EDC
Agent Guide

United Healthcare®

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This Guide is intended for agent use only.

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Welcome to UnitedHealthcare

Thank you for doing business with UnitedHealthcare! You play an important role in helping us achieve our mission of providing innovative health and well-being solutions for Medicare consumers so they can 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

As a trusted agent, we expect you to share our commitment to compliance and to act with integrity by putting the best interest of consumers first in everything you do on behalf of UnitedHealthcare. As a result, 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 sales leader.

Consider this guide your resource to serve consumers. We are honored to serve as your reliable health coverage choice. We strive to provide you with a hassle-free experience and to give members a superior health care experience.

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 – an appropriately licensed, certified, and appointed (as required by the state) 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 (as required by the state) 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

You must be appropriately contracted, licensed, appointed (as required by the state), and certified in order to market or sell any UnitedHealthcare Medicare Plans product including Standalone Dental, Vision, Hearing plans.

Contracting

You must align under a top level up-line (e.g., a National Marketing Alliance (NMA), Strategic Marketing Organization (SMO), or eAlliance organization) approved and contracted with UnitedHealthcare. You may only align in one hierarchy at any given time.

Your top level up-line organization initiates the contract submission process by providing contracting paperwork to you to obtain necessary on-boarding information and documentation. Your top level up-line 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.
- Background Check Authorization Form – 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.
- 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 will be active in the marketing/sales of UnitedHealthcare Medicare Plans products including Standalone Dental, Vision, Hearing plans. 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 top level up-line 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 top level up-line a Party ID Notification Letter.

Certification

You must complete certification requirements annually 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 (Learning Lab) within ***Jarvis***. You must successfully pass all base level 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 a third party certification credit are given credit for the Medicare Basics assessment. Agents must still complete the remaining Base Level assessments (i.e. Ethics and Compliance and AARP) in order to sell non-special needs Medicare Advantage (MA) plans, Prescription Drug Plans (PDP), Medicare Supplement Insurance plans, and Standalone Dental, Vision, Hearing plans.

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 (when applicable and allowed by law), 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 via email 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 will receive a 30-day termination notice (this termination includes agencies of these principals, if the principal does not authorize the background investigation).
- The periodic background investigation review follows the same process outlined in the Initial On-Boarding section above, except credit history information is not collected. 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
  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.
  - 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.

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

Appeal of Decline Due to Background Investigation

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 emailed to the Agent Lifecycle Management Department:

UnitedHealthcare
Attention: Agent Lifecycle Management
Email: big.notifications@uhc.com

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 to you that describes your right to a second appeal and the process. The applicable top level up-line 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 and field sales 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 top level up-line.
- 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 to you. The applicable top level up-line receives a copy of the notification letter.
- The decision of the Background Tier II 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 appointed (as required by the state) in all states you are active in the marketing/sales of UnitedHealthcare Medicare Plans products including Standalone Dental, Vision, Hearing plans. Failure to be appropriately appointed (as required by the state) is subject to corrective and disciplinary action up to and including termination.

State Appointment Requests

- When all contracting and certification requirements have been met, ALM will submit state appointment requests for each state requested on the Relationship Hierarchy Addendum.
- For JIT states, ALM will submit appointment requests after receipt of the first enrollment in that state.
  - If approved, you will be appointed in the state and may be eligible for commission on eligible enrollments.
  - If denied, you are responsible for addressing and meeting all state requirements within the timeframe prescribed by the state. If you do not meet the state requirements within the prescribed timeframe, you will not be appointed in that state and will not be eligible for commissions on eligible enrollments.
  - Select states allow for appointments to be considered valid if the appointment is active within a defined number of days (defined by the state) from the enrollment application. If the state appointment is eligible, the appointment active date for that state will be assigned based on the state tolerance and the actual appointment active date.

On-Boarding and Agent Readiness Fees

Appointment Fees (EDC Only)

- 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 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
Any EDC agent/agency (not including solicitors or eAlliance) who had an active writing number at any time during the recurring 12-month evaluation period (i.e. the period begins the first full month an agent's writing number was issued* and ends 12 months later) and did not write at least one MA plan, PDP, Medicare Supplement plan, or Standalone Dental, Vision, Hearing plan enrollment application (i.e. submitted and approved active member application) will be assessed a $200 administrative fee.

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 top level up-line. You are expected to confirm state appointment approval via ***Jarvis*** prior to conducting any marketing/selling activities in that state.

Agent/Agency Level, Alignment, or Channel Change Requests

For all changes in contracting level, hierarchy, or channel, residual override commissions are retained by the hierarchy in place at the time of the original sale and do not follow the moving agent/agency.

- Release and Notice of Intent to Move Requirements
  When an agent/agency contracted with UnitedHealthcare or a solicitor under an agency wants to align under a new hierarchy or change channels, a Letter of Release or Notice of Intent to Move is required unless the change results in an employment relationship with UnitedHealth Group or its affiliate or a telesales vendor contracted with UnitedHealthcare.
  - ~ Release Process
    - For an EDC agent/agency/solicitor, only the highest contracted entity in the agent/agency/solictor's current hierarchy (or UnitedHealthcare if applicable) may, at its discretion, provide the agent/agency with a full release to leave the hierarchy (even if the agent/agency self-terminated within six months of submitting new contract paperwork).
    - Upon receipt of the release, the agent/agency/solicitor may move to a new channel or hierarchy. While there is no waiting period to contract under a new hierarchy or channel, ALM does not process contracting change requests during a blackout

period that runs annually September 1 through December 31. The new contracting packet, which must include the Letter of Release, must be received by ALM no later than August 31 in order to align under the new hierarchy or channel by the start of the Annual Election Period (AEP).
    - The agent/agency may only move to a contracting level equal to or lower than their current contract level and must stay at that level for a minimum of one year. Solicitors may only move to the same contracting level or agent contracting level and must stay at that level for a minimum of one year.
    - If the current top level up-line (or highest upline agency or UnitedHealthcare, if applicable) will not provide a release, the agent/agency may terminate their agreement with UnitedHealthcare or up-line (for solicitors) and contract under a different top level up-line or field-based channel, at the same or lower contract level no less than six months after their termination effective date. Normal contracting rules apply. Refer to the Termination Section for termination details and treatment of the agency's down-line.
- Notice of Intent to Move Process
    - All eligible agents or agencies may use the Notice of Intent to Move process.
    - You must be in your current channel and under your current top level up-line and/or in your current hierarchy level for at least six months prior to submitting a Notice of Intent to Move and can only change channels or EDC or IMO hierarchy once every 12 months from the effective date of your current agreement or hierarchy change, whichever occurred most recently.
    - You must email your Notice of Intent to Move to UnitedHealthcare at shcerts@uhc.com and 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 to Move, UnitedHealthcare will send a reply letter to you, with a copy to the current top level up-line and intended top level up-line or applicable UnitedHealthcare sales leader if moving to the ICA or IMO channel, indicating the date when the 90 Day waiting period expires.
    - A 90 Day 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 90 Day waiting period, you decide to move to a different entity than indicated in the Notice of Intent to Move, you must submit a new notice, which begins a new 90 Day waiting period.
    - Once the Notice of Intent to Move is submitted to the current up-line, the current 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.
        - 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 Election 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 to Move, which begins a new 90 Day waiting period.

- Solicitor Release Request
  To align under a new hierarchy or move to a different channel, the solicitor must obtain a release from the highest level contracted entity in their up-line.
  - For a solicitor under an agency, the solicitor must follow the release process outlined above.
  - For a solicitor under an eAlliance or telephonic addendum, the solicitor is deemed released as of their employment termination date with the eAlliance or telephonic addendum. The solicitor may only move to the same level contract or agent contracting level and must stay at the level for a minimum of a year.

Non-Employee Field-Based Agent or Agency Hierarchy Change or Move to Different Field-Based Channel

To align under a new hierarchy or move to a different field-based channel you must be active with UnitedHealthcare, submit a Letter of Release or Notice of Intent to Move as required, and when aligning under a new top level up-line or IMO, the new top level up-line or IMO must be active with UnitedHealthcare.

- Agent/Agency Agreement and Writing Number
  - 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 before being eligible for a promotion.
  - A new agent/agency agreement is not required unless you are changing levels or channels.
  - The new top level up-line or UnitedHealthcare sales leader for moves to the ICA or IMO channel must submit required paperwork to ALM, which may include a signed agreement, Relationship Hierarchy Addendum, and W9.
  - If release/Notice of Intent to Move and contracting requirements are met, ALM will deactivate your current writing number, issue a new writing number, and execute a new Agent or Agency Agreement, if applicable, with the Chief Sales Distribution Officer's signature. A Welcome Letter containing the new writing number and copy of the executed Agent or Agency Agreement, if applicable, is emailed to you, with a copy of the Welcome Letter sent to the new top level up-line, IMO, or applicable UnitedHealthcare sales leader. Note: Commission will not be paid on any enrollment when an inactive writing number was indicated on the application.
- Treatment of Down-line Entities
  - All down-line agents will move with the agency.
  - Upon receipt of the Notice of Intent to Move, ALM will temporarily freeze releases and hierarchy movement (promotions within existing structure are allowed) for down-line agents until the move is approved or not.
  - If paperwork requirements are met, the down-line entity's current writing number is inactivated, 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.

Non-Employee Field-Based Agent Move to DTC Sales (Internal or Vendor) Channel

Any non-employee field-based agent who is hired by UnitedHealth Group or its affiliate for an internal sales role (e.g. Direct to Consumer (DTC) Sales) or is hired by a DTC Sales vendor contracted with UnitedHealthcare is deemed released from their prior hierarchy as of their date of hire with UnitedHealth Group or its affiliate or the vendor. The agent's contract must be terminated prior to the date of hire.

Servicing Status and Successor Programs

Servicing Status - Non-Active Renewable Eligible Non-Employee Agent

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) plan and Prescription Drug Plan (PDP) with an effective date on or after 01/01/2014. 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):
  - Electronically 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 the Servicing Attestation 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 Plans products, including Standalone Dental, Vision, Hearing plans, 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 plan and PDP with an effective date on or after 01/01/2014 will permanently cease as of the servicing status termination date.

Successor Agent Program – Renewal Eligible Non-Employee (excludes eAlliance and Telephonic Addendum agencies)

- When all eligibility requirements are met, contracted non-employee agents may request UnitedHealthcare transfer their entire UnitedHealthcare book of business to a successor agent, who agrees to accept and service the original agent's book of business and oversee down-line agents, where applicable.
- Eligible products include all UnitedHealthcare Medicare Plans products, including Standalone Dental, Vision, Hearing plans, and states except for SecureHorizons Medicare Supplement Insurance Plans and Golden Rule plans.
- Original Agent Eligibility and Terms of Agreement
  - Original Agent must be in status with UnitedHealthcare as defined below:
    - For MA plan and PDP enrollments with effective dates prior to 01/01/2014, Original Agent must be in any status other than termed for cause or death;
    - For MA plan and PDP enrollments with effective dates on or after 01/01/2014, 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 and Standalone Dental, Vision, Hearing plans 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 sign the "UnitedHealthcare Medicare Plans 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 their book of business is contingent on their down-line hierarchy, if any, also being transferred to Successor Agent. Standard Release Rules apply.
  - Original Agent's rights related to their 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 their business that is not eligible to be transferred will continue and survive the termination of their Agent Agreement.
  - Original Agent's current debt related to the transferred business is to be paid in full or transferred to Successor Agent upon transfer of the book of business. Debt repayment plans are not allowed.
  - If Original Agent is the assignee of another agent's commission, the assignment of commissions agreement will be terminated.

