External Distribution Channel (EDC)
Agent Guide
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This Guide is intended for agent use only.

Version 6.4 Release Date – October 22, 2019

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Section 1: Introduction

Welcome to UnitedHealthcare

Using this Guide
Welcome to UnitedHealthcare

Thank you for doing business with UnitedHealthcare! We rely on exceptional agents to help us achieve our mission of providing innovative health and well-being solutions that help Medicare consumers live healthier lives.

Here to help you succeed
One tool available is the Agent Guide—a comprehensive resource containing the information you need to conduct business with UnitedHealthcare efficiently and compliantly.

Compliance and integrity
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 UnitedHealthcare, so we have integrated compliance guidelines into each section of the guide.

Easy access
An electronic version of this guide is available on Jarvis and is updated regularly. We welcome comments, suggestions and recommendations for additional content. – simply share your feedback with your UnitedHealthcare Agent Manager.

Consider this guide your resource to serve consumers. We are proud to be your strong, stable health coverage choice and strive to provide you with a hassle-free experience and members with a superior health care experience.

Sincerely,

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

This guide is used to communicate UnitedHealthcare Policies and Procedures. Our policies and procedures provide guidance to ensure compliant and ethical conduct, professionalism, and knowledge of required business processes and responsibilities. Agent guides are confidential and proprietary property of UnitedHealth Group and may not be distributed, reproduced, republished, transmitted, displayed, broadcasted, or otherwise exploited in any manner without express written permission of UnitedHealthcare.

The Agent Guide has been developed for use by all National Marketing Alliance (NMA) agents and solicitors. Throughout the guide the words “agent” and “you” are used to refer to any NMA 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.

- 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.
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On-Boarding

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On-Boarding
You must be appropriately contracted, licensed, appointed (if applicable), and certified in order to market or sell any UnitedHealthcare Medicare Solutions product.

Contracting
You must align under an NMA or eAlliance organization approved and contracted with UnitedHealthcare.

Your NMA or eAlliance organization initiates the contract submission process by providing contracting paperwork (via hardcopy, electronic copies, or a link to either an internal or external on-line contracting system) to you to obtain necessary on-boarding information and documentation. Your NMA or eAlliance is responsible for verifying the accuracy and completeness of the contracting packet paperwork.

A complete contracting packet contains:

- Agreement (not applicable for solicitor) – First and signature pages, at a minimum, must be submitted. Note: The signature date must be within 30 days of the date received by Agent Lifecycle Management (ALM).

- Appointment Application – Signed and dated. Note: The signature date must be within 30 days of the date received by ALM.

- Errors & Omissions Attestation of Coverage within the Appointment Application – Signed and dated. Note: The signature date must be within 30 days of the date received by ALM.

- NMA Relationship Hierarchy Addendum – With all required signatures and dated. Note: The signature date must be within 30 days of the date received by ALM.

- W-9 Form (not applicable for solicitor) – signed and dated. Note: The signature date must be within 30 days of the date received by ALM.

Licensing
You must be licensed in your resident state and in all states for which you have requested appointment. You are responsible for maintaining an active license including all educational requirements. ALM will verify license status using NIPR (National Insurance Producer Registry). Failure to maintain valid licensing is grounds for not-for-cause termination.

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

ALM must receive a complete contracting packet in order to assign you a Party ID. If an incomplete packet is received, ALM will suspend the contracting process and notify the applicable NMA or eAlliance via email identifying the missing, incomplete, and/or outdated items. The contracting process will resume when the packet is complete.

Upon receipt and review of a complete contracting packet, ALM will assign the Party ID and email you and the applicable
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NMA or eAlliance a Party ID Notification Letter.

Certification
You must complete certification requirements in order for ALM to process the appointment request. (Refer to the Certification section for details.)

90 Day Requirement
The Party ID Notification Letter includes instructions for accessing the Learning Management System within Jarvis. You must successfully pass all pre-requisite assessments, within 90 days of the date of the Party ID Notification Letter, in order to move forward in the contracting process. Note: Agents transferring AHIP certification credit or passing Medicare Basics are given credit for Medicare Advantage, Prescription Drug Plans, and Medicare Supplement Insurance plans product certification pending successful completion of the remaining pre-requisite assessments.

Failure to Certify Timely
The contracting process terminates if you fail to complete the certification requirement within 90 days of the date of the Party ID Notification Letter. You may reapply without a waiting period by submitting a new contract packet.

Background Investigation

Initial On-Boarding
You must pass a background investigation in order for ALM to process the appointment request. The investigation is ordered at the time the Party ID is issued and may be ordered when a new contract packet is received based on when the last investigation occurred.

A background investigation collects information regarding an agent’s history of criminal charges, credit history, insurance licensing history, 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.

Pass – the contracting process continues

Fail – the results of the background investigation are reviewed by a senior ALM analyst. If the review supports the initial result, the contracting process terminates and you receive notification of the decline to appoint due to background investigation. The notification letter includes appeal submission instructions. (Refer to Appeal of Denial Due to Background Investigation section).

Periodic Investigation
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 informing you of the upcoming background investigation. The notification letter provides instructions on how to notify ALM if you do not authorize the investigation.
- Agents, solicitors, and principals who do not authorize the background investigation are immediately terminated not-for-cause upon such notification to ALM (this termination includes agencies of these principals, if the principal
Section 2: How do I Get Started?

The periodic background investigation review follows the same process outlined in the Initial On-Boarding section above, except that an active agent who fails the periodic background process will receive a 30-day termination notice, regardless of channel or level (solicitors included).

- **Proactive Background Review**
  Effective August 1, 2017, to expedite the periodic background investigation process, an investigation may be paused temporarily in order to obtain clarification of data reported by the background investigation vendor and an Appeal Request may be opened on behalf of the agent.

  - If an Appeal Request is opened, a communication is sent to the agent requesting the necessary documentation for the agent to pass the review. You must respond to the request within 10 days to complete the background review process.
  - If you miss the deadline or chooses not to participate in the process, the background review will proceed as usual, which may result in a failed background review.
  - Agents who do not pass the review are entitled to the standard two-tiered appeal process.

On a monthly basis, ALM 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.

**Appeal of Decline Due to Background Investigation**

<EDC and ICA>

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

Appeals must be in writing, include your 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 mailed, faxed, or emailed to the Agent Lifecycle Management Department:

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

First-Level Appeal – Tier I

Initial, Tier I, appeals are reviewed and determinations made by designated ALM staff specifically trained to review background investigation results. If the ALM analyst who made the original decision to decline the agent based on the background investigation results also conducts the Tier 1 appeal review, in order to obtain an impartial decision the analyst will solicit input from other analysts trained in background investigation reviews or a review by leadership will be requested.

- The ALM 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.

- If the appeal is denied, a denial notification letter is sent via email and postal mail to you that describe your right to a second appeal and the process. The applicable NMA or eAlliance 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 Appeal Committee. The committee includes senior-level distribution operations, field sales, and compliance representatives; meets, as needed; and maintains meeting notes (used to document relevant aspects of the meetings including attendees, appeals reviewed, decisions rendered and by whom).

- Tier II appeals must contain additional information explaining what was missed in the initial reviews and/or errors regarding the background investigation not revealed previously.

- The Background Tier II Appeal Committee reviews the appeal and pertinent documents, renders a decision, and forwards the appeal documentation with noted decision to ALM.

- ALM facilitates processing and documenting the appeal, including the communication of the final decision to you and the applicable NMA or eAlliance.

- If the appeal is approved, the contracting process will resume. New documents may be required if they no longer meet signature date requirements.
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- If the appeal is denied, a denial notification letter is sent via email and postal mail to you. The applicable NMA or eAlliance receives a copy of the notification letter.

- The decision of the Contract Appeal Committee is final and may not be appealed.

Waiting period to Submit a New Contract Packet
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 you appeal the decline, you 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.

Errors and Omissions (E&O)/Professional Liability Insurance
Each non-employee agent representing UnitedHealthcare must carry and maintain continuous E&O/Professional Liability insurance coverage and provide proof of coverage (e.g. carrier’s declaration page) upon request. 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 is 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.)
- Blanket E&O/Professional Liability 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
the business entity’s letterhead, provide covered individual’s full legal name and signed by the entity’s principal. 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 covers the corporation, but not specifically the employees or subcontractors of the corporation.

- If you are not insured by a corporate policy, you may have individual E&O/Professional Liability insurance. The policy should be in your name.

- Submission of E&O/Professional Liability coverage documentation is not required unless specifically requested and may be sent to uhpcred@uhc.com.

### Appointment

You must be licensed and appointed (if applicable) in each state in which you represent UnitedHealthcare in the marketing and/or sale of UnitedHealthcare Medicare Solutions products.

When all contracting and certification requirements are met, ALM will submit state appointment requests to each state requested on the Relationship Hierarchy Addendum.

### On-Boarding and Agent Readiness Fees

#### Appointment Fees (EDC Only) Effective April 19, 2013

- 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.

#### Annual Sales Production Evaluation Period Administrative Fee (EDC Only) Effective July 1, 2018

UnitedHealthcare will charge an administrative fee to an EDC agent/agency (does not include solicitors) with an active contract that has not sold at least one UnitedHealthcare Medicare Advantage, Prescription Drug Plan, or Medicare Supplement Insurance plan during the annual agent sales production evaluation period. For 2019 and beyond, the
Section 2: How do I Get Started?

evaluation period is July 1 through April 1 of each year. Agents/agencies that newly contract on or after December 1 are excluded from the evaluation period in progress.

The following guidelines apply:
- After the evaluation period, if you fail to meet minimum production requirements, an administrative fee will be charged (some exceptions may apply). After the initial period, all policy rules will apply if you are active any time during the evaluation period. The annual administrative fee for non-production is:
  - $150 fee for first appointed state
  - $100 additional fee for additional states
  - Maximum of $250 per agent per year
- UnitedHealthcare will initiate a not-for-cause termination for any non-producing agent that does not have an active book of business (some exceptions may apply). Refer to the Termination Process section for details.
- If after six months, UnitedHealthcare cannot recover the administrative fee from you, your immediate up-line will be charged for the unpaid fee amount. For 2019, UnitedHealthcare has extended the collection period of unpaid administrative fees for applicable up-lines until the end of the year.

Writing Number (Agent ID) Notification

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, must be indicated on each enrollment application written by you, and is used to accurately credit you with the sale of a policy. Once the appointment request is submitted to the state, you are set to active status in the contracting system, a writing number is issued and your Agent Agreement is executed with the Chief Sales Distribution Officer’s signature. A Welcome Letter, which contains your writing number and the first page and the executed signature page of your Agent Agreement, if applicable, is emailed to you with a copy of the Welcome Letter sent to your NMA or eAlliance. All agents are expected to confirm state appointment approval via Jarvis prior to marketing/selling any product.

Agent/Agency Level, Alignment, or Channel Change Requests

EDC Agent Requesting to Change NMA or ICA or IMO Channel (effective August 8, 2017)

You must align under an NMA approved by and contracted with UnitedHealthcare. You may only align with one NMA at any given time. You may not align with multiple channels simultaneously. When an agent aligns under a new NMA or moves
to the ICA or IMO channel, the hierarchy structure in place at the time of the original sale retains residual override commissions.

- To align under a new NMA or move to the ICA or IMO channel:
  - You must be active with UnitedHealthcare, and
  - When aligning under a new NMA, the new NMA must be active with UnitedHealthcare, and
  - If your current NMA is actively contracted with UnitedHealthcare, you must submit to UnitedHealthcare a Letter of Release from the current NMA or a Notice of Intent.

- Release and Notice of Intent Requirements
  - Release Process
    - An NMA may provide you with a full release to leave the hierarchy.
    - No waiting period applies; you may move to a new channel/hierarchy as soon as the release is obtained: Note: ALM does not process contracting change requests during the Blackout Period (September 1 through December 31). Therefore, in order to move to a new channel/hierarchy by the start of an Annual Enrollment Period, the new contracting packet must be received by ALM before the blackout period begins September 1.
    - You may only move to a contracting level equal to or lower than your current contract level and must stay at that level for a minimum of one year.
  - If you self-terminated within six months of your current contract submission date, the NMA must include release paperwork with the contract packet. ALM will forward the release request to sales management.
  - Notice of Intent Process
    - You must be under your current NMA and in your current hierarchy level for at least six months prior to submitting a notice of intent and can only change channels or NMA once every 12 months from the effective date of your current agreement or hierarchy change, whichever occurred most recently.
    - You must email a notice of intent to UnitedHealthcare at shcerts@uhc.com and to the top level of your current hierarchy, indicating the name of the up-line under which you intend to move or if you are moving to the ICA or IMO channel.
    - Upon receipt of the notice of intent, UnitedHealthcare will send a reply letter to you, with a copy to your current NMA and intended NMA or applicable sales leader if moving to the ICA
or IMO channel, indicating the date when the six-month waiting period expires.

- A six-month waiting period begins on the date UnitedHealthcare receives the email. During the waiting period, you and your down-line, if applicable, may continue to write UnitedHealthcare business. If, during the six-month waiting period, you decide to move to a different entity than indicated in the notice of intent, you must submit a new notice, which begins a new six-month waiting period.

- Once the notice of intent is submitted to the current up-line, the up-line may not make changes to the transferring agent’s hierarchy unless the transferring agent provides written notice to make changes.

- ALM must receive required contracting paperwork (i.e. Appointment Application and Relationship Hierarchy Addendum, and, only if moving level, a new contract agreement) within 30 days of the expiration of the waiting period except as noted below.
  
  - You may only move to a contracting level equal to or lower than your current contract level and must stay at that level for a minimum of one year.
  - ALM does not process contracting change requests during the Blackout Period (September 1 through December 31). Therefore, in order to move to a new channel/hierarchy by the start of an Annual Enrollment Period, the new contracting packet must be received by ALM before the blackout period begins September 1.
  - If ALM does not receive required paperwork within the required timeframe, you must submit a new notice of intent, which begins a new six-month waiting period.

- Agent Agreement and Writing Number
  
  - A new agent agreement is not required unless you are changing levels.
  - If release/notice of intent and contracting requirements are met, your current writing number is deactivated, a new writing number is issued, and a new Agent Agreement, if applicable, is executed with the Chief Sales Distribution Officer’s signature. A Welcome Letter containing the new writing number and copy of the executed Agent Agreement, if applicable, is emailed to you with a copy of the Welcome Letter sent to the new NMA or applicable sales leader. Note: Commission will not be paid on any enrollment when an inactive writing number was indicated on the application.
  - You must be with the new hierarchy a minimum of twelve months before being eligible for a promotion to a new contract level.
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- Treatment of Down-line Entities
  - It is not required for the down-line agents and agencies to submit separate notices of intent.
  - The new up-line must submit required paperwork (i.e. Appointment Application and Relationship Hierarchy Addendum) for each down-line entity moving with the agent.
  - A down-line entity must contract at a level equal to or lower than their current contract level.
  - If paperwork requirements are met, the down-line entity’s current writing number is deactivated and a new writing number is issued.
  - Note: Commission will not be paid on any enrollment when an inactive writing number was indicated on the application.
  - If ALM does not receive required paperwork for a down-line entity within the required timeframe, the down-line entity will be reassigned to the next immediate level in their current NMA hierarchy.

- Agent Promotion after Realignment
  - Agent promotion to a higher level at the new channel/hierarchy may not occur until one year from the date of the move/new contract effective date.
  - If you have down-line agents or solicitors, all down-line agents will be moved and will not receive new writing numbers.
  - Agent promotion to a higher level at the new channel/hierarchy may occur until one year from the date of the move/new contract effective date.

EDC Agent Requesting a Change in Hierarchy within Same NMA

You, when requesting a change, must align under an NMA approved by and contracted with UnitedHealthcare. The NMA has discretion to move and change the level of agencies, agents, and solicitors within their hierarchy structure. You must agree to the changes, and required paperwork must be submitted by the NMA to ALM. Residual override commissions are retained by the hierarchy structure in place at the time of the original sale. In order for there to be a change in the level of an agency/agent:

- You must be active with UnitedHealthcare.
- The NMA, under which the agency/agent wishes to align, must be active with UnitedHealthcare.
- The NMA must submit a new Relationship Hierarchy Addendum along with a new agreement (if changing levels) and a W-9, if moving from a solicitor to agent level or above.
- Once ALM receives the required paperwork, you are moved per the NMA request. You will retain your existing writing number. A Hierarchy Change Letter, which notifies you of a change in your level/position, is emailed to you along with an executed copy of your Agent Agreement, if applicable. A copy of this letter is also emailed to the NMA.
- If you have down-line agents or solicitors, all down-line agents will be moved and will not receive new writing numbers.

EDC Agent Requesting to Move to a Telesales Vendor

EDC agents aligned under an NMA approved and contracted with
Section 2: How do I Get Started?

UnitedHealthcare may request to move to a Telesales vendor and are subject to the release and notice of intent rules detailed in previous sections. It is within the discretion of the Vice President of Operations whether to allow an EDC agent to move to a Telesales Vendor during the Blackout Period (September 1 – December 31). In place of a “new NMA or applicable sales leader”, the Telesales vendor is responsible for submitting required information and paperwork to ALM.

Servicing Status and Successor Programs

Servicing Status - Non-Active Renewable Eligible Non-Employee Agent (Effective January 1, 2014)

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

- To enter servicing status, you must, (prior to your 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 assessment with a score of 85% or better within six attempts. Thereafter, you must 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 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 you fail to meet servicing status requirements (e.g., no longer has an active license or fails to meet certification requirements). Renewal commissions for MA and PDP 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
Section 2: How do I Get Started?

- Eligible products include all UnitedHealthcare Medicare 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 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), IMO 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. Standard Release Rules apply.
  - 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.
Section 2: How do I Get Started?

- 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, IMO and IMO, ICA and ICA). Standard release rules apply, but EDC agents are not required to be in the same NMA.
  - 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 be of an equal or higher level than the highest level at which the original agent had been contracted in order to receive the original agent’s full book of business.
  - 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/upline 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.
  - Upon transfer, Successor Agent’s Agent Agreement (contract) with UnitedHealthcare will govern the book of business.

- 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 approves or disapproves a 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)

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, IMO, or ICA 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
Section 2: How do I Get Started?

channel as Deceased Agent (e.g. EDC and EDC, IMO and IMO, 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 be of an equal or higher level than the highest level at which the Deceased Agent was contracted in order to receive the original agent’s full book of business.

~ Successor Agent must not be the subject of an open complaint investigation. Open complaint investigations must be closed (refer to policy 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:
  o 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.
  o 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.
  o Successor Agent is not eligible to transfer Deceased Agent’s book of business to another successor agent.

~ 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 60 days of Deceased Agent’s death. If UnitedHealthcare is not properly notified within 60 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
Section 2: How do I Get Started?

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 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.

Appeals must be in writing, include your 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 Medicare & Retirement
Attention: Commissions - Successor Agent
MN006-E800
9800 Health Care Lane
Minnetonka, MN 55343
Fax: 1-866-761-9162
Email: sh_commissions_administration@uhc.com (preferred method)

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

Appeals are forwarded for consideration to the Successor Agent Approval Board (SAAB), which includes senior-level distribution operations, field sales, and distribution compliance representatives; meets weekly, as needed; and maintains meeting agendas and minutes (used to document relevant aspects of the meetings including attendees, appeals reviewed, decision rendered and by whom).

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.

Certification Program

The UnitedHealthcare Medicare Solutions certification program will meet or exceed agent training and testing requirements issued annually by CMS. Certification materials are reviewed and updated annually or as new regulations are released.

Certification materials, which consist of training modules and assessments, for the upcoming plan year are generally available in late June or early July. Once upcoming plan year certification materials are posted, current year certification materials are unavailable; therefore, an individual who is not certified for the current year, must become certified in the product for the upcoming plan year in order to market and sell the current year's product.

Prerequisites include Medicare Basics, Ethics and Compliance, and AARP 101 (or similar).

Product certification may be offered in non-special needs Medicare Advantage (MA) Plans; Dual (DSNP), Chronic (CSNP), Institutional*, (ISNP) and Institutional Equivalent* (IESNP) Special Needs Plans; Senior Care Options* (SCO) plans; Medicare Supplement Insurance plans; and stand-alone Prescription Drug Plans (PDP).

*Certification in ISNP, IESNP, and SCO product is by invitation only.

Each prerequisite and product assessment has a minimum passing score of 85%. Six attempts are permitted to pass an assessment. If you fail to pass a prerequisite assessment within the allotted six attempts, you are prohibited from marketing/selling any product in the UnitedHealthcare Medicare Solutions portfolio for the applicable plan year. If you fail to pass a product assessment within the allotted six attempts, you are prohibited from marketing/selling that product for the applicable plan year.

When you pass or are given credit for the field Medicare Basics assessment, conditional credit is given for product certification in non-special needs MA Plans, Medicare Supplement Insurance plans; and stand-alone PDPs. You must pass the remaining field prerequisite assessments in order to be certified in those products.

External Vendor Certification Courses

- UnitedHealthcare may accept and give credit for successful completion of a third party’s certification program. The compliance department provides course content analysis and determines applicable certification credit and minimum score required to receive credit. Gaps in course content remain your responsibility.
UnitedHealthcare currently accepts and provides partial certification credit to agents who pass the America’s Health Insurance Plans (AHIP) annual certification course with a minimum score of 90% within six attempts. To receive credit, you must transfer your passing score prior to beginning the UnitedHealthcare certification program for the applicable plan year. Upon successful transfer of a passing score, you are given credit for the field Medicare Basics assessment (see the Certification section above for details). If you fail to pass the AHIP course within six attempts, you are not permitted to restart the certification process through UnitedHealthcare and are not permitted to sell any UnitedHealthcare Medicare Solutions products for the applicable plan year.

