroll and provide appropriate service to members. A region may consist of an entire state, several states, or several counties within a state. The service area of a PDP region may vary from a Regional PPO.
Regional Preferred Provider Organization - RPPO	RPPO plans were introduced in an effort to expand the reach of Medicare managed care to Medicare consumers, including those in rural areas. RPPO plans mirror Local PPO plans in functionality and benefit structure, but are available statewide (in one state or multiple states) as opposed to being limited to a defined market. There are 26 regions set by Medicare; a region is defined as one state or multiple states. Members can access network providers throughout the RPPO service area and may access out-of-network services nationwide.
Renewal Eligible Agent	A non-employee agent who is eligible to receive renewal commissions on a sale of a Medicare Advantage or Prescription Drug Plan enrollment. For enrollments effective on or after 01-01-2014, the agent must be contracted,

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	licensed, appointed, and certified as an active or servicing agent in order to receive renewal commissions on the enrollment.
Resident License	An agent who is licensed and appointed (if applicable) to sell in their state of residence.
Responsible Party	A person authorized under applicable law or identified in writing by the individual to act on behalf of the individual in making health care and related decisions for a consumer. Also known as an 'Authorized Representative'.
S	
Sales Distribution	An organization comprised of various distribution channels that market and sell UnitedHealthcare Medicare Solutions portfolio of products.
Sales Leadership	A global term used to describe the sales management hierarchy. Includes both field sales and telesales.
Sales Management	Individual or delegate within UnitedHealthcare Medicare Solutions who is responsible for the management of a sales agent, agency, channel, or geography.
Scope of Appointment (SOA)	The agreement obtained from the consumer to the scope of products that can be discussed at a personal/individual marketing appointment.
Service Area	The geographic area approved by CMS within which an eligible consumer may enroll in a certain plan.
Service Request	The documentation in PCL of all inbound and outbound contacts between the PHD and an agent. <i>See also Coaching Request.</i>
Servicing Status Agent	An inactive, non-employee agent who has signed a servicing agent agreement in order to receive renewal commissions on Medicare Advantage and Prescription Drug Plan enrollments effective on or after 01-01-2014. The agent must maintain an active resident license and appointment and pass Medicare Basics and Ethics and Compliance certification modules on an annual basis.
SMRT Agent Onboarding <i>formerly A360 Daily Onboarding</i>	A tool that resides on the QlikView portal that provides licensing, appointment, and certification status information on agents and sales management.
SMRT Compliance <i>formerly A360 Compliance</i>	A tool that resides on the QlikView portal that provides a holistic view of each agent, NMA/FMO, or manager. The compliance programs reporting tool is refreshed daily and manager threshold evaluation data is refreshed monthly.
Skilled Nursing Facility (SNF)	Skilled Nursing Facility.
Solicitor	A licensed, certified, and appointed agent who sells designated UnitedHealthcare Medicare Solutions products through a contract with an agency (NMA, FMO, SGA, MGA and GA), but does not have a direct contract with UnitedHealth Group.
Special Election Period - SEP	A period when a Medicare consumer may sign up or make changes to their Medicare coverage outside of their initial enrollment period or the Annual Election Period under specified circumstances defined by Medicare.
Special Needs Plans (SNP)	A type of MA plan that provides health care for specific groups of people, such as those who have both Medicare and Medicaid (Dual SNP), those who reside in a nursing home (Institutional SNP), those who have certain chronic

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	medical conditions (Chronic Condition SNP), or those who reside in the community but who qualify to live in a nursing facility (Institutional Equivalent SNP).
Specified Low Income Medicare Beneficiary – SLMB	A program in which Medicaid provides payment of the Medicare Part B monthly premium only. (SLMB-Plus: Payment of the consumer’s Medicare Part B premiums and full Medicaid benefits.)
Star Ratings Program	<p>Medicare has a 5-Star rating system to measure how well plan sponsors perform in different categories. These ratings help consumers compare plans based on quality and performance. Detecting and preventing illness, ratings from patients, patient safety and customer services are examples of categories measured. CMS utilizes one to five stars to determine a Plan’s performance in a particular category; one star denotes poor quality and five stars represent excellent quality.</p> <p>Plan performance summary ratings are issued in October of the previous Plan contract year. Consumers and members may compare Plan rating information by making a request, visiting www.medicare.gov, or checking Plan websites.</p>
State Pharmaceutical Assistance Programs - SPAP	A state program that provides help paying for medication coverage based on financial need, age, or medical condition.
Step Therapy - ST	A utilization tool that requires a member to try first another medication to treat their medical condition before the Medicare Part D Plan will cover the medication their physician may have initially prescribed.
Substantiated Allegation	Following review of the allegations against an agent, appropriate investigation, consideration of the evidence and pertinent circumstances, there is sufficient information to conclude that the allegations are true.
Substantiated Complaint	Following review of the allegations against an agent, appropriate investigation, and consideration of the evidence and pertinent circumstances, there is sufficient information to support the conclusion that the complaint is true.
Successor Agent	The active agent who becomes the Agent of Record (AOR) for the original agent’s book of business.
Super General Agent (SGA)	An independent contractor, with a direct contract with UnitedHealthcare at the SGA level. May refer agents and solicitors for certification and appointment to solicit and sell designated UnitedHealthcare Medicare Solutions products.
Suspension	Temporary removal of an agent’s ability to market and sell products. Suspension is based upon the severity of the allegation(s), the number of pending complaint(s) or investigations, the nature and credibility of information initially provided, and/or the number of members or consumers affected.
T	
Telemarketer/ Telemarketing	A firm or individual who telephonically contacts consumers on behalf of UnitedHealthcare for the purpose of soliciting or selling designated UnitedHealthcare Medicare Solutions products. Telemarketing activities may include lead generation, appointment setting, and/or product marketing.
Telesales Agent	A licensed, certified, and appointed agent who telephonically solicits and