- Minimum Successor Agent Eligibility and Terms of Agreement
  - Successor Agent must have an active contract (i.e. Successor Agent must not be in servicing status at the time they enter the successor agent agreement) with UnitedHealthcare. Standard release rules apply.
  - Successor Agent must be licensed and appointed (as required by the state) in each state in which a currently enrolled MA Plan or PDP member resides and certified in the product type(s) (e.g. MA plan, 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 Medicare Plans Successor Agent Agreement" and agree to the following terms:
    - Successor Agent agrees to accept and service Original Agent's entire eligible book of business and oversee, where applicable, down-line agents transferred to Successor Agent's hierarchy to receive renewal commission/up-line payments.
    - Successor Agent will take on any future charge back debt related to the transferred book of business.
  - 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 Medicare Plans 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 (excludes eAlliance and Telephonic Addendum agencies)

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 Plans products, including Standalone Dental, Vision, Hearing plans, 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 plan and PDP enrollments with effective dates prior to 01/01/2014, Deceased Agent must have been in any status other than termed for cause or death;
    - For MA plan and PDP enrollments with effective dates on or after 01/01/2014, 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 and Standalone Dental, Vision, Hearing plans 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.
  - ~ 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 they enter the successor agent agreement) with UnitedHealthcare. Standard release rules apply.
  - ~ Successor Agent must be licensed and appointed (as required by the state) in each state in which a currently enrolled MA Plan or PDP member resides and certified in the product type(s) (e.g. MA plan, 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 Medicare Plans Successor Agent Agreement" and agree to the following terms:
  - Successor Agent agrees to accept and service Deceased Agent's entire eligible book of business and accept and oversee, where applicable, down-line agents transferred to Successor Agent's hierarchy to receive a renewal commission/up-line payments. UnitedHealthcare reserves sole discretion to remove Successor Agent as Agent of Record (AOR) and to discontinue paying Successor Agent if it is determined that Successor Agent is not servicing the member.
  - Successor Agent agrees that outstanding debt related to the transferred business will also be transferred to Successor Agent. They also will take on any future charge back debt related to the transferred book of business.
- ~ 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 6 months of Deceased Agent's death. If UnitedHealthcare is not properly notified within 6 months 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 7 months from the date of death to identify a potential successor agent who agrees to the terms of the "UnitedHealthcare Medicare Plans Successor Agent Agreement."
    - UnitedHealthcare will work first with Deceased Agent's next of kin/estate to identify a successor agent.
    - If next of kin/estate does not wish to help identify a successor agent, UnitedHealthcare will next work with Deceased Agent's up-line to identify a successor agent.
    - If no successor agent is established and/or no successor agent agreement is signed within 7 months 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 Medicare Plans Successor Agent Agreement" may be executed with the Successor Agent and the original agent's estate representative.
  - ~ 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.

Successor Agent Program Appeal Process

An appeal process is offered to agents who are declined or otherwise determined to be ineligible for the Successor Agent program.

- 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)

- Appeals are forwarded for consideration to the Successor Agent Approval Board (SAAB), which includes senior-level distribution operations and field sales 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.

Non-Employees Who Become Employee Individuals

If a non-employee becomes an employee of UnitedHealth Group, they must be aware of the following:

An employee of UnitedHealth Group or its affiliate must not be simultaneously in an active non-employee contractual relationship with UnitedHealthcare (e.g., an employee is contracted as an ICA or EDC agent) or another carrier. Employees may maintain, at the discretion of UnitedHealth Group, a contracted and/or certified status as an ICA or EDC agent with UnitedHealthcare or another carrier in order or maintain renewal income earned prior to becoming an employee. The employee is not permitted to write new business under the contract.

Certification Program

The UnitedHealthcare Medicare Plans 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 one study guide for all certifications and assessments. 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.

Certification may consist of the following elements:

- Pledge of Compliance agreement.

- Base Level certification requirements which include Medicare Basics (MA Non-SNP, PDP, and Medicare Supplement), Ethics and Compliance, and AARP.
- Next Level product certification which may be offered in; Dual (D-SNP), Chronic (C-SNP), Institutional* (I-SNP), and Institutional Equivalent* (IE-SNP) Special Needs Plans; Senior Care Options* (SCO) plans; Events Basics. *Certification in I-SNP, IE-SNP, SCO product, and UnitedHealthcare Connected for One Care is by invitation only. Note: Next Level certifications are not required to complete certifications. However, agents who will market/sell these plans must complete the corresponding Next Level product certification.

When you pass or are given credit for the field Medicare Basics assessment, you must still pass the remaining Base Level assessments (i.e. Ethics and Compliance and AARP) in order to be able to sell non-special needs MA plans, stand-alone PDPs, Medicare Supplement Insurance plans, and Standalone Dental, Vision, Hearing plans.

An individual is considered portfolio certified when they are product certified in MA plans, PDP, Medicare Supplement Insurance plans, CSNP, and DSNP.

Medicare Basics, Ethics and Compliance, and Next Level product assessments have a minimum passing score of 85%. The AARP assessment has a minimum passing score of 70%. Six attempts are permitted to pass an assessment. If you fail to pass a base level assessment within the allotted six attempts, you are prohibited from marketing/selling any product in the UnitedHealthcare Medicare Plans portfolio including Standalone Dental, Vision, Hearing plans for the applicable plan year. Next Level assessments are only accessible after passing Base Level assessments. 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. Additionally, you cannot attempt to complete a third party certification program upon failure of the UnitedHealthcare Medicare Basics course as a way to avoid the six failure limit.

Events Basics is an elective module. In order to participate in a marketing/sales event or be identified as the presenter of the event, individuals must have received credit for Events Basics.

External Vendor Certification Courses

- UnitedHealthcare may accept and give credit for successful completion of a third party's certification program. Gaps in course content remain the responsibility of you.
- UnitedHealthcare currently accepts and provides partial certification credit to agents who pass select third party certification programs. To receive credit, you must transfer your passing score within six attempts **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 Program section above for details). If you fail to pass a third party certification program within six attempts, you are not permitted to restart the certification process through UnitedHealthcare and are not permitted to sell any UnitedHealthcare Medicare Plans products including Standalone Dental, Vision, Hearing plans for the applicable plan year.
- The accepted third party certification programs and minimum passing scores are as follows:
  - ~ America's Health Insurance Plans (AHIP) annual certification course with a minimum score of 90% within six attempts.
  - ~ National Association of Benefits and Insurance Professionals (NABIP) with a minimum score of 85%.

An optional Fast Track Assessment is available to eligible agents. Applicable for EDC agents and agencies, ICA agents and IMO agencies, Telephonic Addendum (TA) agents, DTC Sales agents, UnitedHealthcare Retiree Solutions (URS) agents, eAlliance agents, and solicitors. DTC Sales vendor agents and Captive eAlliance agents are not eligible.

- All eligibility requirements are as of the measurement date (The measurement date for 2026 certifications will be in May of 2025). Agents must meet the following requirements:
  - Premier producers must have 12 or more months of tenure.
  - Field agents/agencies (EDC, ICA, and IMO), eAlliance agents, TA Agents, and Solicitors must have two consecutive years of selling, 20 or more approved MA plan or Medicare Supplement Insurance plan applications within the last two years (for principals and agents who have sales under both their individual writing ID and agency writing ID, agents must have a combined application production of 20 or more approved applications), and no more than one complaint point in the last year.
  - DTC Sales and URS agents must have one full sales year and no more than one complaint point.
- The Fast Track Assessment will certify the agent to market/sell MA plan, PDP, Medicare Supplement Insurance plan, Standalone Dental, Vision, Hearing plan, DSNP, CSNP, and report and conduct events.
- The Fast Track Assessment has a minimum passing score of 85% within two attempts.
- If you are eligible and want to take the Fast Track option, the Fast Track option must be attempted prior to attempting the standard option. If a standard assessment is failed, the Fast Track option is no longer available.
- If the Fast Track option is failed in two attempts, you may still attempt the standard option.

You must access certification program materials using your assigned log in IDs and passwords and must take and complete assessments on your own behalf. You 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. If you are found to have used assistance in completing an assessment, you will be subject to discipline up to and including termination with cause.

UnitedHealthcare certification materials are produced in written English and Spanish 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, 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

Individuals must be appropriately product certified prior to conducting any marketing/sales activities. 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).

Writing Agent

- Non-employee Agents/Agencies
  - The agent must successfully pass all Base Level 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 a third party certification credit are given credit for the Medicare Basics assessment. Agents must still complete the remaining Base Level assessments (i.e. Ethics and Compliance and AARP) in order to sell non-special needs Medicare Advantage (MA) plans, Prescription Drug Plans (PDP), Medicare Supplement Insurance plans, and Standalone Dental, Vision, Hearing plans.
  - Non-employee agents authorized to market/sell SCO must be SCO product certified for the plan year prior to conducting marketing/sales activities for SCOs.

Non-Writing Individual

- Servicing Status Agents
  Must pass upcoming plan year field Medicare Basics and Ethics and Compliance assessments by December 31.

Individuals Participating in Marketing/Sales Events

- Individuals must have received credit for Events Basics for the plan year prior to participating in or being reported as the presenting agent for a formal or informal, in-person or online marketing/sales event.
- The presenting agent must have received credit for Events Basics at the time the event is reported. (Refer to the Educational and Marketing/Sales Activities and Events section for event reporting requirements).

Validation, Reporting, and Monitoring

- You can verify your own certification status and history through ***Jarvis*** (via Manage Profile > Certifications), Learning Lab, or by contacting the PHD.
- The learning and development and certification operations departments monitor the certification program. Quality indicators have been established and are reviewed on a quarterly basis to ensure that certifications are effective and meet company standards. Quality indicators that are measured may include:
  - Receiving and soliciting feedback including ratings on content, structure, understanding, usability, and value of courses.
  - Knowledge evaluations are conducted through the administration of assessments that have been developed by subject matter and learning experts to sample the key areas of knowledge necessary and required CMS elements to perform the job successfully and compliantly.
  - Activity metrics (e.g., length of time, frequency of access, frequency of assessment taking attempts, average scores) may be reviewed to ensure effectiveness of instruction and measurement of achievement. These metrics are available in the learning management system (Learning Lab) report tracking system.

Requests for Certification Related Information

- Agent or up-line requests for certification related information should be directed to the PHD via Jarvis Chat.

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.

Training Resources

- UnitedHealthcare makes Learning and Development trainings available.
- All UnitedHealthcare Learning and Development training resources are produced in English. Some content is also available in Spanish.
- Some recorded trainings/videos may include closed captioning or will be available in a non-audio format.

Agent Profile

- All individuals and entities with an active Party ID must provide and maintain a unique email address on file with UnitedHealthcare Agent Lifecycle Management (ALM). Use of a shared email address is prohibited. Email addresses can be updated in Jarvis or by emailing UHPCred@uhc.com.
- All individuals and entities with an active Party ID must provide and maintain a unique cell phone number on file with UnitedHealthcare. Use of a shared cell phone number is prohibited. Cell phone number can be added/updated via Jarvis.

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. All communication methods must be conducted in compliance with federal and state laws governing business data use and consent requirements for calls/text where applicable.

Communication Method

Email (including, but not limited to, JarvisWrap newsletters) and ***Jarvis*** (including, but not limited to, ***Jarvis*** notifications) are the primary methods of communication used by UnitedHealthcare to communicate with agents.

All entities with an active Party ID must provide and maintain a unique email address on file with UnitedHealthcare Agent Lifecycle Management (ALM). Use of a shared email address is prohibited. Email addresses can be updated in ***Jarvis*** or by email UHPCred@uhc.com.

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)

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

Communication Management

JarvisWrap

JarvisWrap is distributed to you weekly. Many of the articles from JarvisWrap will be available on ***Jarvis***.

Email (External)

Sales Communications uses email as a means of communicating to agents.

ECard

ECards are written by the Sales Communication team and provided to internal Sales Leaders to send from their own inbox. The emails come from the Sales Leader and are sent to agents.

Jarvis **Notifications**

Jarvis notifications, sent from the Sales Communications team, will be published to alert ***Jarvis*** users (agents) to important information such as member status changes, plan updates, and more. These are in the ***Jarvis*** Notification Center on ***Jarvis***.

Disclosing Proprietary Information and External Engagement

- 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.

Section 3: What Communications are Available to Help Me?

- You must comply with the UnitedHealth Group External Engagement policy and Non-Endorsement policy. Refer to the UnitedHealth Group corporate policies or contact your UnitedHealthcare sales leader for details.
- You must not use any UnitedHealth Group name, logo or trademark for advertising, publicity, or to suggest any endorsement, affiliation or sponsorship of any third-party product or service without prior approval from UnitedHealth Group.
- Prior to accepting an external engagement opportunity, you must follow the UnitedHealth Group approval process. External opportunities include conferences, events, panels, media requests, webinars, interviews, podcasts, statements for public policy organizations and research firms, published material for industry expertise (books, research papers, health care policy papers) and self-promoted content.
- You must engage your UnitedHealthcare sales leader for all external engagement opportunities that may include any UnitedHealth Group or its affiliate's name, logo, or trademark. If you are not representing UnitedHealthcare or do not include any UnitedHealth Group or its affiliate's name, logo, or trademark, the permission to participate requirement does not apply.

Section 4: Agent/Agency Materials, Websites, and Social Media

Materials

Websites and Social Media

Media Engagements

Materials

It is UnitedHealthcare policy to comply with federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules related to the development and use of communications materials, marketing materials, and UnitedHealth Group branded materials.

Material Definitions and Types:

Communication Materials

Communications means activities and use of materials to provide information to current and prospective consumer/member. This means all activities and materials aimed at prospective and current consumer/member.

- Communication materials that do not feature any UnitedHealthcare or AARP brand elements do not require UnitedHealthcare approval prior to use.
- UnitedHealthcare branded communication materials require UnitedHealthcare review and approval prior to use.
- Communication materials must not contain any AARP brand elements.