You must access certification program materials using your assigned log in IDs and passwords and must take and complete assessments on your own behalf. Individuals are not to use assistance when completing an assessment, including, but not limited to sharing/comparing answers, taking the exam as a part of a group, or using answer keys. Any individual found to have used assistance in completing an assessment will be subject to discipline up to and including termination with cause.

UnitedHealthcare certification materials are produced in written English and do not contain audio content. Individuals who are not literate in English may complete certification modules and assessments in a UnitedHealthcare office with an interpreter and proctor present. The proctor must be a UnitedHealthcare employee or a UnitedHealthcare contracted vendor. The use and name of the proctor must be documented. Neither the interpreter nor proctor may provide any assistance in the completing of the assessment.

Records relating to course content, module completion, assessment attempts, and assessment scores are electronically maintained by the certification department and retained for at least ten years. Pass/fail records are uploaded to the ALM system.

**Certification Requirements**

The individual whose writing number is entered on the enrollment application must be appropriately certified in the product in which the consumer is enrolling at the time of sale. No commission or incentive will be paid on any enrollment application written by an individual who was not appropriately product certified at the time of sale (i.e. an unqualified sale). (Refer to the commission section and compliance and quality assurance section for details.)

Individuals are required to complete the following certifications based on role:
- Servicing status agents must pass upcoming plan year field Medicare Basics and Ethics and Compliance assessments by December 31.

**Required Electives**
- Any individual participating in a formal or informal marketing/sales event must pass the Events Basics assessment for the applicable plan year with a minimum score of 85%
within six attempts. The Presenting Agent must pass Events Basics validation at the time the event is reported. (Refer to the event reporting section).

- Effective May 6, 2019, to participate in the Health Assessment Program, agents must complete the Health Assessment Training course for the applicable calendar year.

**Validation, Reporting, and Monitoring**

- You can verify your own certification status and history through Jarvis (via Knowledge Center/Training/Certification) or by contacting the PHD.
- The learning and development, certification operations, and compliance departments monitor the certification program. Quality indicators have been established and are reviewed on a quarterly basis to ensure that training modules are effective and meet company standards. Quality indicators that are measured include the following:
  - Level One: Agent feedback including ratings on content, structure, understanding, usability, and value of courses.
  - Level Two: Knowledge evaluations are conducted through the administration of tests that have been developed by subject matter and learning experts to sample the key areas of knowledge necessary to perform successfully the job.
  - Level Three: Activity metrics (e.g., length of time, frequency of access, frequency of test taking attempts, average scores) are monitored to ensure effectiveness of instruction and measurement of achievement. These metrics are loaded into the Learning Management System report tracking system.

**Requests for Certification Related Information**

- Agent or up-line requests for certification related information should be directed via email to the PHD at phd@uhc.com.
- The PHD forwards requests to the certification operations department for processing according to departmental procedures. Guidelines are established for intake, escalation, and resolution of requests.
- Appeal requests or critical subject matter, such as the employment relationship or compliance, regulatory, audit, ethics, or legal issues, a committee representing sales, compliance, and other relevant leaders will evaluate the request. The manager of certification operations will review and approve information prior to release to the requestor and determine the final factual assessment and outcome.

**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.

**Sales Training and Certification Program Validation**

The Learning Management System allows you to verify your certification status and history. It is the responsibility of your sales management to support the certification process and monitor your certification progress. In addition, corrective action up to and including termination will be assigned due to a certification violation.

- **Validation**
  - Certification status can be confirmed through the Learning Management System, Producer Help Desk (PHD), or Jarvis.

**Requests for Certification Related Information**

Requests for information regarding the certification process, module, and/or assessment content, certification status, or the certification status of a particular individual should be directed to the PHD via email at [phd@uhc.com](mailto:phd@uhc.com) (the subject line should contain your Writing ID number, available 24 hours).
Section 3: What Communications are Available to Help Me?

Agent Communications
Agent Communications

UnitedHealthcare provides you with information related to the product portfolio, applicable federal and state regulations, and UnitedHealthcare rules, policies, procedures, and processes through a variety of means.

Communication Method
Email is the primary method of communication.
- You must provide and maintain a valid email address available to UnitedHealthcare.
- You must receive and read all communications emailed from UnitedHealthcare.

Other Communications Methods
Communications may also be disseminated through the following methods:
- Postal mail
- Manager meetings
- Conference calls
- Telephonic messaging (e.g., text and voice)
- Jarvis

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

Communication Management

JarvisWRAP
JarvisWRAP is distributed to you weekly. All articles will be available on Jarvis.

Emails
Sales Communications maintains and uses email distribution lists for each sales channel.

Agent Surveys
Agent surveys are conducted on an annual or semi-annual basis.

Disclosing Proprietary Information, Media Requests, and Public Relations Materials
- Confidential and/or proprietary data about UnitedHealthcare must not be released to anyone outside the company without first securing approval from the Chief Distribution Officer, Compliance, or Legal.
- Agents are prohibited from speaking to the press regarding UnitedHealth Group related business information (including but not limited to intellectual properties, plan designs, and acquisitions) without first securing approval from the Corporate Communications team. All media inquiries must be directed to the Corporate Communications team.
- Press releases and other public communications must be submitted for approval to the Corporate Communications team. In some cases, press releases must be approved by the UnitedHealthcare Group Chief Communications Officer and head of investor relations.
Section 4: Agent/Agency Materials, Websites, and Social Media

Agent/Agency Materials

Websites and Social Media

Media Engagements
Agent/Agency Materials

Marketing Materials
Materials that are determined to be a marketing material, as defined by CMS in intent and content, require UnitedHealthcare and CMS approval prior to use.

Marketing materials are determined based on the intent and content of the material and include materials that:

- Promote UnitedHealthcare or intended to influence a consumer/member’s enrollment or plan decision.
- Promote any MA plan or PDP offered by UnitedHealthcare.
- Inform Medicare consumers/members that they may enroll in or remain enrolled in a MA plan or PDP offered by UnitedHealthcare.
- Include any benefit or benefit structure information and/or premiums and cost sharing information on a MA plan or PDP.
- Include any plan comparisons, rankings, measurements in reference to other Plan sponsors, or information on Star Ratings.

UnitedHealthcare must submit all MA plan and PDP marketing material (e.g., flyers, business reply cards, print, outdoor, direct mail, radio, online/digital, social media, or television advertising, and presentation slides/charts) to CMS.

Agent/agency created materials must not be marketing materials, as defined by CMS. Note: Agents/agencies may create materials that market or advertise their agency and/or services using generic content.

MA plan and PDP 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 2020 plan year must not be distributed prior to October 1, 2019. Once marketing activities begin for the new contract year, current year marketing activities must cease, except to consumers who are eligible for a valid enrollment (e.g., Age-In, Special Election Period). 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 Advantage and Prescription Drug plans with an effective date of October 1, November 1, or December 1 due to a Special Election Period or a consumer “ages-in” to Medicare due to an Initial Coverage Election Period).

Medicare Supplement marketing materials promote AARP Medicare Supplement plans offered by UnitedHealthcare. Medicare Supplement marketing materials are reviewed by AARP Services, Inc. and UnitedHealthcare, and filed with and approved by the individual state Departments of Insurance to.

Accessing and Ordering Pre-Approved Materials

UnitedHealthcare provides preapproved materials and templates to ensure consistency of branding and messaging, legal and regulatory compliance, and partner approval. All materials made
available and/or provided by UnitedHealthcare are copyrighted and shall remain property of UnitedHealthcare.

You, at your discretion and without further approval, may use materials provided by UnitedHealthcare 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 that can be customized and/or personalized by you, may be used by you 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.

Pre-approved marketing materials for acquired entities might require ordering through the entity’s sales office.

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

Other than the materials and preapproved templates (e.g., logo) provided by UnitedHealthcare, you have no authority to use any UnitedHealth Group or its affiliates or AARP brand names, brand derivatives, trademarks, service marks, logos, or domain names in any agent/agency created content or material, or on any website and/or social media without the proposed use being submitted, reviewed, and approved prior to use. 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 or its affiliates or AARP brand name or brand derivatives.

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, logo, or plan...
information in any manner must be submitted for approval. Use of agent-created marketing materials featuring a UnitedHealthcare brand, logo, or plan information 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.

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 NMA upline. Upon review and approval, the NMA 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 material to agent_marketing_requests@uhc.com.

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

Communications Activities and Materials
Communications means activities and use of materials to provide information to consumers/members. This means that all activities and materials aimed at consumers/members, including their caregivers and other decision makers associated with a consumer/member, are “communications” within the scope of regulations.

Communication Activities
Communication activities that have the potential of becoming a marketing activity must adhere to marketing requirements.

Communication Materials
Generic communication materials do not require UnitedHealthcare approval prior to use. Communication materials are distinguished from marketing materials based on both intent and content. While communication activities may move from communication activities to marketing.
activities, communication materials are static in nature and generally will not move from communication materials to marketing materials.

**Agent Created Materials**
Agent created materials must be generic to be used without approval. Agent created materials that feature the UnitedHealthcare brand name/logo or marketing content promoting UnitedHealthcare must be approved by UnitedHealthcare. Materials that do not include plan specific information, such as plan or product specific names or logos, benefit information, and premiums, are considered generic.

**Generic Materials:**
- May mention Medicare Advantage and/or Prescription Drug Plan products in a general way.
- Must not contain any UnitedHealthcare and/or AARP brand, name, trademark, service mark, logo, and/or domain name.
- Must not include plan specific information, plan or product specific names or logos, benefit or benefit structure information, premium or cost sharing information, comparisons or ranking or measurement information between plans, and/or star rating information.
- Must comply with the applicable CMS Medicare Communications and Marketing Guidelines.
- Do not require CMS or UnitedHealthcare approval prior to use.
- May be reviewed by UnitedHealthcare retrospectively.
- Must include all required disclaimers.

~ Must include the required disclaimer on all advertisements and invitations to events (educational and marketing) “For accommodations of persons with special needs at meetings call <insert phone and TTY number>.”

~ Must include a statement when promoting drawings, prizes, or free gifts that clearly indicates that there is no obligation to enroll in the plan. Example:
  - “Eligible for a free drawing, gift, or prizes with no obligation to enroll.”
  - “Free gift without obligation to enroll.”

**Prohibited/Misleading Terminology**
You are prohibited from providing information that is inaccurate or misleading, or engaging in activities that could mislead or confuse consumers/members or misrepresent UnitedHealthcare.

You must not:
- Claim that you are recommended or endorsed by CMS, Medicare, or the Department of Health & Human Services (DHHS);
- Use unsubstantiated or absolute superlatives or disparaging comments.
- Use the term “free” to describe a zero-dollar premium, reduction in premiums (including Part B buy-down), reduction in deductibles or cost sharing, low-income subsidy (LIS), cost sharing for individuals with dual eligibility.

**Agent Titles**
Agent titles must not mislead or misrepresent that the agent is connected to, approved, endorsed, or authorized by Medicare. Agent titles that imply the agent has additional knowledge, skill, or certification above licensing requirement that cannot be verified is prohibited.

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

UnitedHealthcare has approved the following agent titles based on the agent’s sales channel for proper representation to consumers/members:

Examples of approved EDC agent titles:
- Sales Agent
- Sales Representative
- Independent Sales Agent
- Independent Sales Representative
- Licensed Agent
- Licensed Sales Agent
- Licensed Sales Representative
- Licensed Insurance Representative (eAlliance Partner)

Agents may add their National Marketing Alliance (NMA) after an approved title.

**Medicare name or mark**

You must not use symbols, emblems, images, color schemes, names (including acronyms), words, letters, or any other combination or variation in reference to Medicare, Social Security Administration, Department of Health and Human Service, Medicaid, or any other government entity on communication or marketing materials, electronic communications, websites or social media accounts, broadcasts or telecasts, or company name in a manner that is misleading or conveys or could be reasonably construed as conveying the false impression that you, the business, or content mentioned is connected to, approved, endorsed, or authorized by Medicare or any other government entity.

**Websites and Social Media**

**Agent/Agency Created Websites**

You may create consumer-facing websites, which are directed to consumers to market agent/agency services and announce your affiliation with UnitedHealthcare, and/or agent-facing websites, which might be password protected, that are directed to agents for recruitment activities, education, and communication.

Agent/agency websites that contain marketing content must be approved by CMS prior to publishing. UnitedHealthcare must approve all marketing material content related to a UnitedHealthcare plan. If approved, UnitedHealthcare will file the website containing marketing content related to a UnitedHealthcare plan with CMS for approval. The following provisions apply to agent-created websites. In addition to the guidelines below, you must refer to the Agent Website and Social Media Guidelines job aid for specific instructions related to agent/agency created websites.

**You Must**
- Be licensed, contracted appointed (if applicable), and certified with UnitedHealthcare in order to announce your affiliation with UnitedHealthcare on your website.
Register with UnitedHealthcare any agent/agency created website that contains an affiliation announcement with UnitedHealthcare. You must refer to the Agent Website and Social Media Guidelines job aid for registration instructions.

Follow all applicable CMS regulations, state laws, and UnitedHealthcare rules, policies, and procedures.

On agent-facing websites, include a disclaimer to the effect: “The information on this website is for agent use only and is not intended for use by the general public.”

You May

- If the website is registered with UnitedHealthcare, announce your affiliation with UnitedHealthcare by using one or more of the following brand elements. You must refer to the Agent Website and Social Media Guidelines job aid for instructions related to requesting and/or using these elements.
  - UnitedHealthcare company name
  - UnitedHealthcare provided logo
  - Hyperlink to a UnitedHealthcare approved website
  - AARP web banner, only if the agent is a current Authorized to Offer (A2O) Level 2 agent.

- Place within your website hyperlinks to government websites, such as www.medicare.gov, or other websites as permitted by the other organization and compliant within these guidelines.
- Post current basic Medicare information, such as income limits, Part A and/or B premium and deductible amounts, Part A and B coverage descriptions, Part D coverage stage information, provided the information is accurate for the current plan year.
- Post an electronic Business Reply Card (eBRC) to obtain consumer contact information and permission to contact. You must refer to the Agent Website and Social Media Guidelines job aid for additional details.
- Identify the Medicare product types you are certified to offer, such as Medicare Advantage Plans, Medicare Supplement Insurance, Prescription Drug Plans, and Special Needs Plans.
- On agent-facing websites only:
  ~ Use the pre-approved boilerplate language provided in the Agent Website and Social Media Guidelines job aid to describe UnitedHealthcare plan types.
  ~ Include a link to www.uhcjarvis.com as a convenience for UnitedHealthcare contracted agents.

You Must Not

- Announce your affiliation with UnitedHealthcare through any means unless you have registered the website. All content on an unfiled and unregistered agent/agency website must be generic.
- Use any UnitedHealthcare logo except the one provided by UnitedHealthcare and in accordance with the request process provided in the Agent Website and Social Media Guidelines job aid. Copying and pasting a logo from a UnitedHealthcare website or publication (e.g., communication or marketing material) is prohibited.
Section 4: Agent/Agency Materials, Websites, and Social Media

- Alter the approved logo (except for proportional resizing) or AARP web banner in any way.
- Reference “AARP” or display any AARP logo, brand, or product name, with the exception provided to A2O Level 2 agents who have permission to use the approved AARP web banner. Agents must refer to the Agent Website and Social Media Guidelines job aid for details.
- Place within your website any hyperlinks to any UnitedHealthcare company or affiliate website page except as noted in the Agent/Agency May section.
- Post or repost any UnitedHealthcare owned or provided content or material, such as any material available on Jarvis, the UnitedHealthcare Toolkit, or Sales Material Portal, or distributed by UnitedHealthcare via email, post mail, or instructional or informational sessions (in-person or virtual) or use such content or materials in the creation of content or materials by the agent/agency.

**Use of Social Media Platforms**

Agent use of social media as a communications or marketing tool, including, but not limited to Facebook, LinkedIn, You Tube, Twitter, blogs, chat rooms, and message boards is subject to CMS regulations and UnitedHealthcare rules, policies, and procedures. Any social media platform used to conduct business on behalf of UnitedHealthcare must be a business account, rather than a personal account. In addition to the guidelines below, you must refer to the Agent Website and Social Media Guidelines job aid for additional guidelines.

You must:
- Be licensed, contracted, appointed (if applicable), and certified with UnitedHealthcare in order to download and use designated UnitedHealthcare branded resources available explicitly for use on select business social media accounts.
- Register any business social media account that contains the UnitedHealthcare name, logo, or branded resources available explicitly for use on select business social media accounts with UnitedHealthcare. You must refer to the Agent Website and Social Media Guidelines job aid for registration instructions.
- Follow all applicable CMS regulations, state laws, and UnitedHealthcare rules, policies, and procedures.

You must not:
- Use a social media platforms interactive functionality (or equivalent service) as a means to communicate with consumers/members.
- Feature the UnitedHealthcare or AARP brand name, logo, or branded material unless as a pre-approved branded marketing material explicitly developed for use on a business social media account.
- Copy, feature, or post any materials (with the exception of materials explicitly made available for social media) from the UnitedHealthcare Toolkit.
Feature or post a link to any UnitedHealthcare or AARP website.
Feature an eBRC or online contact form.

You may:

- Display generic materials and content on a business social media account. Refer to the Agent Created and Toolkit Materials job aid (available on Jarvis) for information on generic materials.
  For example:
  - Post basic Medicare information, such as income limits, Part A and/or B premium and deductible amounts, Part A and B coverage descriptions, Part D coverage stage information, provided the information is accurate for the current plan year.
  - Your name and compliant agent title
  - Types of services offered
  - Identify the Medicare products types you are certified to offer, such as Medicare Advantage plans, Medicare Supplement Insurance, Prescription Drug Plans, and Special Needs Plans.
  - Display generic event details, such as the date, time, and location of an upcoming marketing/sales or educational event on your business social media account.
    - Any reference to an event must feature the required disclaimer: “For accommodations of persons with special needs at meetings call <insert phone number and TTY number>.”
  - Link to a compliant agent created business website.

**Monitoring and Corrective Action**

Agent materials are monitored to ensure agents use any UnitedHealthcare and AARP logo, brand material, and language in an approved and compliant manner. Sales leaders and management, including NMAs, are responsible for the appropriate use of brands and logos by their contracted or employed agents.

**Usage Monitoring**

UnitedHealthcare conducts random reviews of brand and logo usage, the use of materials, provided at marketing/sales events, and on agent/agency websites and social media platforms.

**CMS Website Monitoring**

CMS may monitor 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.

**UnitedHealthcare Website/Social Media Monitoring**

UnitedHealthcare expects you and your up-lines to monitor websites and social media for compliance on a routine basis. UnitedHealthcare conducts regular monthly reviews of agent/agency websites and agent outreach related to compliance infractions.

- Websites/social media platforms are reviewed against CMS regulations and UnitedHealthcare rules policies, and procedures.
UnitedHealthcare Agent Oversight will conduct outreach when a website/social media infraction has been identified.

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/social media use of Company information. Legal representatives will review and respond to the incident as required.

Corrective Action

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

Media Engagements

You must receive permission from UnitedHealthcare Corporate Communications prior to participating in interviews with print (i.e. newspaper, magazines) or broadcast (i.e. radio, television) or web-based digital media. However, if you do not represent UnitedHealthcare or do not mention UnitedHealthcare plans (i.e. AARP-branded Medicare plans) by name during the interview, the permission to participate requirement does not apply. You must submit a request to your local agent manager or up-line and include the name of the media outlet, the format of the programming (i.e. live or taped, phone or in-studio) and a description of the focus of the interview. Note: agents who are not employees of UnitedHealthcare are typically not permitted to represent the company during media engagements.
Section 5: How do I Conduct Educational and Marketing/Sales Activities?

Educational and Marketing/Sales Activities and Events

Marketing/Sales Event Reporting

Marketing to Consumers with Impairments or Disabilities

Permission to Contact (PTC)

Lead Generation

Scope of Appointment
Section 5: How do I Conduct Educational and Marketing/Sales Activities?

Educational and Marketing/Sales Activities and Events

Communication Activities/Materials
Activities and the use of materials provided for informational purposes to current members and Medicare consumers.

Educational Events
Educational events are designed to inform Medicare consumers about Original Medicare, Medicare Advantage (MA), Prescription Drug Plan (PDP), or other Medicare-related plans that do not include marketing. The purpose of an educational event is to provide objective information about the Medicare program and/or health improvement and wellness. The plan sponsor or an outside entity may host an educational event.

The following guidelines apply to educational events:

Agents Must
- Be contracted, licensed, appointed (if applicable), and certified in order to conduct any educational activity and/or event on behalf of UnitedHealthcare.
- When promoting the event, advertise or promote the event as educational or in a way that would lead consumers to believe that it is explicitly for educational purposes.
- Include required disclaimer on all advertisements and invitations to educational events, “For accommodations of person with special needs at meetings call <insert phone number and TTY>”.

Agents Must Not
- Proactively approach or engage the consumer at an informal (table/booth/kiosk) setting.
- Engage in any marketing or sales activity at an educational event that would meet the CMS definition of marketing activities/materials. For example, you must not:
  ~ Include marketing or sales activities or distribute or display plan-specific marketing materials such as Enrollment Guides or brochures.
  ~ Distribute or collect enrollment applications
  ~ Discuss plan-specific premiums and/or benefits.
- Provide cash gifts, gifts easily converted to cash, or charitable contributions made on behalf of a consumer regardless of dollar amount.

Agents May
- Distribute communication materials, including the UnitedHealthcare-branded “Medicare Made Clear” booklet, which is free of plan premiums, benefit, and copayment information, and provide 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 a shirt and/or badge with approved plan names and/or logos (e.g., purchased from UnitedHealthcare Group Merchandise eStore accessible via Jarvis).
### Section 5: How do I Conduct Educational and Marketing/Sales Activities?