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	sells designated UnitedHealthcare Medicare Solutions products in a call center environment. May be an employee of UnitedHealthcare or an employee of a delegated vendor.
Testimonial	A short presentation or written narrative that a member of the Storytellers Program provides based on their personal experience with a specific UnitedHealthcare Medicare Solutions plan.
Tier	Covered medications have various levels of associated member cost-sharing. Example: Tier 1: Preferred Generic – Lowest Copayment – Lower- cost commonly used generic drugs Tier 2: Non-Preferred Generic – Low Copayment – Most generic drugs Tier 3: Preferred Brand – Medium Copayment – Many common brand-name drugs and some higher-cost generic drugs Tier 4: Non-Preferred – Higher Copayment – Non-preferred generic and non-preferred brand-name drugs Tier 5: Specialty Tier – Coinsurance – Unique and/or very high- cost drugs
Tier Exceptions	A type of coverage determination to provide coverage (based on clinical justification) of a tier to a lower tier.
Trademark	A word, phrase, or symbol that signifies or identifies the source of the good or service and describes the level of quality that can be expected from a particular good or service.
Trend for agent level inconclusive complaints)	At an individual agent level, UnitedHealthcare defines a trend as number of inconclusive complaints in the same category, based on the number of total enrollments on a 12-month rolling basis while under an active contract with UnitedHealthcare or NMA/FMO. Corrective action and active management/oversight of complaints will occur on a concurrent basis to include enrollee/member counseling and outreach, agent, NMA and/or FMO re-training and certification or possible suspension or termination.
Trend (for global complaints)	A pattern or percentage change in complaints for a particular geography, channel, state, and/or product within a 12-month rolling basis. If a trend is identified, the appropriate Business Unit will be notified, a review for root cause will be conducted and if necessary, the appropriate corrective actions will be carried out in accordance with policies and procedures. Such corrective actions may include, but are not limited to revision of training, coaching and counseling of agent, manager, or entity, and termination of agent or entity.
True Out-of-Pocket Expense - TrOOP	An accumulation of payments – monies spent – by the member of a plan. This will include copayments and deductibles, but does not include premium payments or any payments made by the plan.
TTY	A teletypewriter (TTY) is a communication device used by members and consumers who are deaf, hard-of-hearing, or have severe speech impairment. Members and consumers who do not have a TTY can communicate with a TTY user through a Message Relay Center (MRC). An MRC has TTY operators available to send and interpret TTY messages.
U	
UnitedHealthcare Government Programs <i>formerly Public and Senior Markets Group</i>	A term used internally within the Company to collectively refer to the benefit businesses of UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State, and UnitedHealthcare Military & Veterans.

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<i>of UnitedHealth Group (PSMG)</i>	
Unlicensed Representative	<i>See Non-Licensed Representative.</i>
Unsolicited Contact	Solicitation of a consumer for the purpose of marketing any UnitedHealthcare Medicare Solutions product via door-to-door, telephone, email, voice and text message without the prior explicit permission from the consumer. <i>See also Cold Calling.</i>
Unsubstantiated Allegation	Following review of the allegations against an agent, appropriate investigation, and consideration of the evidence and pertinent circumstances, there is sufficient information to support the conclusion that the allegations are unfounded.
Unsubstantiated Complaint	Following review of the allegations against an agent, appropriate investigation, and consideration of the evidence and pertinent circumstances, there is sufficient information to support the conclusion that the complaint is unfounded.
Unsuccessful Event	A marketing/sales event that could not be evaluated by a CMS secret shopper or UnitedHealthcare vendor evaluator because the agent did not show up for a reported event, the incorrect event type was reported, the agent arrived late and after the evaluator/shopper arrived, the reported and actual addresses of the event are not the same, the event could not be located due to inadequate signage, the time of the event was changed, or the event was cancelled but not reported.
Up-Line	The contracted entities within an NMA/FMO hierarchy that are above the management/reporting level of a specific agent/agency.
V	
Vendor	An entity whose purpose is to perform activities as specified by UnitedHealth Group under mutual agreement.
W	
Writing Number	A UnitedHealthcare generated number, assigned to a contracted, licensed, and appointed agent used for submitting business, to track commissions, and other agent-specific sales statistics. <i>Also known as Writing ID. See Agent ID.</i>
Y	
Yearly Deductible – Medical	The amount the member must pay for health care before the plan begins to pay.
Yearly Deductible – Prescription	The amount the member must pay for prescriptions before the plan begins to pay. Some drug plans charge no deductible.

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