Marketing Materials

Marketing is a subset of communications and must, unless otherwise noted, adhere to all communication requirements. To be considered marketing, communications materials must meet both intent and content standards. In evaluating the intent of an activity or material, CMS will consider objective information including, but not limited to, the audience, timing, and other context of the activity or material, as well as, other information communicated by the activity or material.

- Intent includes materials or activities that are intended to:
  - ~ Draw a consumer/member's attention to a plan or plans;
  - ~ Influence a consumer/member's decision-making process when making a plan selection; or
  - ~ Influence a consumer/member's decision to stay enrolled in a plan (e.g., retention-based marketing).
- Content includes materials or activities that include or address content regarding:
  - ~ A plan's benefits, benefits structure, premiums, or cost sharing;
    - Any material or activity that meets intent and content standards that is distributed via any means that mentions any benefits will be considered marketing.
    - High level mention of plan benefits (e.g., vision, dental, and hearing) will be considered marketing.
    - The use of prescription drugs listed as a benefit will be considered marketing. However, there may be instances where the use is deemed communications (e.g., defining PDP as a Prescription Drug Plan).
  - ~ Measuring or ranking standards (e.g., Star Ratings or plan comparisons); or
  - ~ Rewards or incentives.

Material Rules and Requirements

- All communications and marketing materials must comply with state and federal laws and regulations and UnitedHealthcare policies, procedures, and rules, including but not limited to, Permission to Contact and consent to share consumer data.
- 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 2026 plan year must not be distributed prior to 10/01/2025. 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 period (e.g., aging-ins, special enrollment period) and materials clearly indicate what plan year is being discussed. 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 MA plan and PDP with an effective date of October 1, November 1, or December 1 due to a Special Enrollment Period or a consumer "ages-in" to Medicare due to an Initial Coverage Election Period).

- Medicare Supplement communication and marketing materials promoting AARP Medicare Supplement plans offered by UnitedHealthcare require approval by UnitedHealthcare prior to use and are filed with and approved by the individual state departments of insurance.
- Agents must receive approval from UnitedHealthcare prior to creating any material featuring the UnitedHealthcare brand. Refer to the Exception Process section.

Material Submission Requirements

- All marketing materials and designated communication materials must be submitted to CMS through the CMS Health Plan Management System (HPMS) for review. Materials may only be submitted into HPMS by UnitedHealthcare or individuals who have been granted access to the UnitedHealthcare MA/PDP contracts in HPMS.
  - All marketing materials (as defined by CMS) must be reviewed and approved by UnitedHealthcare prior to filing in HPMS and selecting any UnitedHealthcare MA and PDP contract(s).
  - All multi-carrier marketing material that may be used to generate a lead for or may result in an enrollment in a UnitedHealthcare MA plan or PDP must be submitted to UnitedHealthcare for prospective review and approved prior to filing in HPMS and selecting UnitedHealthcare MA/PDP contracts. Downline agents and agencies (except for Telephonic Addendum agencies) are not permitted to submit marketing materials to UnitedHealthcare and should work with their highest-level agency in their hierarchy.
  - You are not permitted to submit marketing materials to UnitedHealthcare and should work with your highest-level agency in your hierarchy.
- UnitedHealthcare does not review MA or PDP communications materials unless CMS requires that the communication material be reviewed by CMS. However, communications materials must be compliant in order to represent UnitedHealthcare.

Material Content Guidelines

- Materials must be compliant and used in a compliant manner.
- Materials must not provide information that is inaccurate, misleading, confusing, or could misrepresent UnitedHealthcare.
- Materials must not claim that they are recommended or endorsed by CMS, Medicare, or the Department of Health & Human Services (DHHS).
- Materials must not use superlatives, unless sources of documentation or data supportive of the superlative is also referenced in the material. Such supportive documentation or data must reflect data, reports, studies, or other documentation that applies to the current or prior contract year. Including data older than the prior contract year is permitted provided the current and prior contract year data are specifically identified.
- Materials must not 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.

- Materials must not contain disparaging comments, urgency statements, or scare tactics.
- Materials must not use the Medicare name, CMS logo, and products or information issued by the Federal Government, including the Medicare card, in a misleading way. Use of the Medicare card image is permitted only with authorization from CMS. The email containing CMS' approval to use the Medicare card image in the identified material must accompany the material filed in HPMS.
- Materials must not use symbols, emblems, images, color schemes, names (including acronyms), words, letters, or any other combination or variation in reference to Medicare, CMS, Social Security Administration, Department of Health and Human Service, Medicaid, or any other government entity on 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 the agent, business, or content mentioned is connected to, recommended, approved, endorsed, or authorized by the government entity.
- Materials must not include information about savings available to potential enrollees that are based on a comparison of typical expenses borne by uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a Medicare consumer.
- Materials must include all required disclaimers and statements. Disclaimers must be displayed in a font size, color, and style that is reasonably readable by the average consumer in the intended audience. The minimum standard for disclaimer font is 12-point Time New Roman (or equivalent).
- Unless prior written approval from UnitedHealthcare has been received, TPMO created multi-plan marketing materials must not include any benefit that is a Special Supplement Benefit for the Chronically Ill (SSBCI) for a UnitedHealthcare plan.
- Marketing materials must not advertise benefits that are not available to consumers in the service area(s) where the marketing appears, unless the advertisement is in local media that serves the service area(s) where the benefits are available and reaching consumers who reside in other service areas is unavoidable.
- The UnitedHealthcare name may only be listed on a marketing material when a UnitedHealthcare plan is available in the geographic area where the marketing material is distributed (e.g., zip code or county), UnitedHealthcare must have a plan available that includes the benefit mentioned, and any cost mentioned must be applicable for the benefit or plan UnitedHealthcare offers.
  - The UnitedHealthcare name must be one word, with a capitalized "U" and "H", with the registration mark, and only black font.
  - The UnitedHealthcare name must be in 12-point font in print and may not be in the form of a disclaimer or fine print.
  - For television, online, or social media, the UnitedHealthcare name must be either read at the same pace as the phone number or must be displayed throughout the entire advertisement in a font size equivalent to the advertised phone number, contact information, or benefits.
  - For radio or other voice-based advertisements, the UnitedHealthcare name must be read at the same pace as the advertised phone numbers or other contact information.
- Emails
  - Email subject lines must accurately reflect the content of the email and must not be deceptive.
  - Email header information must clearly and accurately identify the individual/business sending the email and must not contain false or inaccurate information.
  - Emails must identify the message as an advertisement.

- Emails must include the sender's mailing and/or physical address.
- Emails must include an opt-out/unsubscribe function.

- Text messages must contain an opt-out/unsubscribe function.
- 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 are prohibited.
  - Agent must accurately state their relationship to UnitedHealthcare and provide an accurate title that reflects the intent of the contact with the consumer. The agent titles listed below are approved by UnitedHealthcare but is not an exhaustive list of all potentially compliant agent titles. UnitedHealthcare has approved the following agent titles based on the agent's sales channel for proper representation to consumers/members:
    - All channels: Licensed Sales Agent, Licensed Sales Representative, Sales Agent, Sales Representative
    - EDC: Independent Sales Agent, Independent Sales Representative. Their up-line name may be added if desired.
    - EDC Premier Producer: May include with a compliant agent title their status as a Premier Producer with UnitedHealthcare. Agents that do not meet the requirements for the Premier Producer status must not use the Premier Producer designation.
    - eAlliance: Licensed Insurance Representative
  - If an agent title is not listed, agents may submit the proposed agent title for consideration to compliance_questions@uhc.com.

TPMO Requirements

TPMOs as defined by CMS must comply with TPMO disclaimer and disclosure requirements. All entities and individuals contracted directly with UnitedHealthcare are considered first tier, downstream or related entities (FDRs) and, therefore, TPMOs. TPMOs also include any entity contracted or subcontracted by an FDR that provides services to UnitedHealthcare or UnitedHealthcare's FDR, including solicitors.

- TPMOs must comply with all disclaimer and disclosure requirements, including but not limited to, the standardized TPMO disclaimers. The TPMO disclaimer is not required for emails and websites only containing communication content.
- TPMOs must use, where applicable, a standardized disclaimer that states:
  - If a TPMO does not sell for all MA organizations in the service area the disclaimer consists of the statement: "We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program to get information on all of your options."
  - If the TPMO sells for all MA organizations in the service area the disclaimer consists of the statement: "Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program for help with plan choices."
- The TPMO disclaimer must be as follows:
  - Used by any TPMO that sells plans on behalf of more than one MA organization.
  - Verbally conveyed within the first minute of a sales call.

  - Electronically conveyed when communicating with a consumer through email, online chat, or other electronic means of communication.
  - Prominently displayed on TPMO websites.
  - Included in any marketing materials, including print materials and television advertisements, developed, used, or distributed by the TPMO.
- Any lead generating material must include a disclosure to the consumer/member that their information will be provided to a licensed agent for future contact. The disclosure must be conveyed using the same manner as the interaction (i.e. written for mail or other paper methods and electronically when communicating through email, online chat, or other electronic messaging platform) and prominently displayed on TPMO websites.
- Effective 10/01/2024 and for consumer data collected prior to 10/01/2024 that will be transferred to another TPMO on or after 10/01/2024, materials used to obtain consumer data that will be transferred to another TPMO must contain a clear and conspicuous disclosure that lists each TPMO receiving the data and allows the consumer to consent or reject to the sharing of their data with each individual TPMO.
- TPMOs must disclose to UnitedHealthcare all subcontracted relationships used for marketing, lead generation, and enrollment activities. TPMOs must complete and submit the TPMO Subcontracted Relationship Submitting Form accessible via ***Jarvis*** for each subcontractor used for marketing, lead generation, and enrollment activities. TPMOs must disclose when a subcontracted relationship ends by completing a new Form that reflects the updated Contract End Date.

UnitedHealthcare Branded Materials
UnitedHealthcare provides preapproved materials and templates to ensure consistency of branding and messaging, legal and regulatory compliance, and when applicable, third-party approval. All materials made available and/or provided by UnitedHealthcare are copyrighted and shall remain property of UnitedHealthcare.

You must:
- Be appropriately contracted, licensed, appointed (as required by the state), and certified in order to access and order preapproved materials through the UHC Agent Toolkit. Your access is limited to the products and/or plan in which you are licensed and certified to sell.
- Use your secure log on to access, download, and/or order materials through the Sales Material Portal and UHC Agent Toolkit. Preapproved materials for acquired entities may require ordering through the entity's sales office.
- Use preapproved materials in the format approved (e.g., advertisements that are only approved for use as print material cannot be used in a digital format).

You may:
- At your discretion and without further approval, use preapproved materials provided by UnitedHealthcare so long as the materials are not altered and used in a manner consistent with all applicable regulations and UnitedHealthcare policy.

You must not:
- Share log on credentials with or provide materials to an agent who is not appropriately contracted, licensed, appointed, and certified.
- Alter preapproved materials in any way, including handwritten notes (e.g., agent contact information) or (e.g., a particular plan benefit). However, you may encourage the

consumer to make notes on the material or add handwritten notes in the presence of the consumer or with the consumer's consent.

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 materials that references or uses a UnitedHealthcare brand, plan information, or logo in any manner must be submitted for approval. Use of agent-created materials featuring a UnitedHealthcare brand, plan information, or logo without prior written approval by UnitedHealthcare is prohibited.

Request for approval of agent/agency created branded material, the development of custom branded material, or the modification of pre-approved materials are processed as follows:

AARP Branded Materials

- Requests for approval of agent/agency created materials, including agent recruitment activity, using any AARP brand name, logo, mark, or branded product name will not be considered.

External Distribution Channel (EDC)

- You must work through your highest level up-line to request a material exception to UnitedHealthcare. Your up-line must work with a UnitedHealthcare sales leader to submit the request to the UnitedHealthcare Field Marketing team for consideration.

The UnitedHealthcare Field marketing team member will only consider requests if all of the following requirements are met:

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

If all of the criteria above are met, the UnitedHealthcare Field Marketing team will coordinate all requests with Compliance, Legal, and other internal reviewers as required. You will be notified if the piece is approved for distribution. Meeting all criteria does not guarantee the request will be approved.

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

Prior to use, you will need to abide by the usage guidelines provided by UnitedHealthcare Field Marketing, which is based on the compliance, legal, and internal review requirements.

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

Websites and Social Media

Agent/Agency Created Websites and Social Media Accounts

General Guidelines
You are solely responsible for the compliance of your agent/agency created websites and social media accounts. In addition to all federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules, the following guidelines apply:

You Must:
- Be active, licensed, appointed (as required by the state), and certified with UnitedHealthcare in order to announce affiliation with UnitedHealthcare on your website, to download and use designated UnitedHealthcare or AARP branded resources available explicitly for use on Facebook, or to feature any UnitedHealthcare or AARP approved brand elements or branded resources. Agents in servicing status or who are inactive must remove all brand elements or branded resources no later than their termination date.
- Comply with all TPMO Requirements. Refer to the TPMO Requirements section for details.
- Refer to the Agent Website and Social Media Guidelines job aid for additional details on agent/agency created websites and social media accounts.