- Schedule future personal/individual marketing appointments, including completing and collecting Scope of Appointment (SOA) forms.
- Distribute and/or display contact information and/or compliant business cards free of any plan marketing or benefit information.
- Attach compliant business cards or agent contact information to communication materials.
- Distribute and/or display compliant business reply cards (BRC) or lead cards, sign-in sheets or SOA forms.
- Invite consumers to or accept RSVPs for future marketing/sales events.
- Respond to consumer-initiated questions asked at an educational event, provided that the scope of the response does not go beyond the questions asked and does not include the distribution or acceptance of enrollment applications and/or marketing materials. If asked about plan benefits, premiums, or copayments, 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 retail value, when combined with any other gift, does not exceed $15 on a per person basis.
- Provide promotional items with agent name and contact information, plan names, logos, a toll-free customer service number, and/or website provided the aggregate retail value of the gifts (including food items) does not exceed $15 on a per person basis.
- Conduct an educational event in a location where an entrance fee may be required to attend (e.g., health fair).

However, no fee can be charged to attend the educational event setup or to receive information.

### Marketing Activities/Materials

Activities and the use of materials with the intent to draw a Medicare consumer’s attention to a Medicare Advantage (MA) plan or a Prescription Drug plan or Medicare Supplement plan and to influence a consumer’s decision-making process when selecting a MA, PDP, or Medicare Supplement plan for enrollment or deciding to stay enrolled in a plan (retention-based marketing). In addition, marketing includes content about the plan’s benefit or benefits structure, information about premiums and cost sharing, comparisons to other plan sponsors, rankings and measurements in reference to other plans and/or information about Star Ratings.

### Marketing/Sales Event

Marketing/sales events are designed to steer, or attempt to steer members or consumers toward a specific plan or a limited set of plans or for plan retention activities. 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 (e.g., marketing for a new plan year prior to October 1) is prohibited and is subject to corrective and/or disciplinary action up to and including termination. The following are types of marketing/sales events:

**Formal marketing/sales events** are typically structured in an audience/presenter style with an
agent formally providing specific plan sponsor information via a presentation on the products being offered. In this setting, the agent usually presents to an audience that was previously invited to attend.

**Informal marketing/sales events** are conducted with a less structured presentation and/or in a less formal environment and are intended for a passerby type of audience. They typically utilize a booth, table, kiosk, or recreational vehicle (RV) that is manned by an agent who can discuss the merits of the plan’s products.

**Personal/individual marketing appointments** typically take place in the Medicare consumer’s residence; however, they may take place in other venues such as a coffee shop or over the phone. All individual appointments between you and a consumer/member are considered marketing/sales appointment regardless of the content discussed. All personal/individual marketing appointments whether or not an enrollment results, require a Scope of Appointment (SOA) agreement and all SOA guidelines apply (refer to the Scope of Appointment section).

The following guidelines apply to marketing/sales activities, appointments, 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 secure all consumer information (e.g., completed SOA forms and enrollment applications).
- Comply with permission to contact guidelines.
- Use only current UnitedHealthcare and CMS approved marketing materials, including scripts, sales presentations, and enrollment materials.
- Use materials as approved and provided for use by the plan.
- Provide an Enrollment Guide for the plan presented upon request by a consumer and/or at the time of enrollment.
- For informal and formal marketing/sales events:
  ~ Take and pass the Events Basics test for the applicable plan year 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/test).
  ~ Report all informal and formal events to UnitedHealthcare according to the process in the “Event Reporting” section.
  ~ Ensure all events, even those with no RSVP collection and/or not advertised, are open to the 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 events in appropriate venues. Prohibited venues include gambling areas of casinos, for-profit bingo facilities, and areas where health care is provided (e.g., pharmacy counter, exam room). 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 to marketing events, “For accommodation of persons with special needs at meetings call <insert phone number and TTY number>.”

Include on all advertisements 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, gift or prizes with no obligation to enroll.” or “Free gift without obligation to enroll.” (See Gifts and Meals section for additional information.)

Clearly announce at the beginning of the presentation the agent’s name and title, the company they represent, and the product/plan types (e.g., HMO, MA, MA-PD, PDP, PFFS, POS, PPO, and SNP) that will be covered during the presentation.

Agent Must Not
- Charge a consumer/member any type of marketing fee in order to conduct marketing/sales activities.
- Provide inaccurate or misleading information or engage in activities that could mislead or confuse consumers/members or misrepresent UnitedHealthcare.
- Use prohibited terminology/statements including:
  - Unsubstantiated qualified superlatives (e.g., one of the best provider networks, the largest health plan), unsubstantiated absolute statements (e.g., “UnitedHealthcare is the best or CMS recommends UnitedHealthcare”), or disparaging statements.
  - Claim to be recommended or endorsed by CMS, Medicare, or the Department of Health & Human Services (DHHS).
  - Use of the term “free” to describe zero-dollar premium, reduction in premiums, reduction in...
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- deductibles or cost sharing, low-income subsidy (LIS), or cost sharing for individuals with dual eligibility.
  - Solicit or accept enrollment applications from individuals who do not have a valid election period (e.g., Annual Enrollment Period (AEP) or Special Election Period (SEP)) as set by CMS.

**Effective 10/01/2018**, knowingly target or send unsolicited marketing materials that reference the Medicare Advantage Open Enrollment Period (“MA OEP”), or otherwise market the MA OEP, to any current MA or PDP member. For example, the following are prohibited:
  - Send unsolicited materials advertising the ability/opportunity to make an additional enrollment change or referencing the MA OEP.
  - Specifically target members who are in the MA OEP because they made a choice during the AEP by purchase of mailing lists or other means of identification.
  - Engage in or promote activities that intend to target the MA OEP as an opportunity to further sales.
  - Call or otherwise contact former members who have selected a new plan during the AEP.

- Discriminate based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, or geographic locations and/or target consumers from higher income areas or state and/or otherwise imply that plans are available only to seniors and not all Medicare-eligible consumers.
- Conduct health screening or other like activities that may be perceived as, or used for, “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 and/or 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, sales event signage, or promotional notification unless requested by the consumer.
- Market non-health related products (e.g., annuities or life insurance) while marketing a Medicare-related product. This is considered cross-selling and is prohibited.
- Compare one plan sponsor to another by name unless both plan sponsors have concurred or you are certified and appointed (if necessary) with both carriers.
- 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) including coupons for a meal or items that, in combination, would reasonably be considered a meal.
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- Provide a meal to attendees (see the Gifts and Meals section).
- For informal or formal marketing/sales events agents must not:
  - Require consumers to provide any contact information as a prerequisite for attending the event.
  - 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 while the meal is being served.
  - Conduct marketing/sales activities or events in restricted areas of a healthcare setting. Restricted areas generally include but are not limited to exam rooms, hospital patient rooms, treatments areas where patients interact with a provider and his/her clinical team and receive treatment (including, dialysis treatment facilities) and pharmacy counter areas.
  - 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.

Agents May

- **Effective 10/01/2018**, during the MA OEP (January 1 – March 31):
  - Conduct marketing activities that focus on enrollment opportunities to age-ins (who have not made an enrollment decision), marketing by 5-star plans regarding their continuous enrollment SEP, and marketing to dual-eligible and LIS recipients who, in general, may make changes once per calendar quarter during the first nine months of the year.
  - At the request of the consumer or member, send marketing materials (i.e. when a consumer or member makes a proactive request.)
  - At the consumer or member’s request, have a personal/individual marketing appointment to facilitate an enrollment.

- Conduct marketing/sales activities, appointments, and events in common areas of a healthcare setting, (e.g., common entryways, vestibules, waiting rooms, hospital or nursing home cafeterias, and community, recreational or conference rooms) after obtaining approval from the provider (refer to the Permission to Call and Lead Generation Activities section for additional guidelines).
- Provide a nominal gift and refreshments to attendees with no obligation (refer to Gifts and Meals section).
- Distribute compliant brochures and enrollment materials.
- Distribute compliant business reply cards (BRC), lead cards, and sign-in sheets as long as the consumer
understands that completing any of them is completely optional.

- Hand out business cards.
- Attach compliant business cards or agent contact information to Medicare Advantage plan or Prescription Drug plan marketing materials with a single staple/single piece of tape provided the card does not cover CMS required language or information.
- Provide and/or discuss plan specific information (e.g., premiums, cost sharing, or benefits) during a valid marketing and election period. **Effective 10/01/2018**, you are permitted to simultaneously market current year plans and prospective year plans starting on October 1, provided the marketing materials clearly indicate what plan year is being discussed.
- Distribute communications materials. You may include educational information or an educational component to marketing/sales activities, appointments, or events.
- Formally present benefit information to the consumers using UnitedHealthcare and CMS-approved materials.
- Solicit and accept enrollments during a valid marketing and election period.
- Assist consumers with the completion of an enrollment application using approved methods of enrollment and submission.
- Provide and obtain a Scope of Appointment form for a subsequent personal/individual marketing appointment (refer to the Scope of Appointment section).
- Market health-related products if the consumer is aware of the scope of products at the start of the sales event and for a personal-individual appointment, if discussion concerns only previously agreed upon products in the Scope of Appointment.

Examples of health-related products include medical, dental, prescription, and long-term care.

- For informal and formal marketing/sales events:
  - Conduct a marketing/sales event immediately following an educational event at the same venue provided each event, in its entirety, is conducted separately and in compliance with applicable rules.
  - 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 Educational or Marketing/Sales Event**

In addition to the previous guidelines, the following guidelines apply to informal educational and 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.
Place the table/booth/kiosk in a manner to protect against the disclosure of consumer PHI/PII.

**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).
- Conduct an event in a provider setting (e.g., pharmacy, clinic, hospital) without first obtaining permission from the provider.
- Leave the event unattended during the advertised event time or when a sign indicates that the agent you will be available.

**Agents May**

- Wait behind the booth/table for a consumer to request information.
- 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, healthcare, 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

UnitedHealthcare MedicareStores are 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) from the consumer prior to discussing any Medicare Advantage and/or Prescription Drug Plan.
- 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 regulations and UnitedHealthcare 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).

### Internet-Based (Virtual) Technology for Formal Events

Conducting marketing/sales events using internet-based virtual technology is limited
to formal marketing/sales events. UnitedHealthcare must approve all virtual events and the corresponding presenting agents 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 One-on-One Marketing Appointments and Telephonic Presentations

Skype, WebEx, FaceTime, and other video chat devices or applications are permitted for use by you to conduct personal/individual marketing appointments. 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 appointment.
- You must conduct a needs assessment in order to determine and present the best plan suited for the consumer and determine consumer eligibility.
- For MA and PDP plan presentations, you must provide an Enrollment Guide via postal mail or email (if the consumer provides permission) for the plan that will be presented during the appointment. You may add your writing number to the enrollment application prior to providing the Enrollment Guide to the consumer.

- Plan presentations generally should not be conducted until the consumer has received the Enrollment Guide. The consumer must have an Enrollment Guide at the time of enrollment.
- A complete presentation of the identified plan must be provided.
- After the sales presentation, you may assist the consumer with the completion of the enrollment application using approved methods of enrollment and submission (refer to the Consumer Enrollment and Disenrollment Request Process section).

Gifts and Meals

Nominal Gifts

You may offer nominal gifts (i.e. giveaway) to consumers at all educational and marketing/sales activities as long as such gifts are of nominal value ($15 or less $75 aggregate, per person per year), provided the gift is given regardless of whether the consumer enrolls and without discrimination.

- Gifts and giveaways offered by you for attending marketing/sales activities must not be items or services that are considered drug or health benefits, including optional mandatory supplemental benefits (e.g., a free checkup, health screening, hearing test; blood pressure and/or cholesterol
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Checks). Note: You are allowed to hold marketing/sales events at health fairs where health screenings are occurring as long as there is a separation between your location and the health screening booth, and you are not providing, or do not appear to be providing, health screening services to the consumers.

- Gifts must not be food items or refreshments that in type or quantity, regardless of value, could reasonably be considered a meal or that are not intended for on-site consumption (e.g., beverages in cartons larger than single serve, raw or unprepared items such as raw eggs or garden produce, and food bank distribution items).
- The nominal retail value of all food items offered combined with all other giveaways, (e.g., promotional items) must not exceed $15 per consumer with a maximum aggregate of $75 per consumer, per year.
- If a nominal gift is a chance to receive one large gift or a communal experience (e.g., a concert, raffle, drawing), the total fair market value must not exceed the nominal per person value ($15) based on anticipated attendance. For example, if 10 people are expected to attend an event, the nominal gift may not be worth more than $150 ($15 for each of the 10 anticipated attendees). Anticipated attendance must be based on venue size, response rate, and/or advertisement circulation.
- Nominal gifts in the form of cash or other monetary rebates are prohibited even if their worth is $15 or less. The following are prohibited regardless of value or merchant: gift cards (except gift cards allowed under an approved marketing promotion as noted below), gift certificates, vouchers, coupons 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, you must submit your proposed giveaway request 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.
- Promotional items may include plan names, logos, toll-free customer service numbers, and/or websites.

Meals/Refreshments
- You may provide refreshments and/or meals, at educational events, if permitted by the venue.
- You may provide refreshments or light snacks at marketing/sales events, if permitted by the venue, and should ensure that the items provided could not be reasonably considered a meal.
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and/or that multiple items are not being “bundled” and provided as if a meal.
  - Appropriate examples of refreshments include pastries, cookies, bars, other dessert items, coffee, lemonade, and other non-alcoholic beverages.
  - Inappropriate examples of refreshments include sandwiches, pizza, other meal items, beer, wine, and other alcoholic beverages.

- You must not provide or subsidize meals at 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).
- The aggregate nominal retail value of the food items in combination with any other gifts or giveaways must not exceed $15 per consumer.

Marketing/Sales Event Reporting

UnitedHealthcare requires all marketing/sales events, formal and informal, be reported. Note: Effective May 24, 2019 educational events conducted on or after June 1, 2019 do not need to be reported to UnitedHealthcare.

New Event Reporting*

- All marketing/sales events must be received into UnitedHealthcare’s event reporting application prior to advertising and no less than seven calendar days prior to the date of the event. You may submit a completed NEW Event Request Form, available on Jarvis.
- Each informal marketing/sales event (e.g., kiosk, booth) shift must be reported separately with a start and end time.
- The agent conducting the event (i.e. presenting agent) must be identified as the Presenter on the NEW Event Request Form.
- Agents who report an event less than seven calendar days before the date of the event without an approved exception (see below) are subject to corrective and/or disciplinary action up to and including termination. It is non-compliant to conduct unreported marketing/sales events.

* 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 Exception Request

Marketing/sales events must be reported according to the guidelines outlined above. The following process is available when extenuating circumstances require a new event to be reported via the NEW Event Request Form less than seven calendar days before the desired event date.

- 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 NEW 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.

### Changes to Reported Marketing/Sales Event

A change includes modification to any aspect of the previously reported event.

- Change requests must be submitted to UnitedHealthcare at least one business day prior to the scheduled date of the event.
- To ensure the one business day reporting requirement is met, you may submit a CHANGE Event Request Form to UnitedHealthcare at least six business days prior to the date of the event.
- If the one business day requirement cannot be met, you must immediately contact your agent manager to discuss required action(s).
- When a change occurs to the venue location, date, start time and/or end time of an event, it is considered a cancellation and requires cancellation of the event and entry of a new event (new event reporting and cancellation notification rules apply). Refer to the “Cancellation of a Reported Event” and “Notification of Change/Cancellation” sections below.
- When a change occurs to the presenting agent, the new presenting agent must meet credential validation (i.e. licensed and appointed, if applicable, in the state where the event will occur, certified in the product indicated, and has passed the applicable Events Basics test) in order for the change request to process.
- 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 Reported 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 less than one business day before the scheduled start time is prohibited except in the case of inclement weather. In such cases, you are expected to exercise appropriate discretion when deciding a course of action.

- A change to the venue location, date, start time and/or end time of an event is considered a cancellation and all cancellation requirements apply.
- Cancellation requests must be submitted to UnitedHealthcare at least one business day prior to the scheduled date of the event.
- To ensure the one business day reporting requirement is met, you may submit a CANCEL Event Request Form to UnitedHealthcare no less than six business days prior to the date of the event.
- If the one business day requirement cannot be met, you must immediately contact your agent manager to discuss required action(s).
- 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:

1. You must submit an email request to AgentOversightAdmin@uhc.com and must include the completed CANCEL Event Request Form.
2. The email request will be forwarded to PHD to cancel the event in the event reporting application.
3. After the cancellation request has been processed, you will be notified.

**Notification of Change/Cancellation**

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. Changes requiring consumer notification do not include change of presenting agent.

- For advertised events, you are responsible for advertising the cancellation in the most feasible manner available based on method used to advertise the event and time between cancellation and the originally scheduled date and time. If it is not feasible to advertise the change/cancellation through the same means as the original advertisement (e.g., via newspaper), you are responsible for working with your agent manager on appropriate notification (e.g. posting a notification at the venue).

- You are responsible for ensuring notification to all consumers that RSVP to an event that has been cancelled (or the venue location, date, or time changed). Only consumers who provided Permission to Call (PTC) can be contacted by telephone.

- 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 less than seven calendar days before 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 attendees 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 seven calendar days or more before the original date of the event, then there is no expectation that a representative of the plan should be present at the site of the event.
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Request for a Sign Language Interpreter
Upon consumer request by a consumer, UnitedHealthcare will provide a sign language interpreter at a formal marketing/sales event or in-person appointment to the consumer.

American Sign Language (ASL) interpreter:
- 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 PHD at asl@uhc.com.
- Within three business days after the request has been made, ASL services, Inc. will contact the agent, at the number on record, to confirm the interpreter request and event/appointment logistics.
- To cancel an interpreter request, 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 days’ notice will be billable for the scheduled event/appointment duration or a two-hour minimum.
- Using a third party individual who is not an employee of UnitedHealth Group or an approved ASL interpreter vendor is prohibited.

Telesales agents will request an interpreter through ASL Services, Inc. when confirming the consumer’s RSVP hard-set appointment to a formal marketing/sales event.

Non-English Sign Language Interpreter
A consumer request for a non-English sign language interpreter will be addressed on an individual basis by forwarding the Sign Language Interpreter Request Form to the Civil Rights Coordinator at UHC_Civil_Rights@uhc.com for processing. Using a third party individual who is not an employee of UnitedHealth Group or an approved sign language interpreter vendor is prohibited.

Agent or Plan-Initiated Provider Activities in a Healthcare Setting
Activities where either you requests contracted providers to perform a task or the provider acts on behalf of UnitedHealthcare. For the purpose of agent-initiated activities, you must ensure compliance with requirements applicable to communication and marketing activities.

Your requests for providers to discuss benefits and cost sharing fall under the definition of marketing and are prohibited from taking place where care is delivered.

Contracted providers may:
- Make available, distribute and display communication materials in all areas of a healthcare setting.
- Provide or make available plan marketing materials and enrollment applications outside of the areas where care is delivered (such as
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common entryways, vestibules, hospitals or nursing home cafeterias, and community, recreational, or conference rooms).

Contracted providers must remain neutral when assisting consumers with enrollment decisions.

Contracted providers must not:

- Accept/collect Scope of Appointment forms.
- Accept MA/PDP enrollment applications.
- Make phone calls or direct, urge, or attempt to persuade patients (or consumers) to enroll in a specific plan based on financial or other interest of the provider.
- Mail marketing materials on behalf of you or UnitedHealthcare.
- Offer inducements to persuade patients to enroll in a specific plan or organization.
- Conduct health screenings (e.g., hearing tests) as a marketing activity.
- Distribute marketing materials/applications in areas where care is delivered.
- Offer anything of value to induce enrollees to select them as their provider.
- Accept compensation for any marketing or enrollment activities.
- Identify, provide names, or share information about existing patients with the plan or agent for marketing/sales purposes.

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

Agent or UnitedHealthcare Activities in the Healthcare setting

You and UnitedHealthcare may conduct sales activities, including sales presentations, the distribution of marketing materials, and the distribution and collection of enrollment applications in common areas of a healthcare setting. Common areas in a healthcare setting include, but are not limited to common entryways, vestibules, waiting rooms, hospital or nursing home cafeterias, and community, recreational, or conference rooms. Communication materials may be distributed and displayed in all areas of the healthcare setting.

You and UnitedHealthcare must not market in restricted areas (generally includes, but not limited to: exam rooms, hospital patient rooms, treatment areas where patients interact with a provider and his/her clinical team and receive treatment (including dialysis treatment facilities), and pharmacy counter areas (where patients interact with pharmacy providers or obtain medications)).

Provider-Initiated Activities

Provider-initiated activities are those conducted by a healthcare professional, including pharmacists, at the request of the patient or as a matter of a course of treatment, when meeting with the patient as part of the professional relationship between healthcare provider and patient. Provider-initiated activities do not include those conducted at the request of UnitedHealthcare or you or pursuant to the network participation agreement between
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UnitedHealthcare and the provider. CMS considers the following contracted provider-initiated activities to be outside the definition of marketing, and therefore, not subject to the regulation as marketing.

Providers may:
- Distribute unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the “Medicare & You” handbook, or “Medicare Options Compare” (from www.medicare.gov) including in areas where care is delivered;
- Provide the names of plan sponsors with which they contract and/or participate;
- Answer questions or discuss the merits of a plan or plans, including cost sharing and benefit information (these discussions may occur in areas where care is delivered);
- Refer patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, State Medicaid Office, local Social Security Office, CMS’ website at www.medicare.gov, or 1-800-MEDICARE;
- Refer patients to Plan marketing materials available in common areas; and
- Provide information and assistance in applying for the Low Income Subsidy (LIS).

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 CMS and state run test demonstration program where individuals receive Medicare Parts A and B and full Medicaid benefits. MMPs are designed to manage and coordinate both Medicare and Medicaid and include Part D prescription drug coverage through one single health plan. Eligible individuals generally are, enrolled passively into the MMP with the
ability to opt-out and choose other Medicare options.