You May
- Display non-carrier branded communication materials and content.

You Must Not
- Feature any hyperlinks to any UnitedHealthcare company or affiliate website page except as noted in the Agent/Agency Created Websites and Social Media Accounts sections.
- Post or repost any UnitedHealthcare owned or provided content or material, such as, material available on Jarvis, the UHC Agent Toolkit, or Sales Materials Portal, or distributed by UnitedHealthcare via email, postal mail, or instructional or informational sessions (in-person or virtual), except:
  - Material/Content that is pre-approved explicitly for use on a website or an approved social media platform, or
  - Sharing or liking of content from the UnitedHealthcare or MMC official Facebook account or YouTube channel.

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. In addition to abiding with all policy guidelines, the following guidelines apply:

You Must

- Obtain permission from UnitedHealthcare to operate a website that contain marketing content prior to submitting the website for prospective review (refer to the Material Submission requirement section). Down-line agencies, agents, and solicitors are not permitted to operate a website that contains marketing content.
- Register with UnitedHealthcare any agent/agency created website that contains an affiliation announcement with UnitedHealthcare.
- Have UnitedHealthcare approval on all marketing content related to UnitedHealthcare plans. UnitedHealthcare at its discretion may permit select contracted entities to feature UnitedHealthcare marketing material and plan information on their website. If approved, UnitedHealthcare will file the website containing marketing content related to a UnitedHealthcare plan with CMS for approval.
- 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.
  - ~ UnitedHealthcare company name
  - ~ UnitedHealthcare-provided logo
  - ~ Hyperlink to a UnitedHealthcare-approved website homepage
  - ~ AARP web banner, only if you are a current A2O Elite 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 with these guidelines.
- Post a compliant electronic business reply card (eBRC) or online contact form to obtain consumer contact information and permission to contact.
- Feature a mechanism to obtain express written consent to share consumer data with other TPMOs
- On agent-facing websites only, 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 with UnitedHealthcare.
- 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.
- Reference "AARP" or display any AARP logo, brand, or product name, except as a pre-approved AARP web banner. The AARP web banner is available to Authorized to Offer (A2O) Elite agents. You must refer to the Agent Website and Social Media Guidelines Job Aid for details.
- Alter the approved logo (except for proportional resizing) or AARP web banner in any way.

Section 4: Agent/Agency Materials, Websites, and Social Media

Agent/Agency Created Social Media Accounts

Your use of social media as a communications or marketing tool, including, but not limited to Facebook, LinkedIn, YouTube, X, blogs, chat rooms and message boards is subject to state and federal regulations and UnitedHealthcare rules, policies, and procedures. In addition to abiding with all policy guidelines, the following guidelines apply:

You Must

- Use a business account, not a personal or multi-purpose (i.e. personal and business) account to conduct business on behalf of UnitedHealthcare on any social media platform.

You May

- Feature pre-approved social media assets available on the UHC Agent Toolkit.
- Link to a compliant agent created business website.
- Share (e.g., post a link, posting the unmodified original post) or like content from the official UnitedHealthcare (www.facebook.com/UnitedHealthcare, www.youtube.com/UnitedHealthcare) or Medicare Made Clear (www.facebook.com/medicaremadeclear, www.youtube.com/medicaremadeclear) Facebook account or YouTube channel on an agent created website or Facebook account.
  - Agents/Agencies may only link to videos from the official YouTube channels and must not embed videos.
  - Unless pre-approved, agents must not share or like content that meets the definition of marketing material (e.g., contains plan benefit information).
  - Agents/Agencies must not add content that features the UnitedHealthcare brand elements, meets the definition of marketing material or is misinformation or misleading content.
  - Agents/Agencies must not modify pre-approved content or UnitedHealthcare original content and must not distribute content through unsolicited contact.
- Feature an online contact form on a business Facebook account. The online contact form must be part of a Facebook advertisement created using the Facebook advertisement creator and comply with all applicable rules, regulations and guidelines.

You Must Not

- Feature the AARP brand name, logo, branded materials or post a link to any AARP website.
- Feature the UnitedHealthcare brand name, logo, or branded material except as a pre-approved social media asset and/or approved sharing or liking content from the approved official UnitedHealthcare social media accounts. Note: Premier Producer agents may use the UnitedHealthcare brand name, provided messaging, and tag UnitedHealthcare on LinkedIn.

Monitoring and Corrective Action

Agent/Agency and third-party materials are monitored to ensure they are compliant and used in a compliant manner. Agent use of any UnitedHealthcare or AARP logo, brand, material, and language is monitored to ensure they are used in an approved and compliant manner.

Created materials may be reviewed by UnitedHealthcare retrospectively.

Section 4: Agent/Agency Materials, Websites, and Social Media

UnitedHealthcare Brand 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 and State Departments of Insurance (DOI) may monitor websites that contains UnitedHealthcare information. CMS or a state DOI may notify UnitedHealthcare of any website violations pertaining to Medicare products and UnitedHealthcare will then notify the website owner and the UnitedHealthcare sales leader or up-line of any CMS or state DOI identified website violations.

UnitedHealthcare Website/Social Media Monitoring
UnitedHealthcare expects agents/agencies and their 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 Sales Oversight will conduct outreach when a website/social media infraction has been identified.
- UnitedHealthcare Sales Oversight will forward to UnitedHealthcare Medicare & Retirement Legal 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.
- UnitedHealthcare Sales Oversight will maintain results of website/social media reviews on a SharePoint site.

Corrective Action

- Agents/Agencies 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/Agencies 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.

Section 5: How do I Conduct Educational & Marketing/Sales Activities?

Educational and Marketing/Sales Activities and Events

It is UnitedHealthcare policy to comply with federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules when engaging or participating in Communication Activities including educational events and/or Marketing Activities including marketing/sales events. Compliance extends to any providers, vendors, or third-party organizations or individuals.

Outreach Activities General Guidelines

The following guidelines apply to in-person, online, or telephonic educational or marketing/sales activities or events.

You must:

- Be appropriately contracted, licensed, appointed (as required by the state), and certified in order to conduct any educational or marketing/sales activity or event on behalf of UnitedHealthcare.
- Comply with all state and federal regulations and UnitedHealthcare policies, procedures, and rules related to the development and use of communications and marketing materials.
- Include all required disclaimers on all advertisements and invitations to events, including but not limited to “For accommodations 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.”
- Obtain permission from the venue or applicable authority to conduct an in-person event.
- Comply with Permission to Contact (PTC) guidelines (refer to the PTC section).
- Comply with the consent to share consumer data guidelines.
- Comply with Scope of Appointment (SOA) guidelines (refer to the SOA section).
- Ensure all consumer Protected Health Information (PHI)/Electronic Protected Health Information (ePHI) and Personally Identifiable Information (PII) information is protected and secure (refer to the Privacy and Security section).
- Keep agent and non-agent activities separate when participating in non-agent events/activities (e.g., volunteering at a food bank).

You 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 cloth with the plan name and logo displayed.
- Wear a shirt and/or badge with approved plan names and/or logos (e.g., purchased from UnitedHealth Group Merchandise eStore accessible via ***Jarvis***).
- Make available and receive consumer contact information, business reply card, or sign-in sheet and/or distribute compliant business cards free of any plan marketing or benefit information.
- Attach compliant business cards or agent contact information to communication materials or 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 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 (refer to the Gifts and Meals section for additional information).

You Must Not:

- Engage in unsolicited contact (e.g., proactively approach or engage the consumer at an informal (table/booth/kiosk) setting).
- Provide cash gifts, including cash equivalents, gifts easily converted to cash, or charitable contributions made on behalf of a consumer regardless of dollar amount (refer to the Gifts and Meals section for additional information).
- 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”), disparaging statements, urgency statements, or scare tactics.
  - ~ Claim to be recommended, approved, endorsed, or authorized by CMS, Medicare, the Department of Health & Human Services (DHHS), Medicaid, or any other government entity.
  - ~ Use of the term “free” to describe zero-dollar premium, reduction in premiums, reduction in deductibles or cost sharing, low-income subsidy (LIS), or cost sharing for individuals with dual eligibility.
- 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.
- Target consumers based on income level or health status, unless it is a dual eligible Special Needs Plan (SNP) or comparable plan.
- State or imply that plans are available to seniors and not all Medicare-eligible consumers.
- State or imply that an MA plan operates as a supplement to Medicare.
- State or imply a plan is available only to or designed for consumers who are dually eligible unless it is a dual eligible SNP or comparable plan.
- Market a non-dual eligible SNP as if it were a dual-eligible SNP.
- Target marketing efforts primarily to dual-eligible consumers unless the plan is a dual-eligible SNP or comparable plan.
- 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.
- Require a consumer to provide any name or contact information with the exception of an email address for an online event to RSVP or receive event-specific details, as a prerequisite for attending or participating during 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.
- Wear UnitedHealthcare branded apparel at an event that is not an educational/marketing/sales event or is not a UnitedHealthcare sponsored event (e.g., volunteering at food distribution event).

- 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.

Third-Party Marketing Organization (TPMO) Outreach Requirements

TPMOs as defined by CMS must comply with TPMO call recording, disclaimer, and disclosure requirements. All entities and individuals contracted directly with UnitedHealthcare are considered first tier, downstream or related entities (FDRs) and, therefore, TPMOs. TPMOs also include any entity contracted or subcontracted by an FDR that provides services to UnitedHealthcare or UnitedHealthcare's FDR, including solicitors.

- TPMOs must record in their entirety all marketing, sales, and enrollment calls, including the audio portion of calls via web-based technology.
- TPMOs must retain recordings for a minimum of 10 years, and make the recordings available upon request. TPMOs must protect consumer/member PHI/ePHI/PII and the recording and storage of calls must meet UnitedHealthcare security requirements. Refer to the Privacy and Security section for guidelines.
- TPMOs must comply with all disclaimer and disclosure requirements, including but not limited to, the standardized TPMO disclaimers.
- TPMOs must use, where applicable, a standardized disclaimer that states:
  - If a TPMO does not sell for all MA organizations in the service area the disclaimer consists of the statement: "We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program to get information on all of your options."
  - If the TPMO sells for all MA organizations in the service area the disclaimer consists of the statement: "Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program for help with plan choices."
- The TPMO disclaimer must be as follows:
  - Used by any TPMO that sells MA plans on behalf of more than one MA organization unless the TPMO sells all commercially available MA plans in a given service area, and by any TPMO that sells Part D plans on behalf of more than one Part D Sponsor unless the TPMO sells all commercially available Part D plans in a given service area.
  - Verbally conveyed within the first minute of a sales call.
  - Electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication.
- TPMOs must comply with lead generation disclosure requirements. Refer to the Lead Generation section for TPMO lead generation disclosure requirements.
- TPMOs must comply with Permission to Contact guidelines.
- TPMOs must comply with consent to share consumer data.

Educational Events

Educational events are designed to inform Medicare consumers about Original Medicare, Medicare Advantage plans, Prescription Drug Plans, 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.

Section 5: How do I Conduct Educational & Marketing/Sales Activities?

In addition to all other regulations, rules, policies, and procedures, the following guidelines apply to educational events:

- When promoting or advertising the event, you must advertise or promote the event as educational or in a manner that would lead consumers to believe that it is explicitly for educational purposes.
- You must not 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:
  - ~ Distribute or display marketing materials.
  - ~ Distribute or collect Scope of Appointment (SOA) forms.
  - ~ Distribute or collect enrollment applications.
  - ~ Discuss plan-specific premiums and/or benefits.

You may:

- Make available and collect consumer contact information (including Business Reply Cards (BRC)).
- 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, visit the plan website, or complete a BRC 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 (refer to the Gifts and Meals section for additional information).
- 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/Sales Events and Appointments

Marketing/sales events and appointments 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. The following are types of marketing/sales events and appointments:

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, over the phone, or online. All individual appointments between an agent and a consumer/member are considered marketing/sales appointment regardless of the content discussed.

In addition to all other regulations, rules, policies and procedures, the following guidelines apply to marketing/sales activities, appointments, and events:

Section 5: How do I Conduct Educational & Marketing/Sales Activities?

You must:

- If marketing materials are used, the marketing materials must be approved by UnitedHealthcare and filed in HPMS prior to use.
- Use UnitedHealthcare approved plan materials to present information on UnitedHealthcare plans.
- Use the most current marketing materials, including scripts, sales presentations, and enrollment materials, unless allowed otherwise.
- Use UnitedHealthcare provided materials for the intended purpose and without modifications.
- Provide plan related materials upon consumer request. Materials may be provided in any available format requested by the consumer.
- For informal and formal marketing/sales events, agents must::
  - ~ Have received credit for Events Basics 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 Events Basics.
  - ~ Report all informal and formal events to UnitedHealthcare according to the process outlined 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.
  - ~ Clearly announce at the beginning of the presentation your name and title, the company you represent, and the product/plan type (e.g., HMO, MA, MA-PD, PDP, PFFS, POS, PPO, and SNP) that will be covered during the presentation.

You must not:

- Charge a consumer/member any type of marketing fee in order to conduct marketing/sales activities.
- 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.
- Market and/or sell outside of eligible periods (e.g., marketing for a new plan year prior to October 1). Marketing, selling, or distributing plan materials outside of eligible marketing periods is prohibited and is subject to corrective and/or disciplinary action up to and including termination.
- 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.
- 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 SOA, 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 a meal to attendees.
- For informal or formal marketing/sales events you must not:
  - ~ 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 their clinical team and receive treatment (including, dialysis treatment facilities) and pharmacy counter areas.
- Conduct an in-person marketing/sales event within the same location (i.e. the entire building or adjacent building) within 12 hours of an educational event. Virtual marketing/sales events may be conducted immediately following a virtual educational event as long as each meeting link is distinct and clearly identifies the event type.

You may:

- 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.
- Invite consumers to or accept a RSVP for a future marketing/sales event.
- Schedule future personal/individual marketing appointments, including completing and collecting SOA forms.
- Provide a nominal gift and refreshments to attendees with no obligation.
- Distribute compliant brochures and enrollment materials.
- Hand out business cards.
- Provide and/or discuss plan specific information (e.g., premiums, cost sharing, or benefits) during a valid marketing and election period. 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.
- Include educational information or an educational component to marketing/sales activities, appointments, or events.
- 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.
- 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 SOA. Examples of health-related products include medical, dental, prescription, and long-term care.
- For a formal event when only one consumer is present, offer to the consumer the option of conducting the event in a sit-down style, similar to a personal/individual marketing appointment, rather than in an audience-presenter format. However, you must still complete a full presentation of the reported plan.

Informal Educational or Marketing/Sales Events

In addition to all other regulations, rules, policies, and procedures related to educational and marketing/sales activities, the following guidelines apply to informal educational and marketing/sales activities:

You 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/ePHI/PII.

You 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 you will be available.

You 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, health care, and/or plan educational content and may be provided by the agent conducting the event or a non-licensed individual such as a provider (all rules related to provider-based activities apply).

Marketing/Sales Appointments

In addition to all other regulations, rules, policies, and procedures related to marketing/sales activities, the following guidelines apply for marketing/sales appointments:

- 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 plan and PDP enrollments, the consumer must have an Enrollment Guide at the time of enrollment. For a Medicare Supplement plan enrollment, the enrollment kit must be provided to the consumer prior to enrollment. Field agents must provide an Enrollment Guide for MA plan or PDP plan presentation. MA plan or PDP information may be provided in-person or via postal mail or email. Enrollment information must be provided for Medicare Supplement plan presentations. Medicare Supplement enrollment information may be provided in-person or via postal mail or with consumer permission via email or text. You may add your writing number to the enrollment application prior to providing the Enrollment Guide to the consumer.
- 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. 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.

Online Events and Appointments

In addition to all other regulations, rules, policies, and procedures related to educational and marketing/sales activities, the following guidelines apply for online events and appointments:

- UnitedHealthcare is online meeting provider agnostic and does not promote, endorse or approve one online meeting provider over another.
- You must take steps to protect consumers during an online interaction, including but not limited to, requiring an event password, muting attendee's lines, and disabling cameras when applicable.
- You must meet a consumer's accessibility need, such as closed captioning features, a sign language interpreter, providing materials in advance, and telephonic participation.

Online Events

You are permitted to conduct online formal educational and marketing/sales events. The following guidelines apply for online events:

You must not:

- Conduct an online informal event.
- Complete an enrollment during an online event.

- Create a resource by recording a live online event. A recorded online event is considered a marketing material and is subject to all rules, including required submission to CMS.

You may:

- Use the Medicare Made Clear® presentation.
- Allow consumers to utilize the online meeting chat function to ask questions or interact with the agent.
- Provide your contact information via the online meeting service provider chat/survey/poll function and advise the consumer may contact you to schedule a future appointment.
- Obtain PTC in a compliant manner. For example, you may provide compliant call-to-action – Permission to Contact text in the online meeting chat. You must collect any PTC provided from the online meeting service provider. All PTC guidelines including retention apply.

Online UnitedHealthcare facilitated formal marketing/sales online events

The following guidelines apply for UnitedHealthcare facilitated formal marketing/sales online events.

- All events must be approved by and scheduled with a UnitedHealthcare sales leader or business development manager online using Zoom as the service provider. Approval is at the discretion of the UnitedHealthcare sales leader or business development manager.
- Upon approval, the UnitedHealthcare sales leader or business development manager must schedule the Zoom and provide the Zoom URL to you. You must coordinate with your UnitedHealthcare sales leader or business development manager to report the event (including the Zoom URL in the Venue field) in UnitedHealthcare's event reporting application (refer to the event reporting section for details).
- Prior to advertising the event, you must have approval to conduct the event and secure a date and time for the event.
- The event must be advertised using pre-approved material from the UHC Agent Toolkit, which must contain all required disclaimers. You must update the pre-approved RSVP communication template available on the UHC Agent Toolkit with event-specific details.
- The event must be facilitated by a UnitedHealthcare sales leader, business development manager, or an agent selected and provided with a Zoom host key. An agent selected to facilitate the online event using Zoom must ensure they are prepared with the meeting date and time, meeting ID, passcode, and the host key.
- You must have access to Mira. Alternatively, the UnitedHealthcare sales leader or business development manager must manage all leads produced from the online event in Mira on behalf of the agent who does not have a Mira account.
- When a consumer calls to RSVP, the agent:
  - ~ May request permission to contact (PTC) for future contact.
  - ~ Must create or have created on their behalf an opportunity in Mira for each consumer that RSVPs and provides PTC.
- During the event, you must use pre-approved presentation materials available on the UHC Agent Toolkit and/or Sales Materials Portal and may only customize/personalize to the extent permitted in the UHC Agent Toolkit or Portal.
- You must not contact attendees using a Zoom roster. The roster is considered the same as a sign-in sheet used at an in-person event, which does not provide PTC.

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 operation 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 SOA from the consumer prior to discussing any Medicare Advantage and/or Prescription Drug Plan (Refer to the SOA section).
- 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 as noted within this guide 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).

Gifts and Meals/Refreshments

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 agents 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 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 does 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).
- 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, cash equivalent, 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 and Sales 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.

- Contests, Drawings, and Games
  Event guidelines vary on whether the winner of a contest, drawing, or game is awarded a prize. Any prize awarded, regardless of value, creates a responsibility on the agent's part.
  - No Prize Awarded
    Agents may conduct in-person or online BINGO games or conduct drawings without obtaining approval from UnitedHealthcare and completing Rules of Entry documentation requirements when no prize will be awarded to a contest winner. Examples of acceptable acknowledgement of a winner include applause or certificate.
  - Prize Awarded
    - Non-UnitedHealthcare-branded Event
      - External Distribution Channel (EDC) agents are responsible for ensuring compliance with all federal and state laws and regulations when conducting non-UnitedHealthcare-branded events during which a prize of any value will be awarded to a contest winner.
      - Agents must obtain written approval from UnitedHealthcare prior to reporting and conducting an event when a drawing will be conducted with a prize worth more than $15 by submitting a detailed contest proposal to compliance_questions@uhc.com at least 30 days prior to the anticipated event date to ensure event reporting requirements can be met. UnitedHealthcare approval of the proposed contest and prize does not constitute a compliance approval. The agent remains responsible for ensuring compliance with all applicable federal and state laws and regulations.
    - UnitedHealthcare-branded Event
      - Agents and sales leaders must obtain written approval from UnitedHealthcare prior to reporting and conducting an event where a prize of any value will be awarded to the winner of a contest, drawing, or game by submitting a detailed proposal to compliance_questions@uhc.com at least 30 calendar days prior to the anticipated event date.
      - If approved, the following requirements must be met:
        - The individual indicated as the "Presenting Agent" must complete, retain, and make available upon request a UnitedHealthcare Rules of Entry document (available via compliance_questions@uhc.com) for the applicable contest. AND
        - All requirements outlined in the Rules of Entry document must be met, including prize value limits, alternate means of entry option, posting the Rules of Entry document at in-person events and displayed or announced at online events, and limitation on use of consumer contact information.
        - If the awarded prize will be $30 or more in value, a liability waiver must be signed by the winner.

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 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, and other meal items.
- You must not provide any alcoholic beverages (e.g., beer, wine, or other alcoholic spirits) at any event.
- 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 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.

Marketing/Sales Event Reporting*
UnitedHealthcare requires all marketing/sales events, formal and informal, in-person and online be reported. Educational events 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 conduct unreported marketing/sales events or 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.

Note: Sales events reported by Market Point for the Multi-Carrier Program presenting Medicare Advantage products must be submitted to UnitedHealthcare in accordance with the requirements outlined in the "Multi-Carrier Program – Sales Events Submission and Reporting" agreement.

Note: National program participating retail partner events must be reported using the Retail selection on the New Event Request Form.

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 you and submitted to the Regional Operations Director (ROD) or Associate ROD for approval.

- After the ROD's/Associate ROD's 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 Manager of Agent Oversight and Agent Oversight Supervisor, 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 a Reported Marketing/Sales Event

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

- Change requests must be submitted to UnitedHealthcare using the CHANGE Event Request Form and entered into the event reporting application at least one business day prior to the scheduled date of the event.
- If the one business day requirement cannot be met, you must immediately contact your UnitedHealthcare sales leader 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.
- When a change occurs to the presenting agent, the new presenting agent must meet credential validation (i.e. licensed and appointed (as required by the state), in the state where the event will occur, certified in the product indicated, and has received credit for Events Basics) in order for the change request to process.
- The UnitedHealthcare sales leader is responsible for ensuring any necessary changes are made to reported events upon termination of an agent.
- 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 using the CANCEL Event Request Form and entered into the event reporting application at least one business day prior to the scheduled date of the event.
- If the one business day requirement cannot be met, you must immediately contact your UnitedHealthcare sales leader to discuss required action(s).
- The UnitedHealthcare sales leader is responsible for ensuring any necessary cancellations are made to reported events upon termination of an agent.
- Agents who fail to cancel an event or report cancellations late are subject to corrective and/or disciplinary action up to and including termination.
- Event cancellation due to inclement weather or other circumstances outside of your control (e.g. venue will not allow the agent to be present) must be approved by the regional Senior Vice President and the following process completed:
  - ~ You must submit an email request to AgentOversightAdmin@uhc.com and must include the completed CANCEL Event Request Form.

- ~ The email request will be forwarded to PHD to cancel the event in the event reporting application.
- ~ 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 UnitedHealthcare sales leader 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, you 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.

Request for a Sign Language Interpreter
Upon reasonable request by a consumer, UnitedHealthcare must provide a sign language interpreter at an in-person or online formal marketing/sales event or an in-person or online appointment at no charge to the consumer. UnitedHealthcare will take reasonable steps to fulfil requests. Available languages, services, and interaction methods may be subject to limitations or change. Alternate arrangements, such as rescheduling the appointment, requesting the consumer attend a different event, or changing the interaction method may be needed. Refer to the "Marketing to Consumers with Impairments or Disabilities" portion of this section for additional interpreter details.

Sign Language Interpreter Requests

- Requests (new or change) for a sign language interpreter must be submitted 14 or more calendar days prior to the event or marketing appointment. Urgent requests within 14 calendar days should be limited to rare and exceptional circumstances. UnitedHealthcare may attempt to accommodate urgent requests but fulfillment may not be feasible.

- Agents with access to Mira must enter the requests in Mira according to established process.
- Agents without access to Mira must submit a Sign Language Interpreter Request Form (accessible via ***Jarvis***) via email to the Producer Help Desk at asl@uhc.com.
- Within three business days after the request has been made, ASL services, Inc. will contact the agent to confirm the interpreter request and event/appointment logistics.
- To cancel an interpreter request, the agents with Mira access must close the contact in Mira. Agents without access to Mira must contact the PHD to cancel the appointment
- Cancellations with less than three business days' notice will be billable for the scheduled/appointment or a two-hour minimum.

Scope of Appointment

All personal/individual marketing appointments whether or not an enrollment results, require an SOA agreement. An SOA agreement is not required for consumers attending an educational or marketing/sales events.