- As of May 20, 2015, twelve states have a signed Memorandum of Understanding (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. CMS and the applicable state jointly determine MMP program requirements. 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 full Medicaid benefits 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 option. 1, option 2) to verify the consumer’s MyCareOhio MMP enrollment status in the applicable twelve Ohio counties.
  - 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 the agent email address and consumer information to the...
UnitedHealthcare Members Matter team and document the agent 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 the agent. The email will advise the agent if they may resume contact with the consumer to market MA and/or SNP plans. 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 outlined in this policy may be subject to disciplinary action.

If the consumer is enrolled through another MyCareOhio carrier and wants to enroll in a plan other than MyCareOhio, refer the consumer to the Ohio Medicaid Consumer Hotline at 1-800-324-8680 to opt-out of the Medicare portion of MyCareOhio. You are not allowed to assist with the opt-out process and must direct the consumer to either the MyCareOhio Medicaid Consumer Hotline or to Ohio Medicaid Consumer Hotline website (www.ohiomh.com).

- 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 only participates in Harris County.
  In general, a consumer must meet all of the following criteria to be eligible to be enrolled in the MMP:
    o Reside in one of the counties where STAR+PLUS MMP is available.
    o Have attained age 21 or older.
    o Is eligible for or enrolled in Medicare and receive full STAR+PLUS Medicaid benefits.
    o Does 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:
    o Disparage the MMP program or make material misrepresentations about the program’s possible impact on MA and/or PDP members.
    o Interfere with the state enrollment process.
    o Inappropriately promote/retain membership in an MA plan if
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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.

Marketing to Consumers with Impairments or Disabilities

Agents serving the Medicare eligible population must be aware of and sensitive to the needs that might reasonably be expected within the defined 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 legal representative is present).

Section 1557 of the Patient Protection and Affordable Care Act prohibits discrimination in certain health programs or activities and extends nondiscrimination protection to consumers. You may not discriminate based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, 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 compliance with the Centers for Medicare & Medicaid Services (CMS) regulations and guidelines, the UnitedHealthcare Marketing Department and Regulatory Affairs Department will review 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. The English version of materials will be submitted to CMS for approval. Non-English language materials that are based on an English version are not required to be submitted. However, if a material is created to be used only in a non-English language, UnitedHealthcare must submit an English translation to CMS for review.
In addition, UnitedHealthcare provides information regarding the availability of free interpreter services in the enrollment guide, Summary of Benefits, and the ANOC/EOC. The information instructs consumers/members on how to obtain free communication services, including the obtainment of an interpreter and/or materials in a variety of non-English languages.

Written Materials (Medicare Advantage Plans)
- If UnitedHealthcare is required to provide materials to enrolling consumers and renewing members in an alternate language for an identified geographic area, approved materials in the non-English language will be available to the agent for order and/or download in the same location as the English version (e.g., Sales Materials Portal).
- Agents requesting the development of custom, non-English materials or the translation of approved materials into a non-English language must submit a request to their 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 and/or authorize an individual, of their choosing, to translate/interpret 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 the content from English to the non-English language and vice versa.
- Non-bilingual field agents may:
  - Direct the consumer to obtain the no-cost interpreter service through the UnitedHealthcare Telesales call center.
  - Refer the consumer to a bilingual field agent contracted with UnitedHealthcare. Note: Permission to Contact (PTC) rules apply.
  - You may, through the assistance of your agent manager, enlist the assistance of a bilingual UnitedHealthcare employee. You are permitted to use bilingual employees of the same agency or up-line or an interpreter services vendor contracted by your agency/up-line. You are prohibited from using individuals who are not employees of UnitedHealthcare (or, for EDC agents, your 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;
    - When routed to Language Line Solutions (Teleperformance), enter access code based on channel and select appropriate
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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, you 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.

**Hearing Impaired:**

- Member Services maintains 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 according to CMS guidelines.
- You may provide the enrollment guide to enable the consumer to read the materials.
- You may allow the consumer to be accompanied by an individual of their choosing, who can translate/interpret the information and/or materials.
- If the consumer has an Authorized Representative, you may provide the enrollment guide directly to the consumer’s Authorized Representative for review and enrollment purposes.

- Upon consumer request, a sign language interpreter must be provided at a formal marketing/sales event or personal/individual marketing appointment at no charge to the consumer. Sign language interpreters are not provided at informal marketing/sales events or any educational events. You must not provide a third-party individual who is not an employee of UnitedHealth Group or an approved sign language interpreter vendor.
- You may request an American Sign Language Interpreter (ASL) Interpreter (See Request for American Sign Language (ASL) Interpreter section).
- You may request a Non-English Sign Language interpreter on behalf of a consumer (See Request for Non-English Sign Language Interpreter section).

**Vision Impaired:**

A visually impaired consumer may request an enrollment guide and other Plan material in large print or braille font through Customer Service. 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.
- If the consumer has an Authorized Representative, provide a complete enrollment guide to the consumer’s Authorized Representative for review and enrollment purposes.
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- 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. If the event site is not accessible to consumers with disabilities, the event must be rescheduled or cancelled until a site with appropriate accommodations is found. You should choose a meeting site that is compliant with the Americans with Disabilities (ADA). For guidance when evaluating the accessibility of a meeting site, review the ADA website: [https://www.ada.gov/business/accessiblemtg.htm](https://www.ada.gov/business/accessiblemtg.htm). Upon reasonable request, you must also provide a wheelchair to a disabled individual at a formal marketing/sales event to provide an opportunity for the individual to attend the event.

A meeting site that is needed by most consumers with disabilities has the following six basic accessibility features that must be considered:
- Parking and Passenger Drop-Off Area
- Routes to the Building Entrance
- Building Entrance
- Routes to the Meeting Space
- Meeting Space
- Restrooms

**Cognitively Impaired**
You should be aware that cognitively impaired consumers may live independently or within a residential facility. If there is any question about the consumer’s cognitive ability, you should ask whether the consumer has an authorized representative (e.g., Power of Attorney). If the consumer has an authorized representative, you should reschedule the appointment for a time when the consumer’s authorized representative can be present.

**Permission to Contact (PTC)**

**Permission to Contact Guidelines**

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 product, including any Medicare Advantage, Prescription Drug Plan, or Medicare supplement insurance products.

- PTC only applies to the entity from which the individual requested contact, the duration and topic requested; is limited to the method of contact (e.g., permission to call, permission to email) in the PTC mechanism (e.g., business reply card); and must be given 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). The PTC mechanism may include statements or options that would lead a consumer to reasonably understand they will be contacted to discuss Medicare insurance options or include the exact individual product types to be discussed such as Medicare Advantage, Part D Plans, or Medicare
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Supplement Insurance or refers to options collectively (e.g., Medicare insurance options).

- PTC expires once contact is made or 90 days after receipt by the company for consumers requesting information on Medicare Supplement insurance or who are on the federal Do-Not-Call Registry or nine months after receipt for MA plan and PDP, whichever comes first. New PTC must be obtained in order to contact the consumer in the future.
- PTC must be documented (in bConnected if available to you) and PTC documentation (e.g., lead source/business reply card) must be retained for ten years from date received and available to UnitedHealthcare upon request.

Prohibited Unsolicited Direct Contact

Unsolicited contact means the consumer did not provide permission to be contacted by the particular method(s) of contact. Unsolicited direct contact is prohibited, except for the use of conventional postal mail. Direct contact includes, but may not be limited to, in-person, telephonic (including voice message, auto-dialed calls/messaging, and text messaging), electronic (including social media interactive functionality, direct messaging, and smart phone applications), email, and conventional postal mail. Examples of prohibited unsolicited direct contact include:

- Approaching a consumer in-person. Prohibited scenarios include, but are not limited to:
  - Approaching a consumer in a common area (e.g., parking lots, hallways, lobbies, sidewalks).
  - Approaching a consumer outside of an educational or marketing/sales event (e.g., you are participating at a volunteer or social/fraternal/service organization activity).
  - Engaging in door-to-door solicitation, including any “bait-and-switch” tactics (e.g., marketing a product that does not require PTC in order to convert the marketing effort to a product that does require PTC).
  - Distributing materials outside of an educational or marketing/sales event setting, such as leaving materials outside a residence, under a door to a residence, on a vehicle, or similar. (Note: You may leave materials at a consumer’s residence when you had a properly pre-scheduled personal/individual marketing appointment and obtained scope of appointment, but the consumer was a “no show”.)

- Contacting a consumer through telephonic means, including manual or automated dialing, voice messaging, or text messaging, or through electronic means, including proximity/push marketing, and smart phone applications or social media interactive functionality (e.g., direct messaging). Prohibited scenarios include, but are not limited to:
  - Any contact with a consumer when the consumer did not provide PTC
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- Contacting a consumer that attended an event or to whom material was mailed under the guise of following up.
- Contacting a referred consumer.
- Contacting a UnitedHealthcare member for whom you are not the Agent of Record and you did not receive delegated PTC from UnitedHealthcare.
- Using lead contact information received from UnitedHealthcare to market any non-UnitedHealthcare product.
- Using lead contact information obtained from 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.
- Engaging in any “bait-and-switch” tactics (e.g., marketing a product that does not require PTC in order to convert the marketing effort to a product that does require PTC).
- Contacting a former member who voluntarily disenrolled or a current member in the process of voluntarily disenrolling to market a product or plan, dissuade them from disenrolling, or to participate in any type of survey. In addition, you must not ask a disenrolling member for PTC to market plans in the future.

Permitted Direct Contact
Permission to Contact (PTC) must be obtained prior to making direct contact with the consumer, except when using postal mail (e.g., advertisements, direct mail). You must follow PTC guidelines described above. For telephonic contact, you must comply, to the extent applicable, with the National Do-Not-Call Registry and abide by federal and state calling hours. Permitted PTC mechanisms include the following:

- A consumer requests a return call from you, an agency, or UnitedHealthcare.
- A compliant Business Reply Card (BRC) or lead card submitted by the consumer.
- A compliant online contact form/electronic BRC submitted by the consumer.
- An email sent by the consumer to you requesting contact.
- During permitted contact with the consumer, you request to renew PTC and the consumer consents to a future contact.

Delegated Permission to Contact - UnitedHealthcare
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 by UnitedHealthcare to the agent. Delegation of PTC occurs when UnitedHealthcare provides the member’s contact information (i.e., name and phone number) to you. You may only use the member’s Protected Health or Personally Identifiable Information (PHI/PII) to the extent necessary to conduct business on behalf of
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UnitedHealthcare. Any other use of PHI/PII obtained through delegated PTC is prohibited.

- A current UnitedHealthcare Commercial member aging in to Medicare to discuss UnitedHealthcare Medicare products, including benefits, or to inform them of general plan information.
- A current UnitedHealthcare MA, PDP, or Medicare supplement plan member to discuss other UnitedHealthcare Medicare products, including benefits, or to inform them of general plan information.
- A current UnitedHealthcare Medicaid/MMP member to discuss UnitedHealthcare Medicare products, including benefits, or to inform them of general plan information (see the Community & State Medicaid Leads for Calling Campaigns). Refer to the Educational and Marketing/Sales Activities and Events for Marketing in a state with an MMP for policies in Ohio and Texas section.
- A consumer who submitted an enrollment application in order to conduct business related to the enrollment.

(e.g., 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 product.

Lead Generation

Overview
You are responsible for ensuring any lead, including those obtained from or provided by your up-line, meets all federal and state regulations and UnitedHealthcare business rules, prior to acting on the lead to market any UnitedHealthcare Medicare product.

Actionable Lead
A lead is the name and contact information of a consumer who might be contacted to market UnitedHealthcare Medicare products. To be considered actionable, the lead must be obtained through means compliant with federal and state 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 the agent and/or their up-line.

Compliant means include, but are not limited to:

- Consumer submitted a compliant BRC (paper or electronic) or lead card. **<EDC ONLY>** If you receive leads from your up-line, you should request documentation from your up-line that attests that the leads were obtained compliantly and are actionable. **<End EDC ONLY>**
- Consumer placed an inbound call, text, email, or voice message requesting to discuss Medicare insurance products. Based on the method of consumer outreach, you may respond accordingly, unless the consumer requests another preferred method of contact.
- [EDC/ICA] The consumer is a current client of yours by virtue of having a current, active contract or business relationship in another product. Refer to the Conflict of Interest section for details regarding situations that may result in a conflict.

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

- You receive the consumer’s telephone number or email address as a referral from an individual other than consumer. For example, a provider gives a list of patients to you or a client gives their neighbor’s contact information to you.
- You use other sources to look-up a telephone number or email address if the contact information provided is not accurate or in-service.
- You use interactive communications via social media platforms or other communication applications to generate leads and to market Medicare insurance products.
- You generate a lead for a non-Medicare insurance line of business and uses that information to market Medicare insurance products via prohibited unsolicited direct contact.

### Lead Referral Programs

**UnitedHealthcare Sponsored Program**
- UnitedHealthcare does not currently sponsor a lead referral program.

**Agent Initiated Programs**
- You may choose to use a third party lead generating option, but are responsible for ensuring the leads are obtained compliantly, 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 product to the consumer.

### Compensation in Exchange for Lead
- You are not permitted to provide anything of value (e.g., gift card, flowers) to a consumer/member in
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- 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 you make with referrers.

Community & State Medicaid Leads for Calling Campaign

Sales Directors are responsible for the compliant execution of any Medicaid call campaigns in their market. A Scope of Appointment is not required in order to briefly list plan benefits as part of the outbound call campaign, the purpose of which is to schedule in-person marketing appointments.

- Call campaigns may only occur in a UnitedHealthcare facility/office location as the control and security of the leads are critical, unless approved in advance by the Director of Sales Oversight.
- All call campaigns must be proctored and monitored by an Agent Manager or Sales Director during the call campaign. Proper coaching and talking points for the agents are the responsibility of the market Sales Director. You 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. If the sales support coordinator enters contact information on a subset of Medicaid leads in bConnected, PTC may only be extended by you if the Medicaid member provides it when you make contact to set a home appointment to present a DSNP. 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 Medicare Beneficiary Identifier number to verify Medicaid level of eligibility). Any additional data must be deleted prior to agent distribution.
- You must have an active current bConnected account to participate in call campaign activity unless approved by the Sales Director. You must commit to using bConnected to record successful attempts in converting a lead to an appointment or follow-up activity. If the Sales Director allows for an exception for an agent to participate in a call campaign activity without having a bConnected account, the sales team must have controls in place to ensure all call activity is documented in bConnected.
Section 5: How do I Conduct Educational and Marketing/Sales Activities?

- Leads that result in an appointment or other follow-up activity must be entered into your 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, they must then be destroyed by inserting them in secured and approved shredding receptacles upon completion of the call campaign. At the discretion of UnitedHealthcare, copies of certain lead lists with sales activity notes may be retained after recording lead and contact activity in bConnected. The lead lists must be securely stored by the sales office.
- 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.

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 for all field sales channels. The outbound calling campaigns may take place on a weekly or monthly basis as lead volume permits. 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. Agent call activity must be monitored and coached immediately when necessary. You must not be 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 Medicare Beneficiary Identifier 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 an active current bConnected account to participate in call campaign activity unless approved by the Sales Director. You must commit to using bConnected to record successful attempts in converting a lead to an appointment or follow-up activity. If the Sales Director allows for an exception for you to participate in call campaign activity without having a bConnected account, the sales team must have controls in place to ensure all call activity is documented in bConnected.

- Permission to contact 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 (e.g., approved shredding receptacles) once the calling campaign is completed and activity record in bConnected. At the discretion of UnitedHealthcare, copies of certain lead lists with sales activity notes may be retained after recording lead and contact activity in bConnected. The lead lists must be securely stored by the sales office.

- You must not market any other products while calling on behalf of UnitedHealthcare Medicare Solutions.

**Virtual Local Market Outbound Call Campaigns**

A virtual call campaign takes place when the campaign leader and field agents participate from their respective locations rather than in-person as a group and may be employed when the market is managed by a remote leader. The purpose of a virtual call campaign (i.e. call blitz) is to re-warm leads for a sales market to increase applications, make appointments, to build an agent’s pipeline through targeted calls for all field sales channels and/or accept enrollments. The outbound call campaign may take place on a weekly or monthly basis as lead volumes permits using lead lists provided to agents via secure email.

Virtual call campaigns must adhere to any applicable UnitedHealth Group corporate policy or UnitedHealthcare sales policy, such as the safeguarding of transmitted consumer/member data and delegated PTC guidelines. The following call campaign guidelines also apply:

- Virtual call campaigns must be managed through the coordination of the local market’s sales leader(s) with appropriate measures taken to secure privacy of both member/consumer and UnitedHealthcare information.

- A virtual call campaign leader, generally a Business Development Manager (BDM) or Agent Manager, must be identified and available during the entire outbound call.
campaign timeframe dictated by the sales management team.

- The campaign leader (or delegate) must communicate to participating agents (e.g., WebEx or teleconference) campaign expectations and guidelines (e.g., use of bConnected and secure email, calling timeframe, expiration of PTC).

- The campaign leader must follow these lead list guidelines:
  - Lead lists contain Personally Identifiable Information (PII) and Protected Health Information (PHI) and must be transmitted in compliance with UnitedHealth Group policy.
  - 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 Medicare Beneficiary Identifier (MBI) number to verify Medicaid level of eligibility). Any additional data must be deleted prior to agent distribution.
  - Permission to contact 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.

- You are only permitted to market products in the UnitedHealthcare portfolio.
- You must comply with Scope of Appointment guidelines when an outbound call results in a telephonic plan presentation and/or future in-person or telephonic marketing appointment.
- You must comply with state calling hour rules and must not call leads outside of the defined campaign timeframe.
- You must not replicate or use the lead list beyond the completion of the calling session.
- Your activity must be monitored and coached immediately when necessary.
- You must have an active current bConnected account to participate in call campaign activity unless approved by the Sales Director. You must commit to using bConnected to record successful attempts in converting a lead to an appointment or follow-up activity. If the Sales Director allows for an exception for an agent to participate in call campaign activity without having a bConnected account, the sales team must have controls in place to ensure all call activity is documented in bConnected.

- You must use secure email when emailing campaign results that contain consumer/member PHI/PII or provide the minimum necessary consumer information results via email (i.e. contact identification number/telephone number and outcome).
- The campaign leader or delegate will manually track performance and communicate results of the call 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 PTC, contacting consumers, use of marketing materials, and marketing/sales activities. Refer to the marketing materials and marketing/sales activities sections for additional details. 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).
- 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 may direct a patient to the lead box or collection station, but must not handle in any manner the leads collected (e.g., empty lead box, forward leads to the agent).
- You must check on and 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.

**Scope of Appointment**

You must obtain a Scope of Appointment agreement through compliant methods from each Medicare-eligible consumer (including any unexpected Medicare-eligible individuals present) prior to the start of a personal/individual marketing appointment (e.g., in-person, telephonic, pre-scheduled, spontaneous, and regardless of the venue) when a Medicare Advantage and/or Prescription Drug Plan may be discussed.

- The agreement must capture the scope of products that the consumer agrees may be presented at the appointment and must reference MA and/or PDP products and may include other health-related products, such as Medicare supplement insurance, dental, vision, and hospital indemnity.
- A Scope of Appointment agreement must be obtained regardless if it is initiated by the consumer or you and must be obtained whether or not the appointment results in an enrollment.
- Scope of Appointment Agreements
  - Compliant Methods to obtain
    - You may use LEAN, UnitedHealthcare branded paper form, or other compliant electronic and paper forms.
~ A Scope of Appointment agreement remains valid until the appointment is held or until the end of the applicable selling season.

~ The consumer (or authorized representative) must select the product type that will be discussed and sign the Scope of Appointment.

~ A Scope of Appointment may be transmitted to a consumer in-person (you must not engage in unsolicited contact), via postal mail, and/or via email (you must have permission to email prior to emailing).

### Retention

A Scope of Appointment agreement must be retained for a minimum of 10 years from the date of the appointment and made available upon request by UnitedHealthcare or CMS.

~ Scope of Appointment agreements completed in LEAN will be retained by UnitedHealthcare.

~ You are responsible for ensuring that all completed Scope of Appointments (e.g., paper forms, non-LEAN electronic versions, forms for cancelled or rescheduled appointments, consumer no-shows, and/or appointments that do not result in an enrollment) are retained and are available upon request. Effective 9/7/19, UnitedHealthcare no longer requires paper or non-LEAN Scope of Appointments to be submitted to UnitedHealthcare. However, Scope of Appointments obtained prior to 9/7/19, must continue to be retained in accordance with the retention requirement above.

### Corrective and Disciplinary Action

An agent who does not obtain a Scope of Appointment from all Medicare-eligible consumers or cannot provide a completed Scope of Appointment upon request may be subject to corrective and disciplinary action. Prior to 9/7/2019, agents were required to submit all completed Scope of Appointments to UnitedHealthcare. Agents that did not submit all completed Scope of Appointment forms to UnitedHealthcare would be non-compliant and may be subject to corrective and disciplinary action.
Section 6: How do I take an Enrollment Application?

Enrollment Methods

MA Plan and PDP Cancellation, Withdrawal, or Disenrollment Requests

Agent Assisted Health Assessment (HA) Process

Enrollment Process – AARP Medicare Supplement Insurance Plans
Enrollment Methods

Enrollment applications cannot be solicited or accepted outside of a valid enrollment election period. Marketing and/or selling outside of eligible periods is prohibited and is subject to corrective and/or disciplinary action up to and including termination. At the time the enrollment application is completed, you must be contracted, licensed, and 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.

The enrollment application should be completed only after you have completed a needs assessment and thoroughly explained to the consumer the plan benefits and associated costs, confirmed eligibility, verified providers and drug coverage (if applicable), 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.

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 Enrollment 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 or Medicare Beneficiary Identifier (MBI) and 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 is 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, if applicable, based on the consumer’s current permanent residential address.
  - 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.
Section 6: How do I take an Enrollment Application?