- You must obtain a SOA agreement through compliant methods from each Medicare-eligible consumer (including any unexpected Medicare-eligible individuals present) within the prescribed timeframe prior to the start of a personal/individual marketing appointment (e.g., in-person, telephonic, online, pre-scheduled, spontaneous, and regardless of the venue) when a Medicare Advantage and/or Prescription Drug Plan may be discussed. When the SOA is recorded telephonically, each Medicare-eligible individual on the call must consent to the SOA. When using paper or electronic SOA forms, a separate SOA form must be obtained for each Medicare-eligible individual.
- The agreement for MA and/or PDP must capture the product types to be discussed, date of the appointment, the consumer contact information, the agent contact information, and a statement stating no obligation to enroll, current or future Medicare enrollment status will not be impacted, and automatic enrollment will not occur.
- The agreement must reference MA and/or PDP products and may include other health-related products, such as Medicare supplement insurance, dental, vision, and hospital indemnity.
- An SOA agreement must be obtained regardless if a marketing appointment is initiated by the consumer or you.
- An SOA agreement must be obtained 48 hours prior to the scheduled marketing appointment, except for:
  - The last four days during a valid election period for the consumer; or
  - Unscheduled in-person meetings (e.g., walk-ins) initiated by the consumer; or
  - Inbound consumer-initiated calls.
- SOA formats and delivery methods
  - UnitedHealthcare provides SOAs in the following formats:
    - Paper and PDF SOA forms are available in Enrollment Guides and as stand-alone documents on the Sales Material Portal. Agents may distribute and/or obtain paper SOA forms in-person, via postal mail, or as a PDF via email. However, the delivery must not be through unsolicited contact.
    - JarvisEnroll eSOA is an electronic format that consumers can sign in-person or remotely using digital signature via email or text.
    - For consumer-initiated inbound calls to the DTC Sales, the SOA requirement is satisfied via Interactive Voice Recording (IVR). DTC Sales agents must follow departmental protocols for obtaining an SOA when making outbound calls.

  - UnitedHealthcare generally accepts all compliant SOA formats available to field agents, including voice recorded and formats offered through other carriers or third-party platforms (e.g., Connecture, MyMedicareBot, and SunFire). Agents are responsible for ensuring the SOA contains all CMS-required elements.
  - Contacted call center agents (eAlliance and Telephonic Addendum) are expected to follow SOA protocols established by their call center.
  - eAlliance agents/agencies and telephonic addendum entities recording an SOA using an approved script.
- An SOA agreement remains valid for 12 months following the date of the consumer signature date or the date of the consumer's initial request for information. A new SOA agreement is required if the consumer request information regarding a different plan type than previously agreed upon.
- Retention
  An SOA agreement must be retained for a minimum of 10 years from the date of consumer signature and made available upon request. Agents are responsible for ensuring that the SOA format meets UnitedHealthcare retention requirements and is made available to UnitedHealthcare upon request.
  - UnitedHealthcare will retain SOA agreements completed in JarvisEnroll (field agent).
  - Field agents who do not use JarvisEnroll are responsible for the retention of SOAs obtained in other formats (e.g., paper).
  - Contracted call centers must retain all recorded SOAs.
- Corrective and Disciplinary Action
  An agent who does not comply with SOA requirements or cannot provide a completed SOA upon request may be subject to corrective and disciplinary action.

Agent or Plan-Initiated Provider Activities in a Healthcare Setting
Activities where either an agent 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.
Agent 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 common entryways, vestibules, hospital or nursing home cafeterias, and community, recreational, or conference rooms). All plan marketing materials (including but not limited to posting on a provider website) must be approved by the plan and filed with CMS if required.

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

Contracted providers must not:
- Accept/collect SOA 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 the agent or UnitedHealthcare.

- Mail provider affiliation announcement that include plan marketing content.
- 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 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 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 their 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 activities conducted by a provider (including a pharmacist) at the request of the patient, or as a matter of a course of treatment, and occur when meeting with the patient as part of the professional relationship between the provider and patient. Provider-initiated activities do not include activities conducted at the request of UnitedHealthcare, agent, or pursuant to the network participation agreement between UnitedHealthcare and the provider. Provider-initiated activities as defined by CMS fall outside of the definition of marketing. Permissible provider-initiated activities include:

- 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).
- Announcing new or continuing affiliations with MA organizations, once a contractual agreement is signed. Announcements may be made through any means of distribution.

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: www.bia.gov)

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/Sales Activities for Massachusetts UHC One Care (HMO DSNP)
Authorized agents must be UHC One Care product certified and have completed the UHC One Care specific training prior to conducting any marketing/sales activities for UHC One Care.

Marketing/Sales Activities for New Jersey Highly Integrated Dual Eligible (HIDE)

- You must not market in or around a Program of All-Inclusive Care for the Elderly (PACE) center. "In or around a PACE center" is defined as being in an area where an agent can be seen from the PACE center and/or where the PACE center can be seen. An obstructed view prohibiting the marketing/sales activities from being seen does not mitigate this prohibition.
- You must not otherwise approach individuals you have reason to suspect are enrolled in PACE.

Privacy and Security
Agents who fail to protect consumer/member PHI/ePHI/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/ePHI/PII (e.g., laptop, mobile/smart phone, or other portable electronic devices) and to corrective and/or disciplinary action up to and including termination, as well as, any actions required by applicable law.

Protected Health Information (PHI) – is individually identifiable information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual that is created, received, transmitted, or stored by a health plan, provider, or their supplier. PHI includes any health information in the foregoing context used to identify an individual.

Electronic Protected Health Information (ePHI) – is PHI that is maintained by or transmitted in an electronic media.

Personally Identifiable Information (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 other State or Federal issued ID, credit card number or debit card number, unique biometric data (e.g., fingerprint, retina or iris image, DNA profile), or Account Number, user name, unique

identifier, phone number, or email address in combination with a password, one time password, access code, or security question and answers that would permit access to an online account.

Interpretation of the above definitions of PHI/ePHI/PII is dependent upon the how the consumer/member information is held (stored), used or treated and the definitions may overlap. PHI/ePHI exists when held by a HIPAA Covered Entity (health plan) or a Business Associate of one (vendor, agent, etc.).

To ensure the proper handling of PHI/ePHI/PII and maintenance of consumer privacy, the following guidelines apply:
Agents must:

- Protect the privacy and security of consumer/member PHI/ePHI/PII at all times.
- Carry only the minimum amount of hard copy documents containing PHI/PII necessary to complete the day's activities.
- Keep documents containing PHI/PII with them at all times while conducting educational or marketing/sales activities or events, placing documents in a folder or locked briefcase.
- Keep documents containing PHI/PII 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/ePHI/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/ePHI/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/ePHI/PII using a 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/ePHI/PII.
- Dispose of documents containing PHI/PII in a secure manner (e.g., cross-cut shred).
- Report suspected privacy incidents to UnitedHealthcare Privacy Office at uhc_privacy_office@uhc.com, UnitedHealthcare sales leader/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/ePHI/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.
- Request a consumer/member Medicare (or similar) account username or password and must not create an account on behalf of a consumer/member.
- Store PHI/ePHI/PII in virtual (cloud) storage unless you (or agency, if you are employed by an agency) has a proper Business Associate Agreement in place with the cloud storage provider, and the cloud storage where PHI/ePHI/PII is stored has appropriate security controls (e.g., encryption, logging, etc.).
- Share user ID's/passwords to UnitedHealthcare systems with others.

- Put consumer/member information on a jump drive (or similar portable storage device) without prior formal approval 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 and/or store paper enrollment applications or business reply cards (BRCs) electronically, except when employee agents use UnitedHealthcare approved applications/platforms (e.g., Workspace One, 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 cross-cut shredded.

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, disability or impairment (e.g., obtaining language translation services, access to venue, 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 must 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. Special Needs Plans (SNP) 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

No cost interpreter services are available to all consumers. Certain required materials are also available in certain non-English languages upon request and on a standing basis. If the consumer prefers to receive required materials in a language other than English, the agent should ensure the consumer's preference is indicated in the appropriate field on the Enrollment Application.

<u>Written Required Materials (Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP))</u>

- 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 you for order and/or download in the same location as the English version (e.g., Sales Materials Portal).
- To request the development of custom, non-English required materials or the translation of approved materials into a non-English language, you must submit a request to your UnitedHealthcare sales leader for approval from the Sales Regional Vice President.

Translation / Interpreter Services

When a consumer speaks a non-English language and is having difficulty understanding or maintaining a conversation in English and you are not fluent in the non-English language, you must utilize one of the following options:

- 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/interpreting the appropriate meaning of the content from English to the non-English language and vice versa.
- Other options:
  - ~ eAlliance agents not fluent in the applicable language must either transfer the consumer to an appropriately skilled agent fluent in the applicable language within the same eAlliance or conference in an interpreter with an interpreter services vendor contracted by their eAlliance entity.
  - ~ Telephonic Enrollment Capabilities Addendum agents not fluent in the applicable language must either transfer the consumer to an appropriately skilled agent fluent in the applicable language within the same agency or conference in an interpreter with an interpreter services vendor contracted by their agency.
  - ~ A field agent not fluent in the applicable language must do one of the following:
    - Direct the consumer to obtain the no-cost interpreter service through the UnitedHealthcare Direct to Consumer (DTC) call center.
    - Refer the consumer to a field agent contracted with UnitedHealthcare who is fluent in the applicable language. Note: Permission to Contact (PTC) rules apply.
    - Through the assistance of your UnitedHealthcare sales leader, enlist the assistance of a UnitedHealthcare employee fluent in the applicable language. You are permitted to use employees of the same agency or up-line fluent in the applicable language 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 Language Interpretation Services.
      - Dial 1-877-530-9750 (24 hours per day, seven days per week)
      - Select the appropriate prompt based on the desired language

If the consumer prefers to receive plan materials 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 or Impairments

Basic plan information must be made available in alternate formats to consumers with disabilities, such as visual or hearing impairments, upon request. Auxiliary aids and services and materials are available for all consumers. If the consumer prefers to receive plan materials in an alternate format, the agent should ensure the consumer's preference is indicated in the appropriate field on the Enrollment Application.

Hearing Disability or Impairment

- Member Services maintains a TDD/TTY line to respond to marketing and membership questions from hearing impaired individuals. The TDD/TTY phone number must be listed on all advertising materials that include a telephone number and the enrollment application.
- If you encounter a hearing-impaired consumer, you may:
  - ~ Provide the enrollment guide to enable the consumer to read the materials.
  - ~ 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 legal representative, provide the enrollment guide directly to the consumer's authorized legal representative for review and enrollment purposes.
  - ~ Provide closed captioning upon request for online formal marketing/sales event presentations.
- Upon reasonable request, a sign language interpreter must be provided at an in-person or online formal marketing/sales event or a personal/individual marketing appointment at no charge to the consumer. Sign language interpreters are not required to be provided at informal marketing/sales events or 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. Refer to the "Request for a Sign Language Interpreter" portion of this section for sign language interpreter request process details.

Vision Disability or Impairment

A visually impaired consumer may request materials in alternate formats through Customer Service. If you encounter a visually impaired consumer, you may:

- Read the materials 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 legal representative, provide a complete enrollment guide directly to the consumer's authorized legal representative for review and enrollment purposes.
- Direct the consumer to Customer Service to request materials in an alternative format. The requested material is provided at no charge to the consumer.

Physical Disability or Impairment

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. 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

Cognitive Disability or Impairment
You must be aware and sensitive to the needs of cognitively impaired consumers. You must be aware that cognitively impaired consumers may or may not have an authorized legal representative (e.g., Power of Attorney) and/or may still make health care decisions themselves. You must 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. If the consumer has an authorized legal representative, you should reschedule the appointment for a time when the consumer's authorized legal representative can be present.

Permission to Contact (PTC)

You must comply with federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules related to permission to contact and lead generation activities.

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 (MA) plan, Prescription Drug Plan (PDP), or Medicare Supplement insurance products.

- PTC only applies to the entity/individual from which the individual requested contact, the duration and topic requested; is limited to the method of contact (e.g., permission to call or text) 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 Supplement Insurance or refers to options collectively (e.g., Medicare insurance options).
- Agents are responsible for ensuring PTC is valid and not expired prior to use.
- PTC Expiration
  - Permission to contact expires 12 months from the date of the consumer signature date or the date of their initial request for information or when the consumer requests no future contact, whichever comes first, unless an exception applies.
  - Exceptions include but are not limited to, consumers on the Do-Not-Call registry, consumers requesting information on Medicare Supplement insurance plans, or on a Medicaid list. For consumers on the Do-Not-Call registry or requesting information on Medicare Supplement insurance plans, PTC expires 90 days after the date of the consumer signature date or the date of their initial request for information.
  - If agents are receiving PTC from UnitedHealthcare, their up-line, or other third-party sources, the date of the consumer signature or the date of their initial request for information may be prior to the date the agent obtains the PTC.
- PTC must be documented (in Mira if available to the agent) and PTC documentation (e.g., lead source/business reply card) must be retained for ten years and made 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 and email. 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:

- 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).
- Distributing materials outside of an educational or marketing/sales event and/or appointment 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".)
- 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 leaving information of any kind (information may be left when an appointment was pre-scheduled and the consumer was not home). PTC requests must not include requests for permission to engage in door-to-door solicitation and having an address does not provide permission to engage in door-to-door solicitation.
- 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 through a compliant mean to be contacted in that manner.
  - ~ Contacting a consumer without valid PTC that attended an event or to whom material was mailed under the guise of following up.
  - ~ Contacting a referred consumer without valid PTC.
  - ~ 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 Mira 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.
  - ~ 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

PTC must be obtained prior to making direct contact with the consumer, except when using postal mail (e.g., advertisements, direct mail) or email. You must follow PTC guidelines

described above. When contacting consumers, the contact and content of the contact must comply with all federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules. For telephonic contact, agents must comply with applicable state and federal telemarketing laws and regulations, including but not limited to, the National Do-Not-Call Registry, the Telephonic Consumer Protection Act (TCPA), federal and state calling hours, and the recording of all telephonic conversations with consumers/members as prescribed by CMS. Contact by email and other electronic means must comply with applicable state and federal laws and regulations, including but not limited to, applicable CAN-SPAM requirements.

- Agents may contact consumers when prior valid permission to contact has been obtained. The contact must be in the method identified in the permission to contact.
- Telephonic contact requires prior permission to contact via telephonic method(s) (e.g., call or text). Both the act of contacting telephonically and the content of the contact must comply with all federal and state laws and regulations, including but not limited to, Do-Not-Call, federal and state calling hours, TCPA requirements, and TPMO call recording and disclaimer requirements.
- Agents may send unsolicited postal mail.
- Agents may send unsolicited emails. Unsolicited emails must not appear to be coming from or on behalf of UnitedHealthcare and must not contain any UnitedHealthcare brand name or elements (except as required to comply with CMS requirements to identify carriers in multi-carrier marketing materials). All material rules and requirements apply. Emails must have an opt-out/unsubscribe function and must comply with all federal and state laws and regulations, including but not limited to CAN-SPAM requirements.
- Agents may meet a consumer in-person for a personal/individual marketing appointment when a valid Scope of Appointment has been obtained. All Scope of Appointment requirements apply (refer to the Scope of Appointment section for details).
- Permitted PTC mechanisms include the following:
  - A consumer requests a return call from you.
  - 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.
  - A text 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 may contact any existing UnitedHealthcare member who meets the criteria listed below. If you are not the Agent of Record, you may only call an existing member in one of the following categories if PTC has been delegated by UnitedHealthcare to you. 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 Information (PHI), Electronic Protected Health Information (ePHI), or Personally Identifiable Information (PII) to the extent necessary to conduct business on behalf of UnitedHealthcare. Any other use of PHI/ePHI/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 plan, 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 member to discuss UnitedHealthcare Medicare products, including benefits, or to inform them of general plan information.
- A consumer who submitted an enrollment application in order to conduct business related to the enrollment.

Delegated Permission to Contact – EDC Agency/eAlliance
Your up-line may delegate PTC to you. Delegation of PTC occurs when your up-line provides the UnitedHealthcare member's contact information (i.e. name and phone number) to you. You may only use the UnitedHealthcare member's PHI/ePHI/PII to the extent necessary to conduct business on behalf of UnitedHealthcare. Any other use of PHI/ePHI/PII obtained through delegated PTC is prohibited. As an example, if a UnitedHealthcare member was enrolled by a solicitor under an eAlliance, the eAlliance is permitted to delegate PTC to another solicitor in its down-line for the purpose of conducting marketing/sales activities on behalf of UnitedHealthcare.

Implied Permission to Contact Current Client
You may contact your current clients from another business relationship with whom you have a current, active contract or business relationship in other products (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.

UnitedHealthcare Book of Business
UnitedHealthcare at its discretion may provide an agency or agent access to their Book of Business member information. Provided member information must only be used to the extent necessary to conduct business (e.g., servicing members and member retention activities) on behalf of UnitedHealthcare. Any other use of provided member information is prohibited. Book of Business reports are confidential and proprietary information of UnitedHealth Group. Do not distribute or reproduce any portion without the express permission of UnitedHealth Group. All federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules apply. Please note that provided member information may not be reflective of all Book of Business or AOR information and does not impact commissions/incentives or renewal payments.

Agencies must have an active Party ID (PID) and be receiving commission payments for the member. Solicitors are excluded from receiving any agency Book of Business member information.

The agency or AOR may contact members in their UnitedHealthcare book of business to the extent necessary to conduct plan business.

- All agency or agent contact must comply with Permission to Contact requirements.
- Agencies and agents, including AOR, are prohibited from contacting a consumer/member who filed a complaint for which the agent is involved.
- Agencies and agents must not conduct plan marketing for the upcoming plan year prior to October 1 under the pretense of plan business.

Outbound Calling Campaigns

General Guidelines

The following guidelines apply to marketing/sales outbound calling campaigns by field agents on behalf of UnitedHealthcare or involving UnitedHealthcare portfolio of products.

- Call campaigns must adhere to all federal and state laws and regulations and UnitedHealthcare or UnitedHealth Group corporate policies, procedures, and rules..
- Call campaigns must comply with TPMO requirements, including but not limited to, call recording and disclaimer requirements. Refer to the TPMO requirements sub-section below.
- Agents/agencies and UnitedHealthcare must abide by the Telephone Consumer Protection Act (TCPA). The guidelines below apply for marketing/sales outbound calling campaigns via phone, text, and fax. The rules below are not an exhaustive list of all laws applicable to the campaigns.
  - ~ Pre-recorded messages are not allowed on residential or cell phones without prior express written consent. Prior express written consent must be consent to be marketed to; not just general consent to be contacted at a particular number.
  - ~ Auto-dialer calls are not allowed without prior express written consent.
  - ~ Manual calls to residential and cell phones may be made as long as artificial or pre-recorded voice is not used.
- You must be appropriately credentialed.
- You must only market products in the UnitedHealthcare Medicare Plans portfolio and must not market any other products while calling on behalf of UnitedHealthcare.
- You must comply with state calling hour rules and must not call leads outside of the defined campaign time frame.
- Lead lists contain PHI/ePHI/PII and must be protected and transmitted in compliance with UnitedHealthcare policy.
- Initial Lead lists provided by UnitedHealthcare must not be transmitted to individuals not participating in the outbound call campaign.
- Lead lists must be immediately and securely disposed in compliance with UnitedHealthcare policy once the calling campaign has completed and activity recorded in Mira.
- 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 (MBI) number to verify Medicaid level of eligibility). Any additional data must be deleted prior to agent distribution.
- Lead lists permission to contact status must be affirmed in Mira 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 Mira.
- You must not replicate lead lists or use the lead lists beyond the completion of the call campaign. Paper lead lists provided to you must not be copied, scanned, photographed, photocopied, or allowed to be used in any other format than what was provided by UnitedHealthcare. Paper lead lists must not leave UnitedHealthcare possession or the location of the call campaign and must be returned to campaign leader upon completion of the calling session. At the discretion of UnitedHealthcare, copies of certain lead lists with sales activity notes may be retained after recording lead and contact activity in Mira. The lead lists must be securely stored.
- You must abide by Scope of Appointment (SOA) guidelines when an outbound call results in a future in-person or telephonic marketing appointment. An SOA 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. Refer to the Scope of Appointment section for SOA requirements.

- You must have an active current Mira account to participate in call campaign activity unless approved by the Growth Director. You must commit to using Mira to record successful attempts in converting a lead to an appointment or follow-up activity. If the Growth Director allows for an exception for you to participate in call campaign activity without having a Mira account, the sales team must have controls in place to ensure all call activity is documented in Mira.

Community & State Medicaid Leads for Calling Campaigns

On a monthly basis, the National Lead Campaign Team may load Medicaid member leads into MIRA for call campaigns (i.e. call blitz). UnitedHealthcare Growth Directors are responsible for the compliant execution of any Medicaid call campaigns in their market. The following guidelines apply:

- Call campaigns may occur in a UnitedHealthcare facility/office location or virtually (see the virtual outbound call campaign section).
- All call campaigns must be proctored and monitored by a UnitedHealthcare sales leader or Growth Director during the call campaign. Proper coaching and talking points for you are the responsibility of the market Growth Director. If you are participating in-person, you are not allowed to stay late or be left alone to make calls without a local sales leader present at all times.
- PTC Medicaid leads expires on the last day of the month the leads were obtained. Medicaid age-in leads expire after 3 months and non-age-in leads expire after 1 month. If the sales support coordinator enters contact information on a subset of Medicaid leads into Mira, PTC may be extended by you only 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 Mira.
- Leads that result in an appointment or other follow-up activity must be entered into the your Mira account within 24 hours and follow-up activity will be managed through Mira from that point.

Local Market Outbound Calling Campaigns

The purpose of a local calling campaign (i.e. call blitz) is for a sales market to increase applications, make appointments and to build your pipeline through targeted calls. The outbound calling campaigns may take place on a daily, 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 may occur 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) or virtually (refer to the virtual outbound call campaign section).
- A call campaign leader, generally a UnitedHealthcare sales leader or Growth Director, must be identified and present during the entire outbound call campaign timeframe. Your call activity must be monitored and you must be coached immediately when necessary. If you are participating in-person, you are not allowed to stay late or to be left alone without a local sales leader present at all times.

- PTC status must be affirmed in Mira 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 Mira.

Virtual Outbound Call Campaign
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 (see the C&S Medicaid and Local Market call campaigns sections) and may be employed when the market is managed by a remote or local leader. The purpose of a virtual call campaign (i.e. call blitz) is for a sales market to increase applications, make appointments, to build an agent's pipeline through targeted calls and/or accept enrollments. The outbound call campaign may take place on a daily, weekly, or monthly basis as lead volume permits using lead lists provided to agents via secure email. The strategy may be modified according to market changes/opportunities that arise.

The following call campaign guidelines also apply:
- Virtual call campaigns must be managed through the coordination of the remote or 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 an UnitedHealthcare sales leader, 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., virtual meeting or teleconference) campaign expectations and guidelines (e.g., use of Mira and secure email, calling time frame, expiration of PTC).
- Your activity must be monitored and you must be coached immediately when necessary.
- You must use secure email when emailing campaign results that contain consumer/member PHI/ePHI/PII or provide the minimum necessary consumer information results via email (i.e. contact identification number/telephone number and outcome).

Lead Generation Guidelines
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. Refer to the Permission to Contact Guidelines section.

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

Compliant means include, but are not limited to:

- Consumer submitted a compliant BRC (paper or electronic) or lead card. If you are receiving leads from your up-line, you should request documentation from your up-line that attests that the leads were obtained compliantly and are actionable.
- 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.
- The consumer is a current client by virtue of having a current, active contract or business relationship in another product.

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

- You receive the consumer's telephone number as a referral from an individual other than the consumer. For example, a provider gives a list of patients to you or a client gives their neighbor's telephone number to you.
- You use other sources to look-up a telephone number provided by the consumer on a BRC or lead card where the telephone number provided is not accurate or in-service.
- You engage in unsolicited contact (e.g., initiating contact with a consumer) via interactive communications on 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 use that information to market Medicare insurance products via prohibited unsolicited direct contact.

Lead Validation Documentation

Upon request, you must provide documentation proving that a lead was actionable (i.e. proof that the lead generation mechanism was compliant and resulted in valid permission to contact).

- Lead Mechanism Documentation*
  Provide proof that the lead generation mechanism (e.g., paper or electronic) used to obtain the particular consumer's permission to be contacted contains all required elements, which include:
  - ~ Name of the individual consenting to being contacted
  - ~ Contact information (e.g., email address or phone number) and permitted method of contact (e.g., telephonically)
  - ~ Name of each TPMO(s) the consumer is consenting to be contacted by. The consent must be obtained through a clear and conspicuous disclosure that lists each TPMO and must allow the consumer to consent or reject contact from each TPMO.
  - ~ The purpose of the contact or topic(s) to be discussed (e.g., scope of product)
  - ~ Explicit statement (e.g., By providing my contact information I am agreeing to be contacted by a licensed sales agent to discuss Medicare Advantage plans) or verbiage that reasonably expresses that the individual is providing permission to be contacted
  - ~ All required disclaimers (e.g., This is a solicitation for insurance)
- Permission to Contact Documentation*
  Provide proof that the consumer completed the lead generation mechanism.
  - ~ Paper Lead Mechanism
    Provide the completed paper document (e.g., lead card or BRC) or copied/scanned image of the actual paper document completed and submitted by the consumer.
  - ~ Electronic Mechanism
    - o Provide documented evidence that captures the real-time consumer completion of an electronic lead form/eBRC (e.g., a documentation solution such as Jornaya or TrustedForm); or

- Provide documentation that provides evidence that the consumer completed the electronic lead generation mechanism. Acceptable documentation includes a lead system generated report or screenshot(s) from an internal lead system including the following data elements:
  - Name of the individual consenting to be contact as provided by the individual completing the form
  - Contact methods and/or contact information provided by the individual completing the form
  - The purpose of the contact or topic(s) to be discussed (e.g., scope of product)
  - Name of each TPMO the consumer is consenting to be contacted by. The consent must be obtained through a clear and conspicuous disclosure that lists each TPMO and must allow the consumer to consent or reject contact from each TPMO
  - Website static or dynamic URL (ad unit and consent language as seen by the individual providing permission)
  - Date and time the permission was provided
  - IP address of the individual providing permission
  - Explicit statement or verbiage indicating the consumer's consent to be contacted

  * An email summarizing the required element or attesting that the individual provided permission is not sufficient.