~ In the case of homeless consumers, a post office box (not for Medicare Supplement), 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:
    o 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.
    o UnitedHealthcare will attempt to verify the qualifying chronic condition with the consumer’s physician for up to two months after the plan effective date.
    o A notice of involuntary termination will be sent to the member (with notification to the agent) if a qualifying condition has not been verified at the end of the first month.
    o The member will be terminated effective the last day of 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.
    o UnitedHealthcare will notify the member (not the agent) regarding a successful verification.
  ~ At the point of sale, complete and submit the Chronic Condition Pre-Assessment and Chronic Condition Release of Information forms with the enrollment application located in the Enrollment Guide and LEAN. There are different forms for each plan.

- **Dual Special Needs Plan (DSNP) Medicaid Status Verification**
  Specific pre-verification and documentation requirements must be met to enroll a consumer in a DSNP. 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 DSNP. You must:
  ~ Complete a review of the DSNP and determine the consumer’s eligibility.
Section 6: How do I take an Enrollment Application?

- Enroll only those consumers who have the appropriate level (e.g., full or partial) of Medicaid based on the specific DSNP. 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.
- 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 within 21 days of receipt of the enrollment application or until the end of the month (whichever is later), a denial of enrollment letter will be sent.
- Explain to the consumer that if they lose their Medicaid status after enrollment, they may enter a grace period during which they will be responsible for cost sharing and/or may 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 plan must only occur after referring to applicable marketing guidelines 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 UnitedHealthcare 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, you must obtain and submit a copy of the applicable pages of the MDS assessment (Sections A0100 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
Section 6: How do I take an Enrollment Application?

Business Manager that indicates that the SNF expects the consumer to require a stay of 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 legal 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) or MBI (effective April 2018), 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 document type of 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 Some states require “Level of Care” assessments and these documents are retained by an outside identified entity or at the local site based on the individual state’s “Level of Care” requirements. Documentation is retained by the entity/local site 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 thoroughly all plan benefits and associated costs 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.
Section 6: How do I take an Enrollment Application?

- Cost sharing including deductible, coinsurance, copayments, and premiums.
- Provider network, if applicable, and coverage and cost-sharing when using in- or out-of-network providers. You must not steer or attempt to steer a consumer/member toward a particular provider or toward a limited number of providers, offered by either the plan sponsor or another plan sponsor, based on the financial interest of you or the provider. You must not enter into arrangements with providers to steer a consumer/member into a UnitedHealthcare Medicare plan based on financial or any other interest of the provider.
- If applicable, formulary, drug tiers, step therapy, prior authorization, quantity limits, exception requests, coverage stages (including the coverage gap), and late enrollment penalty if the plan has prescription drug coverage.
- If prescription drug coverage is included, 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. Determine if the consumer would consider an alternate prescription or change their pharmacy if their current prescription(s) or pharmacy is not in network.
- Selection of a Primary Care Physician (PCP) if required by the plan and any referral requirements.
- For network-based plans, verify all of the consumer’s providers are in the network (e.g., doctors, hospitals, pharmacies). Determine if the consumer would be willing to change to a network provider if the current provider(s) are not.
- The Star Rating for Medicare Advantage (MA) plan or Prescription Drug Plan (PDP) presented, including where to find the rating in the Enrollment Guide, providing Star Rating updates as they are communicated during the year and explaining where to obtain additional information about Star Ratings on the www.medicare.gov website.
- Advise the consumer that no-cost interpreter services are available, as applicable.
- Cancellation, withdrawal, and disenrollment processes and time frames.
- Contact information for the plan.
- Appeals and grievance process, as applicable.

Enrollment Application

You may proceed with enrollment only after explaining thoroughly all Plan benefits and associated costs to the consumer and receiving consent to enroll from the consumer. The consumer or the consumer’s legal representative must sign the enrollment application or request mechanism. The following materials are required to be included with a Medicare Advantage (MA) plan or Prescription Drug Plan (PDP) enrollment form or made available electronically: Star Ratings document and the Summary of Benefits, which includes the availability of free interpreter services. For a Medicare Supplement enrollment, the enrollment kit must be made available to the consumer. You must:

- Ensure that all the 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,
Section 6: How do I take an Enrollment Application?

if there is not a PCP field on the enrollment application, a PCP does not need to be designated.

- If the enrollment application contains a field(s) for the consumer’s email address, you must only enter the consumer’s email address and must not enter any other individual’s email address, including your own. If the consumer does not have an email address or refuses to provide one, you must leave it blank.
- Determine and enter the proposed effective date, election period, and election period reason code (if applicable).
- Explain that the consumer will receive plan letters and information through mailings, phone calls, and/or electronically (if requested and/or if available) regarding their plan enrollment that may include:
  ~ After MA or PDP enrollment, within 10 calendar days of CMS acceptance into the plan a Welcome Call, Welcome Letter (combination of the enrollment verification/welcome letter and membership identification card), a Welcome Kit (post-enrollment Guide) and, if applicable, Health Assessment call (if not completed at the point-of-sale).
  ~ After Medicare Supplement plan enrollment, a copy of the enrollment application, a plan acceptance letter, an insurance membership identification card, a welcome package (including certificate of insurance and coverage details, and a Welcome call.)

- For field agents, ensure that the enrollment application is signed and dated by the consumer once all required information has been entered on to the enrollment application 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 legal 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, if requested, that they have the authority under state law to act on behalf of the consumer.
  ~ Effective December 9, 2017, Medicare Supplement agents in certain states may offer an option for the consumer to complete/sign their enrollment application via voice signature from a location of their choice. However, you must inform the consumer that they are also available to meet face-to-face at a mutually agreed upon location if they prefer that enrollment option.

- Effective 08/06/2018, for field agents using the electronic enrollment method (e.g., LEAN), a consumer/authorized legal representative may sign an enrollment application remotely via email using DocuSign, a secure electronic signing process.
  ~ The consumer is required to sign the enrollment application within 24 hours of when the “Launch Remote Signature” button is enabled by you.
Section 6: How do I take an Enrollment Application?

~ An access code must be created by you and provided to the consumer when electronically signing the enrollment application from UnitedHealthcare by email.
~ Once the consumer has signed the application, it is automatically submitted for processing and may be viewed by you.
~ Both you and the consumer will receive an email from DocuSign with the completed enrollment application attached.

- **For field agents**, leave a receipt of a paper 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.
- **For field agents**, 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 legal representative.
~ Only the agent that explains the plan benefits and rules and completes the enrollment application with the consumer or authorized legal 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.
~ 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 legal 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 MA or PDP 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.
~ You must submit MA and PDP 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, email, **overnight delivery**). Postal mail is not considered an expedient method. Faxed applications must include a coversheet that contains a HIPAA privacy statement. Emailed MA or PDP enrollment applications must be converted to a separate, non-editable PDF and sent “Secure Delivery” when emailed outside of the UnitedHealthcare firewall. All emails must 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.
Section 6: How do I take an Enrollment Application?

MA and PDP enrollment applications received by the enrollment center more than four calendar days after the agent’s signature are considered a late application and you may be subject to disciplinary action.

UnitedHealthcare Public Website and Enrollment Tool
A web-based MA and PDP 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.

- You are prohibited from completing the web enrollment on behalf of the consumer or at the consumer’s request. However, you may be on the telephone in order to assist the consumer with a web enrollment.
- You 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 Senior Vice President Sales and the Compliance Officer.
- Completing a web enrollment through the web-based enrollment tool on behalf of a consumer may be considered fraud.
- If a consumer enters an agent’s writing number in an applicable field, it signifies that the agent assisted in the enrollment by meeting all conditions outlined in this guide and is responsible for any complaints, rapid disenrollments, and other compliance issues related to the enrollment.

<EDC Only>

Multi-Carrier Enrollment Tool - EDC NMA Agent

- An NMA may make a multi-carrier online enrollment tool available to their down-line agent (non-eAlliance) to initiate an MA or PDP plan enrollment application face-to-face with the consumer or remotely with telephonic assistance. Prior to making UnitedHealthcare plans available via the multi-carrier tool, the NMA request must be approved by UnitedHealthcare and submitted to CMS.
- If the consumer is incapable of using the multi-carrier enrollment tool, or the selected plan is not available for enrollment through the tool, an alternate enrollment method must be used by you.
- To receive credit for an enrollment using a multi-carrier enrollment tool, you must imbed your writing number in the application.
- You are prohibited from completing the enrollment on behalf of the consumer or at the consumer’s request.
- Effective October 1, 2018, UnitedHealthcare has approved the use of two online enrollment tools available through Connecture provided the NMA makes them available to their down-line agents.
  - Connecture Broker Enrollment with Signature must only be used for face-to-face non-SNP MA Plan and PDP enrollments.
Section 6: How do I take an Enrollment Application?

- **Connecture Quick Quote** is an online tool that may be used to complete a non-SNP MA or PDP plan enrollment application remotely. To complete a consumer enrollment through the Quick Quote remote enrollment application tool, you must:
  - Conduct a thorough needs analysis, present all aspects of the plan (refer to the Enrollment Process sections), review in-network providers, medications and eligibility, and provide an Enrollment Guide for the selected plan. For example, you may have presented the plan to the consumer at a formal marketing/sales event, but did not elect to enroll at the event, or the consumer requested the meeting be conducted over the phone.
  - Email the online enrollment application link to the consumer and direct the consumer to complete all enrollment information including the listing of their providers and prescriptions. You may be on the telephone in order to assist the consumer complete the enrollment application, but,
  - Must not be physically present with the consumer, and must not engage in any screen sharing with the consumer through an internet connection.

<EDC Only End>

**Force Majeure Resilience Program**

The Chief Distribution Officer or his/her delegate may invoke at his/her discretion the force majeure resilience program when requirements are met in order to provide reasonable alternative enrollment resources on behalf of the field sales channels (i.e. EDC, ICA/IMO, and ISR). The force majeure resilience program must not be invoked in situations in which CMS provides relief to consumers in a particular geography who may have difficulty submitting an enrollment application by the Annual Enrollment Period (AEP) deadline.

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 an MA plan or PDP enrollment application by the AEP deadline.

Upon the occurrence of any force majeure event, the senior sales leader (e.g., **Regional Vice President of Sales or Regional Sales Director**) of a business market may request that the Chief Distribution Officer or his/her delegate implement the resilience program. If the Chief Distribution Officer or his/her delegate invokes the force majeure event resilience program, all of the following must be documented:

- The force majeure event
- The date or span of dates on which the force majeure event took place
- The specific business markets covered by the force majeure resilience program
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- The toll-free number, “PSC” code and skill assigned to process and accept Telesales enrollment
- The selection of the Telesales agent headcount based on the size of the event, trained to handle calls from the toll free number and skilled accordingly.

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 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. Agents cancelling a reported marketing/sales event 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 product, you must provide the consumer with the following enrollment method options:
  ~ **Consumer Portal**
  You can direct the consumer to use the Consumer Portal to enroll in a DSNP plan via a C&S portal. 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.
  ~ **LEAN Remote Signature**
  You may use the electronic enrollment method (e.g., LEAN) remotely via email using DocuSign, a secure electronic signing process.
  ~ **Paper Enrollment Application**
  You can assist the consumer complete a paper enrollment application if the consumer has an Enrollment Guide (hard copy or PDF) for the plan in which the consumer is enrolling.
    o 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.
    o 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 a toll free number provided when the force majeure program is invoked. 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 from Sales Reporting) and the agent’s agent ID and contact information to update the field agent’s commission for all impacted consumers. (The following entities will be notified: Broker, Internal, Field Leadership, Sales Ops etc.) (Refer to the compensation section for details related to non-employee agent commission eligibility and payment.)
- The AOR will be updated the month after the effective date of the plan (or receipt of the file) and a new commission will be paid if you meet 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 AOR and to discontinue paying your commissions if it is determined that you are not servicing the member.

### MA Plan and PDP Cancellation, Withdrawal, or Disenrollment Requests

You are not permitted to make additional contacts with members or their authorized legal representatives who request cancellation or withdrawal of their enrollment application or voluntary disenrollment from the plan in an attempt to keep them in the plan. Unless the disenrollment is due to a plan change that retains the member’s current Agent of Record (AOR), the AOR must cease any contact with the member once the disenrollment request has been submitted. For MA Plans and PDPs:

**Withdrawal of Enrollment Application**
Withdrawal of an enrollment application occurs prior to the effective date and prior to UnitedHealthcare submission of the enrollment data to CMS.
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- If a paper enrollment application was signed by the consumer and you have not submitted it to UnitedHealthcare, you are required to return the paper enrollment application to the consumer. You are 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, you 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
Cancellation of an enrollment application occurs prior to the effective date and 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.

Request to Disenroll
After the MA Plan or PDP effective date, the member must have a valid election period in order to disenroll.
- The member may disenroll by:
  ~ Enrolling in another MA plan or PDP
  ~ 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, the agent must instruct the member to make the request in one of the ways described above.

Agent Assisted Health Assessment Process
UnitedHealthcare uses a third-party vendor to administer the Health Assessment (HA) program. You may assist a consumer complete a Health Assessment (HA) at the time of sale. To assist a consumer to complete an HA:
- You must complete any required HA training prior to registration/user set-up with the vendor and on an annual basis thereafter.
- You must not complete an HA prior to the consumer signing a Medicare Advantage enrollment application.
- You must obtain the consumer’s agreement to complete the HA. You must not require or pressure a consumer to complete an HA at the point of sale.
- You must use the vendor’s web-based HA form. You must not use a paper HA form and/or transfer information from another format to the web-based HA form.
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- You must have an internet connection. If you do not have an internet connection at the point-of-sale, you may contact and complete the HA with the consumer over the phone up in order to have access to an internet connection.
- You must not share your log-on credentials with another individual or have another individual complete an HA on your behalf.

Enrollment Process – AARP Medicare Supplement Insurance Plan

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 application is taken in October 2018 for a January 2019 effective date, the agent must be certified for 2019 AARP Medicare Supplement Insurance Plans prior to taking the enrollment application.

You must use the agent version of the AARP Medicare Supplement Insurance Plan enrollment application that 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.) The agent version of the enrollment applications will be included in the Enrollment Guides available through the agent website in the “Product Information and Materials” section. You 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. Note: AAPR membership dues are not deductible for income tax purposes. If the consumer is not a member; you may assist the consumer in setting up a new or renewing an AARP membership; however, you must not purchase the AARP membership for the consumer. You may assist the consumer in setting up or renewing the membership by:
  ~ Calling 1-866-331-1964 or logging in to www.myAARPconnection.com to enroll using the consumer’s credit card.
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- Mailing the AARP membership application and dues (with a separate consumer’s check payable to AARP) with the insurance enrollment application.
- Utilizing the Online Enrollment tool for AARP Medicare Supplement Plans to enroll using the consumer’s credit card.

You must not accept money from the consumer and send your personal/agency check/money orders to pay AARP membership dues.

**Explain Benefits, Rules, and Member Rights**

- You must 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 agent and product specific disclaimers, and the consumer agrees to proceed with enrollment.
- You will 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.
- You must provide their agent writing number on each enrollment application you write.
- Only the agent that completes the enrollment application with the consumer or their responsible party may affix his/her 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 the agent commission for the sale.

All enrollment applications must be submitted promptly to UnitedHealthcare. AARP Medicare Supplement enrollment applications received by Enrollment more than 16 days after the agent signature will be considered a late enrollment application and the agent may be subject to disciplinary action.

**Post-Sale Requirements**

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

- Outlines of Coverage and Rate Sheet
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- 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

- You 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 Guide. 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.
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Commission Overview

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Commission 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. Up-line 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. It is the responsibility of the level that receives payment to administer commissions to the solicitor who made the sale. Specific credential requirements for the writing agent and up-line agents/entities are outlined in sections below.

Agent Compensation

Credential Validation Rules for the Writing Agent

- First-year commissions
  To be eligible to receive first-year commissions, as of the consumer’s application signature date, the writing agent (including solicitors) 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).
  ~ For MA/PDP applications must be certified in the product in which the consumer enrolled for the applicable effective year.
  ~ Effective 01/01/2017, for AARP Medicare Supplement applications must be certified in the product at the time of sale (i.e., not based on the plan year).

- Monthly Renewals (Year Two and Subsequent Years)
  To be eligible to receive renewal commissions for year two and beyond, the writing agent must be properly credentialed as outlined below:
  ~ For MA/PDP applications effective prior to 01/01/2014, to receive monthly renewal commissions, the writing agent (or immediate up-line if writing agent was solicitor level) must not be termed for-cause or deceased.
For MA/PDP applications effective 01/01/2014 and later for agents to be eligible to receive monthly renewals, the writing agent (or immediate up-line if writing agent was solicitor level) must be properly credentialed as noted below.

For MA/PDP applications, credentialing requirements for writing agents include:

- 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.

For AARP Medicare Supplement applications with all plan effective dates, to receive renewal commissions:

- The writing agent (or immediate up-line if writing agent was solicitor level) must not be termed for-cause or deceased. (Exception: for AARP Medicare Supplement Insurance plans issued in the state of Washington, agent commissions will continue to be paid to a successor agent in cases where the writing agent (or immediate up-line if writing agent was solicitor level) is termed for-cause or deceased.)
- First Year commission was processed and paid.

Compensation Structure – MA and PDP

Compensation is defined by the Centers for Medicare & Medicaid Services (CMS) as monetary or non-monetary remuneration relating to the sale or renewal of a policy including, but not limited to, commission, bonuses, gifts, prizes, awards, and finder’s fees.

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.
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- 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.
    - 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 2019 effective date will begin January 2020 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.

**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.

**Compensation Structure – AARP Medicare Supplement**

Most states generally define 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.

**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 Supplement products. However, if plan sponsors do compensate agents or brokers, such compensation must comply with state law and other regulatory guidance.

- Plans must establish a compensation structure for new enrollments and renewals for plans effective in a given 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 available upon Department of Insurance (DOI) request for audits, investigations, and to resolve complaints.
- If plans pay commissions they must abide by state law and regulations by paying commissions for first year enrollments and renewal compensation. In accordance
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with state law and regulations, UnitedHealthcare determines if an enrollment qualifies for first year or renewal compensation. The following rules pertain to the compensation cycle:

- The commission amount paid to an agent or broker for enrollment into an AARP Medicare Supplement Insurance Plan is as follows:
  For the upcoming plan benefit year, UnitedHealthcare will determine the commission rates by plan and state based on market specific objectives. Such commission rates are filed for approval with applicable state regulatory agencies and are subject to state approval. UnitedHealthcare may modify the compensation rate as required for state approval and will communicate any such modification as appropriate.

- If the member leaves the plan:
  - Commission paid is charged back on a pro-rated basis based on the number of months the member was in 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.

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

For AARP Medicare Supplement, 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 under state laws and regulations.
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. 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 the 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.

Direct Deposit (Does not apply to SecureHorizons Medicare Supplement products)
Non-employee agents may follow the instructions below to request direct deposit.
- Access Jarvis (www.uhjarvis.com)
- Under “Knowledge Center” tab, Access “Account Info”
- Under “Profile”, Access “Edit Direct Deposit Info”
- Enter the direct deposit information
- An email confirmation is sent to the email address on file
- The updated direct deposit change is effective immediately for the next commission cycle.
- For any issues, email the PHD at phd@uhc.com.

Commission Sharing

Commission payments may not be shared within a hierarchy. For example, an NMA may not share or split its commission payments with an FMO, MGA, GA, or Agent in its
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hierarchy. For each enrollment, an entity/agent within a hierarchy is entitled only to the appropriate amount listed on the Company commission schedule.

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.

Health Assessment (HA) Payment Program (updated October 1, 2019)

You will be paid for completing a Health Assessment (HA) when program and eligibility requirements have been met.

To be paid for completing a HA, you must be eligible, the member must enroll in an eligible plan, the enrollment must be completed in LEAN, and the HA must be completed timely. As of October 1, 2019, the following eligibility requirements must be met:

- Agent eligibility: You must be product certified and Special Needs Plan (SNP) Model of Care training for the applicable year (refer to the certification section for details).
- Plan Eligibility: The member must be enrolled (i.e. an accreted application) in a UnitedHealthcare non-SNP MA/MAPD, Dual SNP (DSNP), or (CSNP) that is deemed commissionable at the time of enrollment. Any stand-alone PDP, Medicare Supplement, Institutional SNP (ISNP), or non-commissionable MA/MAPD, DSNP, or CSNP is not eligible for payment. Enrollment applications that do not result in an approved enrollment are not eligible.
- Other Eligibility Criteria:
  - The HA must be completed fully and accurately on UnitedHealthcare’s third-party microsite.
  - The enrollment application must be submitted via LEAN and the LEAN confirmation number must be entered on the HA.
  - The HA must be submitted within 3 calendar days of the consumer signature date on the LEAN enrollment application.
  - The LEAN application must be submitted on or after October 1, 2019 to qualify for payment (including 11/1, 12/1, and 1/1 effective dates).
- The following apply to the HA payment:
  - Contracted amount will be paid for each HA that meets the eligibility requirements outlined above.
  - A HA payment will not be charged-back for rapid disenrollment. HA payments may be charged-back for other reasons, such as canceled, withdrawn, or denied enrollment applications, payment corrections or abuse of the HA payment program.
HA payments are reported on the 1099 in the year they are paid.

Agent of Record (AOR) 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 or immediate up-line if the original agent was a solicitor 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.);
  - 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 or immediate up-line if original agent was a solicitor must be an active renewal-eligible agent or an agent not in servicing status 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 or immediate up-line if original agent was a solicitor 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).
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- The current member must switch from the current plan to another qualifying UnitedHealthcare Medicare & Retirement managed Medicare Advantage plan with no gap in coverage. 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 or immediate up-line if original agent was a solicitor must be an active renewal-eligible agent or an agent not in servicing status 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 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 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%.

#### Assignment of Commission Process

Agents can request to assign commissions by submitting a completed Assignment of Commissions form to **SH_Commissions_Administration@uhc.com** or faxing it to 1-866-761-
9162. Forms are available through Jarvis (www.uhcjarvis.com) under the Commissions tab > Statements and More.

**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.

**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.

**Reporting and Communication Process**

- You and your up-line or manager/supervisor can review commission status and statements under the Commissions tab on Jarvis. If a commission is pended, the reason(s) for payment ineligibility is provided.
- The Commissions Department generates a pended transaction report on a weekly basis and distributes it to EDC channel leadership and the impacted EDC agencies.

**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 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 ALM, 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:
- You may request exception process review under one of the following circumstances:
  - You knew, in good faith, that you were certified in the product and can provide documentary evidence, but UnitedHealthcare internal business process or technical error did not reflect that you had passed the test in that product.
  - You were told you were certified and can provide evidence, but due to internal business process errors, were 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:
  - You must have taken the appropriate certification tests by the time the exception is being considered.
  - A UnitedHealthcare /UnitedHealth Group system or process created the certification error.
  - You were 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 ALM 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.
Section 7: How am I Paid?

Plan Changes
MA/MA-PD or PDP

- 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 also the “Agent of Record (AOR) Retention” section).
- 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, except as noted below.
- If the effective date of the plan change is in month four through eleven of the original/prior effective date, except as noted below, 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 initial year and the second plan is a like plan (Medicare Supplement Plans excluded) with the same agent, same carrier, and the member remains enrolled through 12/31, the agent will retain the full initial year commission.
- 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.

AARP Medicare Supplement

- Plan changes within the AARP Medicare Supplement product, if there is no break in coverage, the initial agent will retain commission eligibility, and the agent on the plan change if different from the initial agent, will not receive commissions.

Commission Payment Audit/Appeals

You or your up-line may submit an audit or appeal request when you disagree with a payment amount, including instances when you have not been paid, but feel you 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 you are 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 you. 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.
Section 7: How am I Paid?

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.

- You 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.

Repayment Process

Debt Repayment Plan

- UnitedHealthcare 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.
- 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.


**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: What are Expected Performance Standards?

Compliance and Ethics

Agent Performance Standards

Performance that may result in Immediate Termination

Monitoring Program

Agent Complaint Process

Revocation of Authority to Sell

De-authorization/Demotion of Status to Offer AARP Medicare Supplement Insurance Plans

Suspension of Agent Marketing and Sales Activities

Termination of Non-Producing EDC Agent/Agency

Termination of Non-Certified EDC Agent/Agency – Non-Employee

Termination – Disciplinary Action

Termination – Administrative

Termination – Due to Unqualified Sale

Discretionary Termination without Cause

Termination Process

Request for Reconsideration
Section 8: 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 www.unitedhealthgroup.com > Corporate Governance.

Conflict of Interest

A conflict of interest occurs when an individual’s interests or activities, or those of their immediate family (spouse/domestic partner, child, parent, or sibling, including step-relations and in-laws), could affect or appear to affect their
decision making on behalf of UnitedHealthcare or because their objectivity could be questioned because of those interests or activities. Individuals, representing UnitedHealthcare, including employees, contractors, and agents, must not engage in any activity that conflicts with, or gives the appearance of conflicting with, their responsibility to UnitedHealthcare or competes with, or gives the appearance of conflicting with, the interests of UnitedHealthcare or its consumer/members unless approved by management and in accordance with the Conflict of Interest policy. On an annual basis, all employees, contractors, and agents employed by or contracted with UnitedHealthcare must attest that they have read, understand, and will abide by UnitedHealth Group’s Code of Conduct.

Types of Conflict of Interest

Situations arise that can create a potential conflict of interest when acting as a representative of UnitedHealthcare. A list of activities that may create a conflict of interest is provided below. The list does not cover every possible situation, and the appearance of an activity on the list does not mean that it will always create a conflict of interest.

Ownership or Employment Interest in or Position of Influence with a Provider or UnitedHealthcare Business Partner

- An employee, contractor, agent, or their immediate family member, has one or more of the following relationships/interests in a health care provider or UnitedHealthcare business partner, including, but not limited to, equipment provider, vendor, supplier, or manufacturer:
  - Has a direct or indirect ownership interest (e.g., an agent owns a Durable Medical Equipment (DME) company or an ISR’s sister owns and/or operates a DME);
  - Is an employee, contractor, or consultant; or
  - Holds a position of influence (e.g., a UnitedHealthcare appointed agent serves on the Board of Directors of a dental clinic)

Relationship between UnitedHealth Group Employee and Agent/Agency

- An employee of UnitedHealth Group or its affiliate has an immediate family member who is an agent/agency employed/contracted by and/or appointed with UnitedHealthcare. For example, an ISR’s mother is an Agent Manager or the wife of a Sales Director is an EDC agent.

UnitedHealth Group Employee Simultaneously Contracted with UnitedHealthcare

- An employee of UnitedHealth Group or its affiliate is simultaneously in a non-employee contractual relationship with UnitedHealthcare. For example, an employee has an active contract as an EDC agent.

Relationship between a Non-Employee Agent/Agency and a UnitedHealthcare Competitor

- A non-employee agent (e.g., EDC agent) is contracted and appointed with multiple carriers, including direct competitors of UnitedHealthcare.
Section 8: What are Expected Performance Standards?

Disclosure of a Conflict of Interest and Attestation of Conflict of Interest Status

Non-Employee Contractors/Agents

- A contractor/agent must disclose any real or potential conflicts of interest at the time of contracting/on-boarding and within three business days of discovery for conflicts that 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.

- To disclose a real or potential conflict, the non-employee contractor/agent must submit a Conflict of Interest Disclosure form, along with any supporting documentation to Agent_COI@uhc.com.

- For purposes of this section and the Management of Conflict of Interest section, an EDC (i.e., non-captive, broker agent) whose conflict is limited to “Relationship between Non-Employee Agent/Agency and a UnitedHealthcare Competitor” is not required to submit a Disclosure of Conflict of Interest Form or have the conflict managed.

Attestation of Conflict of Interest

- All agents must attest to their conflict of interest status at the time they take the Ethics and Compliance assessment. If the agent attests that they have or may have a conflict of interest, even if previously disclosed, the agent will be required to submit a Conflict of Interest Disclosure Form.

Failure to submit a disclosure form when required may result in disciplinary action up to and including termination.

Management of Conflict of Interest

Conflict of Interest Disclosure Forms will be reviewed and an outcome decision made by the Distribution Compliance Officer and Vice President Operational Support and Forecasting. Agents will be notified of the decision and, if directed, must acknowledge receipt of the notification and agreement to any actions outlined in the notification. If it is determined a conflict of interest exists, UnitedHealthcare may take one or more of the following actions:

- Develop a conflict resolution and management plan approved by the Distribution Compliance Officer and Vice President Operational Support and Forecasting.

  For example, if it is determined that a conflict of interest exists between an employee and a non-employee, a decision will be made about whether the conflict can be managed, and all parties will be notified. If it is determined that the conflict can be managed, UnitedHealthcare will share with the parties how it intends to manage the conflict. Failure to comply with the management plan could result in termination of the agent(s).

- Require the employee, contractor, or agent to divest of the conflict.
Section 8: What are Expected Performance Standards?

~ For example, 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 the purpose and requirements of the UnitedHealth Group Code of Conduct and the Avoiding Conflicts of Interest Policy. The employee could be required to terminate their contract with a competitor in order to continue working as a sales employee for UnitedHealth Group.

- 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
Section 8: What are Expected Performance Standards?

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](http://www.uhghelpcenter.ethicspoint.com) (available 24 hours a day, 7 days a week.)
- 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.

Protected Health Information (PHI)

PHI is individually identifiable information (including demographics) that relates to health condition, the provision of care/coverage, or payment of such care.

Personally Identifiable Information (PII)

PII is a person’s first name or first initial and last name in combination with one or more of the following:

- 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.

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, you 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 financial responsibility for the payment of identity theft protection (e.g., LifeLock) for impacted members resulting from the loss of a device containing PHI/PII (e.g., laptop, mobile/smart phone, or other portable electronic device) and to corrective and/or disciplinary action up to and including termination.
Interpretation of the above definitions of PHI/PII is dependent upon the how the consumer/member information is held (stored), used or treated and the definitions may overlap. PHI exists when held by a HIPAA Covered Entity (health plan) or a Business Associate of one (vendor, agent, etc.)

Agents Must:
- Carry only the minimum amount of hard copy documents with consumer/member PHI or PII necessary to complete the day’s activities.
- Keep documents 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).
- 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, laptops, and other screens 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 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 by others (e.g., desk, vehicle, table, or booth)
- Discuss consumer/member information in public spaces, including halls, elevators, lobbies, lunchrooms, cafeterias, restaurants, lavatories, parking lots or other unsecured public places where the conversation could be overheard. You must 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, unless the agent (or agency, if the agent is employed by an agency) has a proper Business Associate Agreement in place with the cloud storage provider, and the cloud storage where PHI/PII is stored has appropriate security controls (e.g., encryption, logging, etc.).
Section 8: What are Expected Performance Standards?

- Share user ID’s/passwords to UnitedHealthcare systems with others.
- Put consumer/member information on a jump drive (or similar portable storage device) and enable a technical control to restrict use of such devices. Formally documented business justification is needed if portable storage is necessary to conduct business and the device must be enabled with a minimum of 256 bit encryption.
- Scan or store paper enrollment applications or business reply cards (BRC) electronically, except when employee agents use UnitedHealthcare approved applications/platforms (e.g., Optum Technology Tiger Text, Blackberry Work or employee’s home directory) or 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.

**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:
- 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.

**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:

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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 8: 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

UnitedHealthcare has developed performance standards and oversight programs to monitor agents and agencies that market and sell UnitedHealthcare Medicare Solution products to ensure adherence to applicable CMS and Company rules, policies, and procedures.

This guide outlines agent performance standards, sales management review, and oversight monitoring programs designed to ensure all agents are conducting sales, marketing, and enrollment activities in accordance with applicable rules, regulations, and UnitedHealthcare business requirements.

Your manager/supervisor or agency representative is responsible for completing the following oversight and development activities:

- Ensuring you complete all required UnitedHealthcare training.
- Communicating all product and regulatory information from UnitedHealthcare.
- Ensuring you participate in any UnitedHealthcare required remedial training.

Non-employee agents authorized to sell the UnitedHealthcare Senior Care Options

Your Sales and Development manager is responsible for ensuring that agents authorized to sell UnitedHealthcare Senior Care Options plans complete required product specific training, attend periodic meetings, and complete ongoing monitoring activities. Your Sales and Development manager will monitor and enforce your attendance at meetings and trainings.

- 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 product.
- You are required to attend quarterly meetings with UnitedHealthcare sales management for continuing education, training, and case reviews and best practices.
- You will receive periodic ride-alongs to observe you at face-to-face presentations.

Performance that may result in Immediate Termination
In some circumstances a recommendation for immediate termination (for-cause or not-for-cause) may occur.

Engaging in the following activities may result in a recommendation for immediate termination (refer to the Agent Termination section for details):
- Any occurrence of fraud, forgery, payments, inducements, deception, or coercion
- 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

Monitoring Programs
UnitedHealthcare has implemented a variety of monitoring programs to ensure all agents are conducting sales, marketing, and enrollment activity in accordance with federal regulations and UnitedHealthcare rules, policies, and procedures. Calculation methods and thresholds have been established for all compliance monitoring programs and are periodically reviewed. Deficient performance is categorized as Yellow (Complaint Monitoring only) or Red depending upon severity and patterns of performance. Monitoring programs reported in SMRT-Compliance include:
- Quality Call Monitoring
- Cancelled Enrollment Applications
- Complaints
- Late Enrollment Applications
- PCP Auto-Assign
- Rapid Disenrollment

Other monitoring programs are not reported through SMRT-Compliance and include:
- Unqualified Sales
- Suspicious Sales
- Event Related Infractions
- Web Enrollment

UnitedHealthcare reserves the authority to monitor additional issues and circumstances as deemed warranted.

For addition questions regarding the compliance monitoring thresholds, contact your manager.

Cancelled Enrollment Applications
A consumer can cancel an enrollment application received by the enrollment center prior to the plan’s effective date. The Cancelled Enrollment Application monitoring program calculates the cancellation rate by effective date for a given agent.

Complaints
The complaint investigation outcome or process to which you are referred (e.g., CEC, CAR, DAC) determines the threshold reported in SMRT Compliance (see the Agent Complaint Process section for details). If you are referred to the CAR process, you must successfully complete...
the assigned sales remediation training course(s) and corresponding assessment, with a minimum score of 80% within six attempts, within five calendar days of availability. Additional outreach is conducted based on accumulated complaint points.

**Late Enrollment Applications**
Late Enrollment Applications monitors the timely submission of enrollment applications.

**PCP Auto-Assign**
PCP Auto-Assign monitors the accurate indication of a valid PCP identification number on a Medicare Advantage (MA) enrollment application. Effective March 1, 2018, monitoring will be limited to paper and LEAN Office enrollment applications for MA HMO plans (some exceptions apply) submitted by you. Sales Oversight maintains the list of included plans.

**Rapid Disenrollment**
Rapid Disenrollment monitors voluntary member disenrollment from a Medicare Advantage or Prescription Drug Plan within three months of the effective date.

**Unqualified Sales and Corrective/Disciplinary Action**
An unqualified sale occurs when you are not licensed and/or appointed (if applicable) in the state in which the consumer resides and/or certified in the product in which the consumer is enrolling at the time of sale.

- For the first instance of an unqualified sale in a rolling 12-month period, you will be assigned a CAR and two complaint points.

- You will be terminated not-for-cause when a new unqualified sale is validated within a rolling 12-month period subsequent to a completed corrective action on the same type of unqualified sale. (Refer to the Termination Process section for termination details.)

**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**
The presenting agent is responsible for the accurate and timely reporting of events as indicated in the event reporting section. Prior to reporting and/or conducting an event, the presenting agent must pass the applicable Events Basics assessment.

- **Late Reported, Changed, or Cancelled Event**
  ~ A report is generated that identifies events entered in UnitedHealthcare’s event reporting application less than 7 calendar days prior to the date of the event and events that are changed or cancelled in the reporting application less than 1 business day prior to the date of the event.

- **Failure to Report**
  ~ A failure to report infraction, results in a formal Operational
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Issues complaint against the presenting agent and a CAR.
- You will be assessed two complaint points
- You must complete assigned corrective action, which includes completing the on-line Operational Issues remediation module and a second session of the Events Basics module
- You will receive manager/supervisor/BDE coaching
- You must complete an attestation of understanding that a second identical offense within the 12-month period following coaching will result in a DAC referral and may result in termination.

- **Failure to Complete Events Basics Assessment**
  - A presenting agent who did not pass the applicable Events Basics assessment prior to conducting an 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 assessment as assigned.

- **Presenting Agent is not Contracted with UnitedHealthcare**
  - If it is determined that a non-contracted agent conducted a marketing/sales event on behalf of UnitedHealthcare, the intended presenting agent will be determined and an attempt will be made to determine 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 Infractions**
  - Unsuccessful Event infractions result when you did not show up for a reported event, the incorrect event type was reported, you arrived late and after the evaluator 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.
  - You must complete assigned corrective action, which includes completing the Operational Issues remediation module and a second session of the Events Basics module. Failing a second event observation/secret shop due to Unsuccessful Event in a 12-month rolling period after having been coached, you will be assigned corrective actions. 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.

**Use of a Public Web Enrollment Portal**
You must not enroll a consumer using a consumer-facing website or be physically
present with a consumer who is completing an enrollment application via a UnitedHealthcare public web enrollment 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 enrollment portal. When it is determined that you completed an enrollment via a UnitedHealthcare public web portal or were physically present when a consumer submitted an enrollment via a UnitedHealthcare public web enrollment portal, a formal Operational Issues complaint is substantiated and two complaint points and a CAR are assigned. If you complete a second enrollment in the same manner in a 12-month rolling period, after having been coached, you will be assigned corrective action. Submitting a third enrollment via a UnitedHealthcare public web enrollment portal, after having been coached, will result in a DAC referral.

**Agent Complaint Process**

Complaints, allegations of agent misconduct, and issues of non-compliance are serious matters that require prompt attention; will have reasonable, timely, and well-documented inquiry into, and identified problems will be promptly and thoroughly corrected to reduce the potential of reoccurrence.

**Sources of Complaints**

Complaints and allegations of misconduct can originate from both internal and external sources. All complaints against agents must be provided to the Agent Complaint Tracking (ACT) team via the agent complaint tracking tool within five business days of initial receipt.

Sources of Complaints and Allegations of Misconduct:

- Internal sources include, but are not limited to, UnitedHealthcare Government Programs, Appeals and Grievances, Sales and Marketing, Service Integrity and Member Support, Provider Services, Care Coordination, Producer Help Desk (PHD), UnitedHealth Group Ethics and Compliance (Ethics Point), and other UnitedHealth Group lines of business.
- External sources include, but are not limited to, 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.

**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
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- The product identified in the complaint is not a UnitedHealthcare 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) – CEC 2 – Corrective Action Referral (CAR) – Disciplinary Action Committee (DAC) Referral Criteria Grid to determine if the complaint is referred to the CEC process or the Compliance Investigations Unit (CIU) for investigation and in some circumstances, directly referred to Corrective Action Referral (CAR). The status of the complaint is updated in the agent complaint tracking tool.

Complaint Education Contact Process
The Complaint Education Contact process provides two levels of engagement (i.e. CEC and CEC2) and is used as an intermediary measure to proactively address agent complaint behavior in an effort to prevent repeat infractions and/or more egregious behavior by facilitating the training and coaching of agents based upon established criteria. Throughout this guide, the term CEC is used to include the processes related to both levels, CEC and CEC2.
  - The ACT team uses the CEC-CEC2-CAR-DAC Referral Criteria Grid to determine appropriate outreach.
  - If you are an active agent, the ACT team creates a Coaching Request (CR) in PCL and assigns it to the appropriate Broker Development and Education Specialist (BDE) or your agent manager/supervisor.
  - If you are an inactive agent, a CR is not created. The ACT team updates the complaint status in the agent complaint tracking tool and notifies ALM to flag you DNR, which serves as an alert in the event you attempt to re-contract. When you re-contract and become active, any outstanding coaching must be completed prior to conducting any marketing/selling activities.

Agent Complaint Investigation Process
The Compliance Investigation Unit (CIU) is responsible for the investigation of complaints involving agents who market and sell UnitedHealthcare Medicare Solutions products. Complaints referred to the CIU are repeat issues or severe allegations of misconduct. At any point during the investigation, the ACT team or CIU may determine by using a severity grid that a recommendation to suspend your ability to market and sell UnitedHealthcare Medicare Solutions products is justified. The CIU will forward the suspension recommendation to the Director or Agent Complaint Tracking.

Initial Review and Assignment of Case
Upon receipt of a complaint referral from the ACT team, the CIU makes a preliminary assessment of the case and assigns the case to an investigator who initiates an investigation as quickly as possible.

Investigation
The investigation process consists of obtaining information, documenting
findings, and determining allegation outcomes.

Obtaining Information and Documenting Findings

- Generally, a Request for Agent Response (RAR) is prepared and sent directly to you and to your sales or External Distribution Channel (EDC) management hierarchy. The RAR requests that you provide specific detailed responses to each allegation as well as other pertinent questions, facts, and circumstances. You must submit your 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 EDC management hierarchy, are 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 with 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.

Allegation Outcomes

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:

- Substantiated: Based on the evidence and facts that existed at the time the investigation was conducted and applicable CMS Medicare Communications and Marketing Guidelines (MCMGs), 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 MCMGs, 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
Section 8: What are Expected Performance Standards?

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 the agent for sales or marketing misconduct in accordance with MCMGs 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.

Assignment of Final Disposition
The ACT team considers each allegation outcome to determine the final disposition. 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 have 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.

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/CEC 2 opportunities for the same allegation family (-ies) within the past twelve months and the event/enrollment application for the current allegation took place after those previous CEC/CEC 2 outreaches occurred.
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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 process within the past twelve months and the event/enrollment application for the current allegation took place after that previous CAR or DAC outreach occurred.
- You have had repeated instances of lower severity complaints.
- Your behavior poses a continuing risk to company reputation or harm to members.
- You have been terminated for cause from another UnitedHealth Group line of business (e.g., Employer and Individual (E&I)).

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. The retraining efforts through the CAR process are 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:

- If you are an active agent, the ACT team creates a Coaching Request (CR) in PCL and assigns it to the appropriate BDE or agent manager/supervisor and submits a request to certification operations to assign the applicable sales remediation module(s) to you.
- If you are an inactive agent, a CR is not created. The ACT team updates the complaint status in the agent complaint tracking tool and notifies ALM to flag you DNR, which serves as an alert in the event you attempt to re-contract. When you re-contract and becomes active, any outstanding coaching must be completed prior to conducting any marketing/selling activities.

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 seven management-level representatives from Compliance, Regulatory Affairs, sales, and sales operations.
- A representative of the Legal Department serves as a legal advisor to the committee.
- The DAC meets once a week if there are cases to be reviewed or as needed to ensure referrals to the committee are addressed in a timely manner.
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- A quorum of voting members is required to review referrals and vote on recommendations for disciplinary action.
- An agenda and minutes are filed for each meeting and the DAC docket and agent complaint tracking tool are updated with the meeting outcomes.

DAC Proceedings
- The DAC reviews the merits of the complaint and the investigation findings, and any other pertinent information (e.g., agent complaint and compliance history).
- If additional information is required, the DAC may request and consider other relevant information. As necessary, the case is deferred and placed on a future DAC meeting agenda.
- The committee determines and votes on an outcome. Approval by a majority of voting members present is required.

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 and sending a formal corrective action letter that is sent to you and your manager/supervisor notifying the appropriate manager to facilitate appropriate outreach and training to you.
- 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 chairperson is responsible for notifying your 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 you, the DAC must determine if the termination is for-cause or not-for-cause. ALM is notified to flag you DNR. (Refer to the Agent Termination Process section for termination process details.)

Complaint point System
Points will be accessed to actionable complaints (i.e. Inconclusive or Substantiated outcomes) based on the outcome of the complaint with point accumulation over a rolling 12 months. A CEC or CEC2 is accessed 1 point, a CAR 2 points, and a DAC with actionable outcomes 3 points. An agent will receive training/outreach or escalated disciplinary action when their accumulated points meet or exceed a threshold.

Coaching Request Extension Process
Under certain circumstances, a BDE/BA or agent manager/supervisor may request
from ACT an extension to the required CR completion date. Contact your BDE/BA or agent manager/supervisor for process details.

## Section 8: What are Expected Performance Standards?

### Revocation of Authority to Sell

#### Revocation of Authority to Sell Specific Medicare Advantage Products

Your performance is monitored in a variety of areas including rapid disenrollment rates and complaint ratios, and 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 Authority 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. The process for implementing a revocation of authority includes:

- You will receive a notification letter detailing the authority revocation, the product, and the effective date. Note: the effective date is 30 days or the based on the terms of your agent agreement. The notification letter also provides you with reinstatement rights and instructions.
- Commissions will not be paid on any enrollment applications written for the applicable 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.

#### Revocation of Authority Appeal Process

You may appeal the revocation of your authority to sell a specific product.

- An appeal can be filed when you are notified of the revocation for the current sales year or in the future for a new sales year.
- 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.
- Written notification of the DAC’s decision is sent to you via carrier for expedited delivery and by email.
- The decision of the DAC is final.
- You must wait a minimum of six months after a notification of denial to submit a request for reauthorization to sell a product.
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- Contact your sales leadership for additional appeal process details.

De-authorization/Demotion of Status to Offer AARP Medicare Supplement Insurance Plans

Agent Performance Standards and Thresholds
To retain active status, as an Authorized to Offer AARP Medicare plans program (A2O) agent, you must meet certification requirements and quality production minimums (QPM) to continue to offer/market AARP Medicare Supplement plans and retain access to marketing and enrollment materials for that product. The QPM period is measured annually and based on production from January 1 through December 31. If you are an up-line agent, you will be credited with production from your down-line agents based on QPM. The following quality production guidelines apply to obtain/retain active statuses:

A20 Level 1 Status:
- To obtain/retain A20 Level 1 status, you must meet the annual QPM by submitting at least five commission-eligible accepted and paid enrollment applications of AARP Medicare Supplement plans during the annual production measurement period to avoid de-authorization.
- If you fail to meet the annual QPM, you will be temporarily de-authorized from offering AARP Medicare Supplement plans for 60 days.

Notification of temporary de-authorization will be sent to you. The letter will include an effective date (30 days from the notification date), de-authorization period (dates included), and reinstatement and appeal rights.

- If you fail to meet the annual QPM for two consecutive years, you will be permanently de-authorized and no longer permitted to offer AARP Medicare Supplement plans. Notification of permanent de-authorization will be sent to you. The letter will include an effective date (30 days from the notification date), and appeal rights.

- If you have 100 or more active AARP Medicare Supplement members in your book of business at the end of the annual production measurement period, you will be excluded from production requirements and retain your status.

A20 Level 2 Status:
- To obtain/retain A20 Level 2 status, you must meet the annual QPM by submitting at least thirty commission-eligible accepted and paid enrollment applications of AARP Medicare Supplement plans during the annual production measurement.
- If you fail to meet the annual QPM, you will be demoted to Level 1 status. If you are demoted to Level 1, you may continue to offer AARP Medicare Supplement plans; however, you will not have access to Level 2 marketing materials. Notification of demotion will be sent to you. The letter will include an effective date (30 days
from the notification date), and reinstatement and appeal rights.
- If you have 200 or more active AARP Medicare Supplement members in your book of business at the end of the annual measurement period, you will be excluded from production requirements and retain your status.

**Note:** If you become temporarily or permanently de-authorized from offering AARP Medicare Supplement plans, you may continue to offer UnitedHealthcare (including AARP branded) Medicare Advantage and Prescription Drug Plans provided you have met all relevant credentialing and certification requirements.

**De-Authorization/Demotion Appeal Process**
You may appeal an A2O level demotion or a temporary or permanent de-authorization to offer AARP Medicare Supplement plans. UnitedHealthcare Insurance Solutions will review and respond to any appeals and render a decision.
- All appeals must be in writing, include your name, ID number, contact information, and reason for appeal and be submitted via secure delivery email to phd@uhc.com no later than the date indicated in the notification.
- In the written appeal, you must clarify and provide detail, or explain mitigating circumstances, supporting your reason for the appeal.

At any time should UnitedHealthcare believe your performance or actions pose a potential threat to consumers/members, threaten or damage the reputation of UnitedHealthcare, or do not meet company and compliance standards, UnitedHealthcare can initiate the suspension of your ability to market and sell UnitedHealthcare Medicare Solutions products.
- If a determination to suspend your ability to market or sell is made, you will receive a suspension notification letter. The suspension letter will be mailed overnight via carrier for expedited delivery.
- The suspension is effective immediately as of the date of the letter of notice and shall continue until the investigation is complete and a final disciplinary recommendation has been made and completed or as indicated in the notification letter.
- You are not to market or sell UnitedHealthcare Medicare Solutions products while on a suspension status.
- New business written during the suspension period will not be eligible for commission. UnitedHealthcare reserves the right to hold commission payments, while on suspension status.
- Contact your sales leadership for additional details regarding a suspension of marketing and sales activities.

**Suspension of Agent Marketing/Sales Activities**

**Termination of Non-Producing EDC Agent/Agency**
Effective June 25, 2018, UnitedHealthcare may at its discretion assess a fee and
Section 8: What are Expected Performance Standards?

initiate a not-for-cause termination of an agent/agency (excluding solicitors) that is identified as non-producing during an annual evaluation period. Refer to the On-Boarding and Agent Readiness Fees section for details.

- To avoid termination, you must have one sale of any UnitedHealthcare Medicare Advantage, Prescription Drug Plan, or Medicare supplement product within the 30-day termination notification period. The administration fee will still apply.
- You may submit an appeal of the fee and/or termination within the 30-day notification period if one of the following conditions can be met:
  - Proof of sales (e.g., a copy of a commission statement or a screen shot from Jarvis).
  - Proof that you were in a non-selling role (e.g., training, operations, administrative) and do not write business (e.g., a signed letter from their NMA verifying the individual’s role) for the evaluation period only. Thereafter, if you have not moved to a solicitor level, the termination will apply.
  - 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 is denied, a not-for-cause termination will be processed on the termination effective date (see the Termination Process section).
- You are eligible to apply to re-contract 60 days following the termination effective date. Any outstanding administrative fee must be paid prior to re-contracting.

Termination of Non-Certified EDC Agent/Agency – Non-Employee

UnitedHealthcare may at its discretion terminate you if you fail to certify for a new plan year.

- You will be terminated and you will be sent a termination notification letter detailing the reason for termination, the effective date of termination, and instructions for submitting an appeal to Producers Help Desk (PHD). A copy of the notification letter is sent to your NMA and is uploaded to your agent sales file.
- An appeal may be submitted within the notification period (typically 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 a screen shot from Jarvis).
  - 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 is denied, a not-for-cause termination will be processed on the termination effective date. (see the Termination Process section)
- 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 termination determinations made by the DAC.

Termination – Administrative

Administrative terminations are disciplinary, not-for-cause terminations initiated by the Agent Complaint Tracking (ACT) team in certain circumstances including:

Administrative Termination – Compliance Investigations Unit (CIU)
If you fail to respond within the prescribed timeframes to the Request for Agent Response (RAR) and Non-Response Letters (NRL) sent by an investigator during a complaint investigation (See the Agent Complaint Process for details to the investigation process section).

- The ACT team sends you a notification of termination letter detailing the reason for termination, the termination effective date, and the appeal process via carrier for expedited delivery, and by email, with a read receipt, to your address in DCM. A copy of the notification is sent to your NMA and to ALM.
- ALM will process the termination 30 days from the termination notification date and add a Do Not Re-Contract flag to your file.
- If within 30 days from the date of the letter you provide a sufficient RAR/NRL response to the investigator, the investigator will alert the ACT team and a retraction to the notification of termination letter will be sent by mail to you and via email with a read receipt. A copy is sent to your NMA and to ALM.
- If the termination becomes effective, you may request a reconsideration of an administrative termination. (See the Agent Request for Reconsideration – Non-Employee Agent section)

Administrative Termination – Broker Development Education (BDE)
If you fail to complete required training/coaching resulting from a Complaint Education Contact (CEC/CEC2), Corrective Action Referral (CAR), or Disciplinary Action Committee (DAC) referral or any required compliance monitoring program coaching.

- The ACT team sends you a notification of termination letter detailing the reason for termination, the termination effective date, and the appeal process via carrier for expedited delivery and by email, with a read receipt, to your address in DCM. A copy of the notification is sent to your NMA and to ALM.
- ALM will process the termination 30 days from the termination notification letter and add a Do Not Re-Contract flag to your file.
- If within 30 days from the date of the letter, your manager or Broker Development Education (BDE) provides
notice that you have completed all coaching and corrective action requirements, your manager or BDE will alert the ACT team and a retraction to the notification of termination letter will be sent by mail to you and via email with a read receipt. A copy is sent to your NMA and to ALM.

~ If the termination becomes effective, you may request a reconsideration of an administrative termination. (See the Agent Request for Reconsideration – Non-Employee Agents section)

**Termination – Due to 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 resides or certified in the product in which the consumer enrolled.

- An unqualified sale does not necessarily affect the member’s enrollment in the plan, but the member may request to make a plan change.

- UnitedHealthcare will not pay a commission on any enrollment application determined to be an unqualified sale.

- Termination due to Certification or Appointment Issue or License Issue effective 07/01/2018
  You will be terminated not-for-cause when a new unqualified sale is validated within a rolling 12-month period subsequent to a completed corrective action on the same type of unqualified sale. (See the Termination Process section.)

~ You may submit an appeal during the termination notification period (typically 30 days or based on the terms of your agent agreement) by providing documentation that includes proof of an active license, state appointment, and/or product certification at the time of sale.

~ You must wait a minimum of 12 months from the date of the unqualified sale that initiated the termination process before you can seek to re-contract.

~ You may request a reconsideration of a termination (See the Agent Request for Reconsideration – Non-Employee Agents section).

**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 terminations must be classified for-cause or not-for-cause.
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**Not-for-Cause Termination**

A not-for-cause termination may be initiated for you by UnitedHealthcare, or requested for any reason by you or your NMA (if applicable). The termination notification period is 30 days or per your agent agreement unless immediately effective as requested by you. Depending on the reason for termination, you may be flagged Do Not Re-Contract in contracting system.

**Not-for-Cause Termination Process**

- When UnitedHealthcare initiates a not-for-cause termination a not-for-cause termination letter, detailing the reason for termination, the termination effective date, and the appeal process (if applicable) may be sent to you via carrier for expedited delivery and/or by email, with a read receipt if applicable, to your address in DCM.
- When the DAC initiates a disciplinary action not-for-cause agent termination, a not-for-cause termination letter, detailing the reason for termination, the termination effective date, and the appeal process (if applicable), is sent to you via carrier for expedited delivery and by email, with a read receipt, to your address in the contracting system.
- Agent and/or NMA initiated not-for-cause termination requests are submitted for processing to ALM via email to UHPcred@uhc.com with the subject “Termination”.
- Upon receipt of a not-for-cause termination request, ALM updates the contracting system with the appropriate termination effective date.
- The appointment termination is processed by ALM 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.
- You are flagged Do Not Re-Contract in the contracting system upon the DAC referral for disciplinary termination, directed by Legal, ACT team (for administrative terminations), field sales leadership, or as the result of an unqualified sale due to no license or repeated appointment or certification failures (i.e. not properly appointed/certified at time of sale).
- If you are terminated for disciplinary or administrative termination, you may request a reconsideration of termination. (See Request for Reconsideration section)

**For-Cause Termination**

UnitedHealthcare may initiate for you a for-cause termination. If you are terminated for-cause, you will be flagged Do Not Re-Contract in the contracting system. UnitedHealthcare will report for-cause terminations to the appropriate state.
Section 8: What are Expected Performance Standards?

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 via carrier for expedited delivery and by email, with a read receipt, to your address in DCM.
- ALM is notified of the termination request by the ACT team.
- ALM 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 termination effective date.
- You are flagged Do Not Re-Contract in the contracting system.
- If you are terminated for disciplinary or administrative termination, you may request a reconsideration of a termination. (See Agent Request for Reconsideration section)
- UnitedHealthcare reserves the right to adjust the agent’s final commission payments.

State and CMS Notification Process

UnitedHealthcare will comply with all regulatory requirements regarding state and CMS notification of appointment termination of agents.

- Contact your agent manager/supervisor for additional details.

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 disciplinary termination or an 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 the ACT team and Sales Operations Leadership.
- 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
Section 8: What are Expected Performance Standards?

- 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 assigned corrective action must be processed and completed by you upon on-boarding.

- If you are denied reinstatement after DAC Determination, the Do Not Re-Contract status remains indefinitely.

Agent Request to Re-contract after Denial – Non-Employee Agents
Under certain circumstances, if you are denied reinstatement through the process previously outlined in the Agent Request for Reconsideration – Non-Employee Agents section above, you are permitted to re-contract. The following guidelines apply to disciplinary and Administrative terminations:

DAC For-Cause Termination
- A minimum waiting period of 36 months from your termination effective date is required before your re-contract request is considered.
- You must have the approval and support of a UnitedHealthcare senior sales leader (e.g., Regional Senior Vice President) to proceed with your re-contract request.
- You and your 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 unless an exception is granted by Sales Operations Senior leadership.
- The DAC reviews the re-contracting request, sales behavior changes made by you, and a detailed future action plan by the sales leader or up-line in order to make a determination. The DAC may amend your action plan or deny re-contracting based on an insufficient action plan.
- If the DAC approves the re-contracting request, both the Chief Compliance Officer and the Chief Distribution Officer will cast the final approval/rejection votes and may request additional information to make their decision.
- The DNR flag will be removed and you must address any outstanding member complaints following the reappointment.
- If the DAC denies the re-contracting request, the DNR flag will remain and you are prohibited from future contracting opportunities.

DAC Not-for-Cause Termination
- A minimum waiting period of 24 months from your termination effective date is required.
You must have the approval and support of a UnitedHealthcare sales leader in order to submit a request to re-contract. You and the 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, you will be denied a re-contracting request unless an exception is granted by Sales Operations Senior leadership.

The DAC reviews the re-contracting request, sales behavior changes made by you, and a detailed future action plan by the sales leader or up-line in order to make a determination. The DAC may amend your action plan or deny re-contracting based on an insufficient action plan.

If the DAC approves the re-contracting request, the DNR flag will be removed and you must address any outstanding member complaints 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 - CIU**

A minimum waiting period of 12 months from your termination effective date is required.

You must have the approval and support of a UnitedHealthcare sales leader in order to submit a 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. You must respond and cooperate with the CIU until the outstanding investigation is completed. Note: If the initial receipt date exceeds 24 months prior to the request for reconsideration the reconsideration 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 allegation outcomes for allegations within the Risk to Consumers/Organization or Prohibited Activities allegation families, the re-contracting request will be denied, unless an exception is granted by Sales Operations Senior leadership.

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 following the reappointment. If the DAC denies the re-contracting request, the DNR flag will remain and you are prohibited from future contracting opportunities.
the ACT team will disposition the investigation findings 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 effective date is required.
- You must have the approval and support of a UnitedHealthcare sales leader in order to submit a 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](mailto:business_monitoring@uhc.com).
- The ACT team will review your complaint history. Re-contracting requests are denied when you have received complaints after termination that have an allegation within the Risk to Consumers/Organization or Prohibited Activities allegation families with a substantiated allegation outcome, unless an exception is granted by Sales Operation Senior leadership.
- 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 following the reappointment. If you fail to complete the previous corrective action, you will be terminated and 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.
## 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.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>AARP*</td>
<td>AARP (formerly known as American Association of Retired Persons) is a membership organization for people age 50 and over.</td>
</tr>
<tr>
<td>AARP Services, Inc. (ASI)</td>
<td>The organization that administers AARP.</td>
</tr>
<tr>
<td>Agent Complaint Tracking (ACT) Team</td>
<td>The team that manages the intake, review, and disposition of agent related complaints.</td>
</tr>
<tr>
<td>Administrative Termination</td>
<td>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.</td>
</tr>
<tr>
<td>Advertising Materials</td>
<td>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 advertisements, print advertisements, billboards, and direct mail.</td>
</tr>
<tr>
<td>Agent</td>
<td>A global term to refer to any licensed, appointed (if applicable), and certified individual soliciting and selling UnitedHealthcare products, including, but not limited to, NMA, FMO, MGA, GA, ICA, IMO, ISR, Broker, Solicitor, or Telesales agent. See also Solicitor and Producer.</td>
</tr>
<tr>
<td>Agent ID</td>
<td>See Writing Number.</td>
</tr>
<tr>
<td>Agent Manager</td>
<td>A UnitedHealthcare employee responsible for the relationship between a field agent and UnitedHealthcare.</td>
</tr>
<tr>
<td>Agent of Record</td>
<td>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.</td>
</tr>
<tr>
<td>Agent Lifecycle Management</td>
<td>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.</td>
</tr>
<tr>
<td>Allegation</td>
<td>A claim or assertion that an agent violated CMS Medicare.</td>
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<td><strong>Section 9: Glossary of Terms</strong></td>
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<td>---------------------------------</td>
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<tr>
<td><strong>Communications and Marketing Guidelines, Company policy, or engaged in other inappropriate sales activities.</strong></td>
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<tr>
<td><strong>Americas Health Insurance Plans (AHIP)</strong></td>
<td>A national trade association whose agents sell health insurance coverage and provide health-related services.</td>
</tr>
<tr>
<td><strong>Annual Election Period (AEP)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Annual Notice of Change (ANOC)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Anti-Kickback Statute</strong></td>
<td>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. (See 42 U.S.C. 1320a–7b)</td>
</tr>
<tr>
<td><strong>Examples of activities that may be prohibited under the statute:</strong></td>
<td></td>
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<tr>
<td>- Offering cash reimbursement in exchange for an enrollment or referral.</td>
<td></td>
</tr>
<tr>
<td>- Offering gifts or services greater than a nominal amount permitted by federal guidelines.</td>
<td></td>
</tr>
<tr>
<td>- Offering gifts or services dependent on enrollment or referral.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td><strong>Appeal (Part C)</strong></td>
<td>A formal request of UnitedHealthcare to review and possibly change a medical coverage decision that has been made. Also referred to as plan reconsideration. To initiate a fast or standard appeal, the member, member’s representative, or doctor must contact UnitedHealthcare via phone, fax, mail or the website. UnitedHealthcare will consider the appeal and provide an outcome. If the plan denies some or all of the appeal, it will be automatically sent to the next level of the appeals process. An Independent Review Organization will review the appeal and</td>
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### Section 9: Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
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<tbody>
<tr>
<td>Appeal (Part D)</td>
<td>A formal request of UnitedHealthcare to review and possibly change a prescription drug coverage decision that has been made. Also referred to as a plan redetermination. UnitedHealthcare will consider the appeal and provide an outcome. If the plan denies some or all of the appeal, it will be automatically sent to the next level of the appeals process. An Independent Review Organization will review the appeal and provide an outcome. If the decision is upheld and the request meets certain requirements, the appeal may be taken further. Refer to the plan’s Evidence of Coverage for details on filing.</td>
</tr>
<tr>
<td>Appointment (Agent)</td>
<td>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.</td>
</tr>
<tr>
<td>Appointment – Sales Presentation</td>
<td>See Personal/Individual Marketing Appointment</td>
</tr>
<tr>
<td>American Sign Language (ASL) Interpreter</td>
<td>An individual that translates verbal language into sign language for the hearing or speech impaired.</td>
</tr>
<tr>
<td>Authorized Representative</td>
<td>The person authorized under state law to make health care related decisions on behalf of another individual. For example, power of attorney with appropriate authority.</td>
</tr>
<tr>
<td>Background Investigation</td>
<td>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.</td>
</tr>
<tr>
<td>bConnected</td>
<td>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...</td>
</tr>
<tr>
<td><strong>Book of Business</strong></td>
<td>appointments and marketing/sales events. See also Lead. The collection of leads, contacts, and/or members assigned to a particular agent.</td>
</tr>
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</tr>
<tr>
<td><strong>Brand</strong></td>
<td>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 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.</td>
</tr>
<tr>
<td><strong>Broker Development and Education Specialist (BDE)</strong></td>
<td>UnitedHealthcare employee that reaches out to educate agents on specific monitoring program issues such as complaints, rapid disenrollment, and Secret Shopper results. Proactive positive reinforcement contacts might also be conducted.</td>
</tr>
<tr>
<td><strong>Business Reply Card - BRC</strong></td>
<td>A paper or electronic document returned by a consumer to the plan or agent as a response/request for more information or permission to be contacted by an agent.</td>
</tr>
<tr>
<td><strong>Call Monitoring</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Captive Agent</strong></td>
<td>An agent, who by virtue of employment or contract, must solicit and sell exclusively a UnitedHealthcare Medicare product or products. For example, all employee agents are captive to UnitedHealthcare Medicare and ICA agents are for Medicare Advantage products only.</td>
</tr>
<tr>
<td><strong>Certified/Certification</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>The Centers for Medicare &amp; Medicaid Services (CMS)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>CMS Data Use Agreement</strong></td>
<td>As part of the Medicare contracts UnitedHealthcare maintains with CMS, the company is required to attest annually that it will...</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>only use CMS data and their systems for</td>
<td>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.</td>
</tr>
<tr>
<td>the administration the Medicare managed</td>
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<td>care and/or outpatient prescription drug</td>
<td></td>
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<tr>
<td>benefit programs.</td>
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<tr>
<td>Coaching Request</td>
<td>The documentation in PCL of all coaching interaction between the manager/supervisor or BDE and an agent/agency. See also Service Request.</td>
</tr>
<tr>
<td>Code of Conduct</td>
<td>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.</td>
</tr>
<tr>
<td>Code of Conduct</td>
<td>The Code of Conduct applies to all employees, directors, and contractors and represents a core element of the Company’s compliance program.</td>
</tr>
<tr>
<td>Code of Conduct</td>
<td>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.</td>
</tr>
<tr>
<td>Code of Conduct</td>
<td>• Act with Integrity: Recognize and address conflicts of interest.</td>
</tr>
<tr>
<td>Code of Conduct</td>
<td>• Be Accountable: Hold yourself accountable for your decisions and actions. Remember, we are all responsible for Compliance.</td>
</tr>
<tr>
<td>Code of Conduct</td>
<td>• Protect Privacy. Ensure Security: Fulfill the privacy and security obligations of your job. When accessing or using protected information, take care of it.</td>
</tr>
<tr>
<td>Cognitive Impairment/Cognitive Ability</td>
<td>The consumer’s capacity to understand, assemble and reason based on the information provided including a decline in memory and thinking skills.</td>
</tr>
<tr>
<td>Cognitive Impairment/Cognitive Ability</td>
<td></td>
</tr>
<tr>
<td>Cognitive Impairment/Cognitive Ability</td>
<td>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.</td>
</tr>
<tr>
<td>Cognitive Impairment/Cognitive Ability</td>
<td></td>
</tr>
<tr>
<td>Cold Calling</td>
<td>The act of cold calling, including, but not limited to, telephone</td>
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### Section 9: Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
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<tbody>
<tr>
<td>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. (See also Unsolicited Contact and Door-to-Door Solicitation)</td>
<td></td>
</tr>
<tr>
<td><strong>Commission</strong></td>
<td><strong>Refer to Compensation.</strong></td>
</tr>
<tr>
<td><strong>Community Rating</strong></td>
<td>All members in the same rating class pay the same rate within a given territory and without medical underwriting (excludes discounts and surcharges). See also Issue Age Rating and Attained Age Rating.</td>
</tr>
<tr>
<td><strong>Compensation</strong></td>
<td>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, commissions, 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 appointments with consumers; and reimbursement for actual costs associated with sales appointments such as venue rent, snacks, and materials.</td>
</tr>
<tr>
<td><strong>Compensation Recovery (Charge Backs)</strong></td>
<td>Plan sponsors must recover compensation payments from agents under two circumstances: 1. The member disenrolls from the plan within the first three months of enrollment (rapid disenrollment), and Any other time a member is not enrolled in a plan but the plan sponsor had been paid compensation for that time period.</td>
</tr>
<tr>
<td><strong>Complaint</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Complaint Education Contact (CEC)</strong></td>
<td>A process to address agent behavior to prevent repeat complaint infractions through training and coaching.</td>
</tr>
<tr>
<td><strong>Compliance Investigations Unit (CIU)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Conflict of Interest</strong></td>
<td>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</td>
</tr>
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## Section 9: Glossary of Terms

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</thead>
<tbody>
<tr>
<td><strong>Consumer</strong></td>
<td>The customer, Medicare beneficiary, lead, or prospect for all products who is not currently enrolled in particular a UnitedHealthcare Medicare plan.</td>
</tr>
<tr>
<td><strong>Copayment</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Corrective Action Plan (CAP)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Corrective Action Referral (CAR)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Cost Sharing</strong></td>
<td>The amount a member pays for services or drugs received and includes any combination of a deductible, copayment or any coinsurance.</td>
</tr>
<tr>
<td><strong>Coverage Gap</strong></td>
<td>Most Medicare prescription 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.</td>
</tr>
<tr>
<td><strong>Credentialing</strong></td>
<td>Process of contracting, appointment, certification, and approval for an agent to sell any UnitedHealthcare Medicare products.</td>
</tr>
<tr>
<td><strong>Cross-Selling</strong></td>
<td>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 prohibited.</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Disciplinary Action Committee</strong></td>
<td>Committee responsible for determining appropriate disciplinary and/or correction action up to and including agent termination.</td>
</tr>
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### Section 9: Glossary of Terms

<table>
<thead>
<tr>
<th><strong>DAC</strong></th>
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<tbody>
<tr>
<td><strong>Distribution Channel (Sales)</strong></td>
</tr>
<tr>
<td>Categories of individuals or organizations that market and sell the Company’s products. UnitedHealthcare Medicare utilizes four distribution channels: Telesales, Internal Sales Representative (ISR), Independent Career Agent (ICA), and External Distribution Channel (EDC).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Door-to-Door Solicitation</strong></th>
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</thead>
<tbody>
<tr>
<td>The practice of <em>Unsolicited Direct Contact</em> for the purposes of marketing/selling any product in the UnitedHealthcare Medicare 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.</td>
</tr>
</tbody>
</table>

In-home and personal/individual marketing appointments *are allowed* if the following conditions are met:

- 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.

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. *See also* Cold-Calling and Unsolicited Contact.

<table>
<thead>
<tr>
<th><strong>Down-Line</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A term used to describe agents within an NMA or FMO hierarchy that are below the management/reporting level of a specific entity/agency.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Dual-eligible</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>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:</td>
</tr>
</tbody>
</table>

- 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.

*Note: QMBs, SLMBs, and QIs are automatically enrolled in the low-income subsidy program which provides assistance with prescription drug costs.*

### eAlliance
A UnitedHealthcare approved agency/organization operating a telephonic enrollment call center and/or electronic enrollment capability in the External Distribution Channel (EDC)

### 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.

### Educational Information
Communications free of plan specific information or marketing toward a specific plan.

### 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).

### External Distribution Channel (EDC)

One of four sales distribution channels that market and sell UnitedHealthcare Medicare products. The channel consists of contracted entities, including NMAs, agencies (FMO, 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.

### 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 portfolio of products through its network of down-line contracted and appointed agents. The FMO is the top level in its hierarchy structure.

### Finder’s Fee

See Referral/Finder’s Fee.

### 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).

### 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 products.
### Geographic Area
A specific region, state, county, or zip code.

### 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 down-line that is defined as part of the NMA 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
A HIPAA Privacy Statement must always be included on a fax cover sheet when sending PHI/PII via fax machine or electronic/desktop fax.

Sample HIPAA Privacy Statement:

> CONFIDENTIALITY NOTICE: Information accompanying this facsimile is considered to be UnitedHealthcare’s confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it is addressed. Such recipient shall be liable for using and protecting UnitedHealthcare’s information from further disclosure or misuse, consistent with applicable contract and/or law. The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including, but not limited to HIPAA. Individuals who misuse such information may be subject to both civil and criminal penalties. If you believe you received this information in error, please contact the sender immediately.

### Incentive
Refer to Compensation: ISR, sales management, Telesales.
## Section 9: Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inconclusive Allegation</strong></td>
<td>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).</td>
</tr>
<tr>
<td><strong>Independent Career Agent (ICA)</strong></td>
<td>A non-employee agent licensed, appointed, and contracted with UnitedHealthcare Insurance Company to solicit and sell the UnitedHealthcare Medicare portfolio of products. The ICA contract provides that they are exclusive for UnitedHealthcare Medicare Advantage products.</td>
</tr>
<tr>
<td><strong>Independent Marketing Organization (IMO)</strong></td>
<td>An agency model created to support field growth. IMO agencies are exclusive to UnitedHealthcare and the agents are captive to UnitedHealthcare.</td>
</tr>
<tr>
<td><strong>In-Home Appointment</strong></td>
<td>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. See also Out-of-Home Appointment and Personal/Individual Marketing Appointment.</td>
</tr>
<tr>
<td><strong>Initial Coverage Election Period (ICEP)</strong></td>
<td>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 Part A and Medicare Part B and ends on the later of:</td>
</tr>
<tr>
<td></td>
<td>1. The last day of the month preceding entitlement to both Medicare Part A and Medicare Part B, or;</td>
</tr>
<tr>
<td></td>
<td>2. The last day of the consumer’s Medicare Part B initial enrollment period.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Internal Sales Representative (ISR)</strong></td>
<td>A UnitedHealthcare employee who is appointed (if applicable) to solicit and sell UnitedHealthcare Medicare products in the field.</td>
</tr>
<tr>
<td><strong>Jarvis</strong></td>
<td>The agent website that provides access to product, commission, and resource information. The agent’s central point of communication and sales distribution resources.</td>
</tr>
<tr>
<td><strong>Knowledge Central</strong></td>
<td>A portal that houses information, materials, and documents. It is</td>
</tr>
</tbody>
</table>
**Section 9: Glossary of Terms**

<table>
<thead>
<tr>
<th>Term</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>the primary source of information, materials, and documents for</strong></td>
<td>Telesales agents.</td>
</tr>
<tr>
<td><strong>Late Enrollment Penalty (LEP)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Lead</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>LEAN Office (formerly eModel Office)</strong></td>
<td>An electronic enrollment tool available to authorized External Distribution Channel (EDC) offices to convert paper enrollment applications submitted by their down-line agents to an electronic format for submission to UnitedHealthcare.</td>
</tr>
<tr>
<td><strong>Learning Management System (LMS)</strong></td>
<td>Online training and certification portal. UnitedHealthcare’s LMS is LearnSource (formerly ULearn).</td>
</tr>
<tr>
<td><strong>License</strong></td>
<td>A certificate giving proof of formal permission from a governmental authority to an agent to sell insurance products within a state.</td>
</tr>
<tr>
<td><strong>Logo</strong></td>
<td>A mark or symbol that identifies or represents a company, business, product, and/or brand.</td>
</tr>
<tr>
<td><strong>Low Income Subsidy (LIS)</strong></td>
<td>A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.</td>
</tr>
<tr>
<td><strong>Marketing Materials</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
| **Marketing/Sales Events - Formal and Informal** | 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...
<table>
<thead>
<tr>
<th><strong>Master General Agent (MGA)</strong></th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicaid</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
| **Medicare**                  | A federal government health insurance program for:  
• 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) |
<p>| <strong>Medicare Advantage “Medical Only” Plan – MA Only</strong> | A Medicare Advantage Plan with only medical coverage. It does not have an integrated Medicare Part D prescription medication benefit. |
| <strong>Medicare Advantage Plans</strong>  | 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. |
| <strong>Medicare Advantage Prescription Drug - MA-PD</strong> | A Medicare Advantage Plan that integrates Medicare Part D prescription drug benefits with the medical coverage. |
| <strong>Medicare Beneficiary</strong>      | One who receives Medicare. Referred to as “consumer” or “member” (see separate definitions) throughout this document. |</p>
<table>
<thead>
<tr>
<th><strong>Glossary of Terms</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare-</strong></td>
<td>One who is entitled to Medicare Part A and eligible for Medicare Part B.</td>
</tr>
<tr>
<td><strong>Medicaid Plan (MMP)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Medicare Part A</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Medicare Part B</strong></td>
<td>The part of Medicare that provides help with the cost of physician visits and other medical services.</td>
</tr>
</tbody>
</table>
| **Medicare Part C** | Medicare Part C Plans are referred to as Medicare Advantage Plans.  
- 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. |
| **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 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 |
### Section 9: Glossary of Terms

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Medicare Supplement policy</td>
<td>The plan can and is sold to members in Medicare Part D (not MA-PD) Plans. Also referred to as “Medigap”.</td>
</tr>
<tr>
<td>Member</td>
<td>The enrollee, Medicare beneficiary, or customer who is currently enrolled in a UnitedHealthcare Medicare Advantage Plan, Prescription Drug Plan, and/or Medicare Supplement plan.</td>
</tr>
<tr>
<td>Member-Only Educational Event</td>
<td>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.</td>
</tr>
<tr>
<td>Minimum Data Set (MDS)</td>
<td>A form that the nursing home is required to complete and submit to Medicare for each resident upon admission, on a quarterly basis or with significant changes. The MDS contains a significant amount of demographic and medication assessment information.</td>
</tr>
<tr>
<td>Monthly Plan Premium</td>
<td>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.</td>
</tr>
<tr>
<td>National Marketing Alliance (NMA)</td>
<td>An independent marketing organization that is licensed, appointed, and directly contracted with UnitedHealthcare Insurance Company to solicit and sell the UnitedHealthcare Medicare portfolio of products through its network of down-line licensed, certified, and appointed agents. The NMA is the top level in its hierarchy structure.</td>
</tr>
<tr>
<td>Network</td>
<td>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.</td>
</tr>
<tr>
<td>New Agent</td>
<td>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.</td>
</tr>
<tr>
<td>National Insurance Producer Registry (NIPR)</td>
<td>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.</td>
</tr>
<tr>
<td>Nominal Value</td>
<td>Items or services worth $15 or less based on the retail purchase price.</td>
</tr>
<tr>
<td>Non-Captive Agent</td>
<td>A licensed, certified, and appointed, non-exclusive independent</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>contractor who solicits and sells any UnitedHealthcare Medicare product. For example, a UnitedHealthcare EDC agent.</td>
<td>Non-Complaint</td>
</tr>
<tr>
<td>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.</td>
<td>Non-Licensed Representative</td>
</tr>
<tr>
<td>A non-licensed individual, who represents UnitedHealthcare in triaging inbound Telesales calls or taking telephonic enrollments and other related activities, but who is prohibited from performing solicitation or selling activities. In addition to taking telephonic enrollments, the representative can set appointments, process sales event RSVPs, and provide basic benefits statements per CMS regulations.</td>
<td>Non-Resident License</td>
</tr>
<tr>
<td>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.</td>
<td>Not-For-Cause Termination</td>
</tr>
<tr>
<td>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.</td>
<td>Original Medicare</td>
</tr>
</tbody>
</table>
| One of the consumer’s health coverage choices when they become eligible for Medicare.  
  - 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 (OEV)                                                                                                       |
| Outbound letter sent by the plan to consumers who recently enrolled in a Medicare Advantage plan to ensure consumers requested enrollment into a plan by agents/brokers and they understand the plan benefits, costs, and plan rules. | Out-of-Network Provider                                                                                                                         |
| 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. | Party ID                                                                                                                                         |
| A number assigned by ALM that provides primary identification of an individual. All writing numbers assigned to the individual are tied to their Party ID. |
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<td>Permission to Call (PTC)</td>
<td>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.</td>
</tr>
<tr>
<td>Pended Commission</td>
<td>A commission for the sale of a policy that cannot be paid as a result of one or more impedance.</td>
</tr>
</tbody>
</table>
| Personally Identifiable Information (PII) | PII is a person’s first name or first initial and last name in combination with one or more of the following:  
- 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. |
<p>| 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 | A type of MA Plan in which the member can use either network |</p>
<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Organization - PPO</td>
<td>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.</td>
</tr>
<tr>
<td>Premium</td>
<td>The amount paid by a member to participate in a plan or program. Includes LEP, LIS reductions, Employer Subsidy reductions, and rider premiums.</td>
</tr>
<tr>
<td>Prescription Drug Plan - PDP</td>
<td>A stand-alone plan that offers Medicare Part D prescription medication coverage only.</td>
</tr>
<tr>
<td>Primary Care Physician - PCP</td>
<td>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.</td>
</tr>
<tr>
<td>Prior Authorization - PA</td>
<td>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.</td>
</tr>
<tr>
<td>Producer</td>
<td>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, MGA, GA, ICA, ISR, Broker, Solicitor or Telesales representative.</td>
</tr>
<tr>
<td>Producer Contact Log (PCL)</td>
<td>A contact management system used to document agent/agency interactions with the PHD and/or sales managers/supervisors or BDEs.</td>
</tr>
<tr>
<td>Producer Help Desk (PHD)</td>
<td>A UnitedHealthcare call center whose purpose is to provide support to all agents with issues that pertain to the agent experience.</td>
</tr>
<tr>
<td>Protected Health Information (PHI)</td>
<td>PHI is individually identifiable information (including demographics) that relates to health condition, the provision of care, or payment of such care.</td>
</tr>
<tr>
<td>Provider</td>
<td>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.</td>
</tr>
<tr>
<td>Quality Call Monitoring</td>
<td>A monitoring program evaluating telephonic enrollment conversations between a Telesales agent and the consumer to...</td>
</tr>
<tr>
<td>Glossary of Terms</td>
<td>Definition</td>
</tr>
<tr>
<td>------------------</td>
<td>------------</td>
</tr>
<tr>
<td><strong>Quantity Limits - QL</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Rapid Disenrollment</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Ready to Sell</strong></td>
<td>An agent has met the certification requirements for their channel in order to market/sell for the plan year.</td>
</tr>
<tr>
<td><strong>Referral – Medical</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Referral – Sales</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Referral/Finder’s Fee</strong></td>
<td>UnitedHealthcare does not pay employee or 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.</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Renewal Compensation</strong></td>
<td>For EDC and ICA agents, 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.</td>
</tr>
<tr>
<td><strong>Renewal Eligible Agent</strong></td>
<td>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-</td>
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<tr>
<td><strong>Section 9: Glossary of Terms</strong></td>
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| **2014** | The agent must be contracted, 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. |
| **Sales Distribution** | An organization comprised of various distribution channels that market and sell UnitedHealthcare Medicare portfolio of products. |
| **Sales Incentive Plan** | Employed agents are paid an incentive when specific sales goals have been met. In order to be paid an incentive, the agent must meet all conditions set forth within their Sales Incentive Plan (SIP) in effect at the time. Employed agents should refer to their SIP for details. |
| **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 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. *See also Coaching Request.* |
| **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 formerly A360 Daily Onboarding** | A tool that resides on the QlikView portal that provides licensing, appointment, and certification status information on agents and sales management. |
| **SMRT Compliance formerly A360 Compliance** | A tool that resides on the QlikView portal that provides a holistic view of each agent, NMA, or manager. The compliance programs reporting tool is refreshed daily and manager threshold evaluation data is refreshed monthly. |
| **Skilled Nursing** | Skilled Nursing Facility. |
## Section 9: Glossary of Terms

| Facility (SNF) | A licensed, certified, and appointed agent who sells designated UnitedHealthcare Medicare products through a contract with an agency (NMA, FMO, MGA and GA), but does not have a direct contract with UnitedHealth Group. |
| Solicitor | 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 medical conditions (Chronic Condition SNP), or those who reside in the community but who qualify to live in a nursing facility (Institutional Equivalent SNP). |
| Star Ratings Program | 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. 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](http://www.medicare.gov), or checking Plan websites. |
| 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. |
| Successor Agent | The active agent who becomes the Agent of Record (AOR) for the original agent’s book of business. |
| 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... |
## Section 9: Glossary of Terms

<table>
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<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Telemarketing</td>
<td>A firm or individual employed by a firm who telephonically contacts consumers on behalf of UnitedHealthcare for the purpose of soliciting or selling designated UnitedHealthcare Medicare products. Telemarketing activities may include lead generation, appointment setting, and/or product marketing.</td>
</tr>
<tr>
<td>Telesales Agent</td>
<td>A licensed, certified, and appointed agent who telephonically solicits and sells designated UnitedHealthcare Medicare products in a call center environment. May be an employee of UnitedHealthcare or an employee of a delegated vendor.</td>
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<tr>
<td>Tier</td>
<td>Covered brand name and generic medications have various levels of associated member cost-sharing.</td>
</tr>
<tr>
<td>Trademark</td>
<td>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.</td>
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<tr>
<td>Trend</td>
<td>At an individual agent level, a trend or “look-back” is defined as number of inconclusive complaints in the same category on a 12-month rolling basis while under an active contract with UnitedHealthcare or a NMA. Corrective action and active management/oversight of complaints will occur on a concurrent basis to include enrollee/member counseling and outreach, agent, NMA re-training and certification or possible suspension or termination.</td>
</tr>
<tr>
<td>Trend (for Telephonic Quality Monitors)</td>
<td>A pattern or percentage change in errors 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.</td>
</tr>
<tr>
<td>True Out-of-Pocket Expense (TrOOP)</td>
<td>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.</td>
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<tr>
<td>TTY</td>
<td>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.</td>
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## Section 9: Glossary of Terms

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<td>UnitedHealthcare Government Programs formerly Public and Senior Markets Group of UnitedHealth Group (PSMG)</td>
<td>A term used internally within the Company to collectively refer to the benefit businesses of UnitedHealthcare Medicare &amp; Retirement, UnitedHealthcare Community &amp; State, and UnitedHealthcare Military &amp; Veterans.</td>
</tr>
<tr>
<td>UHIC</td>
<td>UnitedHealthcare Insurance Company</td>
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<tr>
<td>Unlicensed Representative</td>
<td>See Non-Licensed Representative.</td>
</tr>
<tr>
<td>Unsolicited Contact</td>
<td>Solicitation of a consumer for the purpose of marketing any UnitedHealthcare Medicare product via door-to-door, telephone, email, voice and text message without the prior explicit permission from the consumer. See also Cold Calling.</td>
</tr>
<tr>
<td>Unsubstantiated Allegation</td>
<td>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.</td>
</tr>
<tr>
<td>Unsuccessful Event</td>
<td>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.</td>
</tr>
<tr>
<td>Up-Line</td>
<td>The contracted entities within an NMA hierarchy that are above the management/reporting level of a specific agent/agency.</td>
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<tr>
<td>Vendor</td>
<td>An entity whose purpose is to perform activities as specified by UnitedHealth Group under mutual agreement.</td>
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<tr>
<td>Writing Number</td>
<td>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. Also known as Writing ID. See Agent ID.</td>
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