Consent to Share Consumer Data

Effective 10/1/2024 and for consumer data collected prior to 10/1/2024 that will be transferred to another TPMO on or after 10/1/2024, TPMOs (as defined by CMS) must obtain prior express written consent from the consumer before sharing personal consumer data collected by the TPMO for marketing or enrolling them into an MA/PDP plan with another TPMO. Prior express written consent from the consumer to share the data must be obtained through a clear and conspicuous disclosure that lists the TPMO receiving the data and allows the consumer to consent or reject to the sharing of their data with each TPMO except as provided below in 4.a.

- Exceptions to the written consent requirement:
  - TPMOs contacted telephonically may transfer or connect a consumer to another TPMO in real time without obtaining prior express written consent as long as the consumer has verbally agreed or consented to being transferred during the live phone call.
  - Two agents working directly for the same TPMO as employees (not independent contractors) may share consumer data as long as the consumer has freely provided that data to the TPMO or it was obtained with the consumer's consent.
- Upon request, TPMOs must provide proof that written consent was obtained from the consumer to share their data and the specific TPMOs the data can be shared with.
- Express written consent must be securely retained for a minimum of 10 years and be made available upon request.
- The express written consent mechanism must contain the following elements:
  - Name of the individual consenting to their data being shared
  - Explicit statement or verbiage that reasonably expresses that the individual is consenting to their data being shared with the selected TPMOs for marketing or enrollment purposes
  - The ability of the consumer to consent or reject to each of the TPMOs their data can be shared with
  - All required disclaimers

- Express written consent documentation
  - For paper mechanism, the completed paper document or copied/scanned image of the completed paper document that was completed and submitted by the consumer can be used to provide documentation of the consent.
  - iFor telephonic mechanism, the recorded call can be used to provide documentation of the consent provided by the consumer.
  - For electronic mechanism:
    - Provide documented evidence that captures the real-time consumer completion of providing consent (e.g., a documentation solution such as Jornaya or TrustedForm); or
    - Provide documentation that provides evidence that the consumer provided express written consent. Acceptable documentation includes a system generated report or screenshot(s) from an internal system including the following data elements:
      - Name of the individual consenting to their information to be shared as provided by the individual completing the form
      - Date and time the consent was provided
      - IP address of the individual providing consent
      - Explicit statement or verbiage that reasonably expresses that the individual is consenting to their data being shared with the selected TPMOs
      - The TPMOs that the consumer consented or rejected to their data to be shared with
      - All required disclaimers
- All Permission to Contact and lead generation guidelines apply.

Third-Party Marketing Organization (TPMO) Lead Generation Disclaimer and Disclosure Requirements

TPMOs as defined by CMS must comply with TPMO disclaimer and disclosure requirements. All entities and individuals contracted directly with UnitedHealthcare are considered first tier, downstream or related entities (FDRs) and, therefore, TPMOs. TPMOs also include any entity contracted or subcontracted by an FDR that provides services to UnitedHealthcare or UnitedHealthcare's FDR, including solicitors.

- TPMOs must record in their entirety all marketing, sales, and enrollment calls, including the audio portion of calls via web-based technology.
- TPMOs must comply with all disclaimer and disclosure requirements, including but not limited to, the standardized TPMO disclaimers.
- TPMOs must use, where applicable, a standardized disclaimer that states:
  - If a TPMO does not sell for all MA organizations in the service area the disclaimer consists of the statement: "We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program to get information on all of your options."
  - If the TPMO sells for all MA organizations in the service area the disclaimer consists of the statement: "Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program for help with plan choices."
- The TPMO disclaimer must be as follows:
  - Used by any TPMO that sells MA plans on behalf of more than one MA organization unless the TPMO sells all commercially available MA plans in a given service area, and

by any TPMO that sells Part D plans on behalf of more than one Part D Sponsor unless the TPMO sells all commercially available Part D plans in a given service area.
  - Verbally conveyed within the first minute of a sales call.
  - Electronically conveyed when communicating with a consumer/member through email, online chat, or other electronic means of communication.
  - Prominently displayed on a TPMO website. Refer to the Agent/Agency Website section for requirements.
  - Included in any marketing materials, including print materials and television advertisements, developed, used, or distributed by the agent/agency. Refer to the Materials section requirements.
- When applicable, TPMOs must disclose to the consumer/member that their information will be provided to a licensed agent for future contact. This disclosure must be made using the same method of contact as the interaction (i.e. verbally for telephonic, conveyed in writing for paper methods, and electronically for email, online chat, or other electronic messaging platforms) and displayed prominently on an agent/agency websites.
- When applicable, TPMO must disclose to the consumer/member that they are being transferred to a licensed agent who can enroll them into a new Medicare plan. Note: In some instances, TPMOs generate a lead and may or may not conduct eligibility screening activities. Regardless of the interaction this disclosure requirement applies.
- TPMOs must make consumers/members aware of the role of the individual with whom they are interacting and must use a title that accurately describes their role in the chain of enrollment (the steps taken by a consumer/member from becoming aware of a Medicare plan(s) to making an enrollment decision). Refer to the Materials section for approved agent titles.
- TPMOs must disclose to UnitedHealthcare all subcontracted relationships used for marketing, lead generation, and enrollment activities. TPMOs must complete and submit the TPMO Subcontracted Relationship Submitting Form accessible via ***Jarvis*** for each subcontractor used for marketing, lead generation, and enrollment activities. TPMOs must disclose when a subcontracted relationship ends by completing a new Form that reflects the updated Contract End Date.

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, comply with compensation requirements, 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 exchange for a referral (i.e. contact information including name and telephone number/email).

- You must comply with CMS regulations related to compensation, 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.

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. 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 consumers 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.

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 appropriately contracted (as required for non-employee agents), licensed, appointed (as required by the state) and certified (refer to the Certification Requirements section for details).

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. Non-licensed representatives must be certified in the product in which the consumer is enrolling.

Pre-Enrollment Information, Benefits, Eligibility, and Member Rights

Prior to enrolling a consumer, agents must ensure that required questions and topics regarding consumer needs in a health plan choice are fully discussed and thoroughly review all eligibility requirements, plan benefits, associated costs, and member rights. Questions and topics the agent must ensure are fully discussed, includes but is not limited to:

- Review consumer specific information, such as:
  - ~ Review the kind of health plan the consumer want to enroll in.
  - ~ For network-based plans, verify (if applicable) all of the consumer's Primary Care Provider (PCP), specialist, and providers (e.g., doctors, hospitals, pharmacies, and facilities) are in the network. If the PCP, specialist, and/or providers are not in network, agents must explain that the consumer would need to choose a new in-network PCP, specialist and/or provider or may have to pay a higher cost share for benefits and services. Agents must explain that if the consumer uses an out-of-network provider, that except in emergency or urgent situations, non-contracted providers may deny care. Agents must explain that the plan does not pay for non-covered benefits and services. Agents 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 the provider or agent. Agents must not enter into arrangements with providers to steer a consumer/member into a UnitedHealthcare Medicare Plans plan based on financial or any other interest of the provider.
  - ~ Review the selection of a Primary Care Provider (PCP) if required by the plan and any referral requirements.
  - ~ If prescription drug coverage is included, verify (if applicable) all of the consumer's current prescription medications are on the formulary, in what tier, and if the consumer's pharmacy is in network. If the consumer's prescription(s) are not on the formulary, agents must explain that alternative drugs may be available and that the consumer may be responsible for the full price of the prescription(s) not covered by the plan. Agents must explain that if the consumer uses an out-of-network pharmacy, the plan may not pay for the consumer's prescription(s) or the consumer may pay more than at a network pharmacy.
  - ~ Determine if the consumer requires hearing, dental, and/or vision coverage.
  - ~ Determine if the consumer has any other health care needs (e.g., durable medical equipment or physical therapy).

  - ~ Determine if the consumer has any other specific health care needs.
  - ~ Review the cancellation, withdrawal, and disenrollment processes and timeframes.
- Review plan benefits.
- Review premiums, including Part B premium, [insert dollar amount] per month/quarter/year. [This only applies if there is a premium greater than $0]. If applicable, review current premium vs another plan premium.
- If the plan has prescription drug coverage, review the formulary, drug tiers, step therapy, prior authorization, quantity limits, exception requests, coverage stages (including the coverage gap), and Late Enrollment Penalty (LEP).
- Review cost sharing including deductible, coinsurance, and copayments. Go over deductible cost, PCP copay, specialist copay, inpatient hospital copay, and any other copays for services or items the consumer needs.
- Review costs and limitations on dental, vision, and hearing.
- Review in-network and out-of-network coverage for providers and services (e.g., explain that except in emergency or urgent situations, the plan does not cover services by out-of-network providers (i.e. doctors who are not listed in the provider directory).
- Review coverage outside of the United States.
- Explain the potential effect that enrolling in a plan will have on other current coverage, which may in some cases mean that the consumer is disenrolled from their current health coverage (e.g., another MA plan or PDP).
- Explain that the plan is not a hearing, dental, or vision rider but a full plan.
- Explain that the plan operates on a calendar year basis, so benefits may change on January 1 of the following year.
- Explain that the Evidence of Coverage ("Certificate of Insurance" for Medicare Supplement plans and "Policy" for Standalone Dental, Vision, Hearing plans) provides all of the costs, benefits, and rules for the plan.
- Review how to file a complaint.
- Review items only applicable to certain plan types.
  - ~ Review PPO or PFFS out-of-network coverage.
  - ~ Review chronic/disabling condition qualifying requirements for CSNP.
  - ~ Review the requirement to have Medicaid to qualify for a DSNP.
  - ~ Review the need to remain in an institutional skilled nursing facility in order to qualify for ISNP.
- Review election period and effective date for enrollment.
- Review plan eligibility requirements.
- Review the Star Rating for the Medicare Advantage (MA) plan or Prescription Drug Plan (PDP) presented, including where to find the rating in the Enrollment Guide, provide Star Rating updates as they are communicated during the year and explain 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.
- Advise where the consumer can find contact information for the plan.
- Explain the appeals and grievance process, as applicable.

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 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. For Medicare Supplement Insurance plans, the consumer must be enrolled in both Part A and Part B. This requirement is not applicable for Standalone Dental, Vision, Hearing plan applications.
- 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. For Medicare Supplement Insurance plans and Standalone Dental, Vision, Hearing plans, the consumer must reside in the state of the plan in which they are enrolling.
  - ~ 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 Direct to Consumer (DTC) Sales call center or the public website to complete an enrollment application (excludes Standalone Dental, Vision, Hearing plans). For Standalone Dental, Vision, Hearing plans, the consumer must be physically present in the United States. Consumers must be advised that in most cases, Medicare and UnitedHealthcare will not pay for health care or supplies obtained outside of the United States. Medicare drug plans do not cover prescription drugs bought outside of the United States.
  - ~ In the case of homeless consumers, a post office box (not for Medicare Supplement Supplement or Standalone Dental, Vision, Hearing plans), 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.
  - ~ Ensure the consumer understands that if their qualifying condition cannot be verified, the consumer will not be enrolled into the plan or will be disenrolled from the plan, depending on the Plan's method of 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 JarvisEnroll. 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.
  - ~ 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 using the Medicare & Medicaid Verification (MMV) tool in ***Jarvis*** or by contacting the Producer Help Desk (PHD) 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-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.)
- **Enrollment of Consumers into a Minnesota Fully Integrated Dual Eligible (FIDE) or Highly Integrated Dual Eligible Special Needs Plan**
  - ~ Enrollments must be completed using the specific paper enrollment application.
  - ~ You must make consumers aware that the premium is on the enrollment application and what the premium will be if they lose Medicaid eligibility.
  - ~ The enrollment application must be faxed, using the specific fax cover sheet, to both the MN DHS and UnitedHealthcare enrollment center. Only one enrollment application per fax. The enrollment application must first be faxed to the MN DHS. The second fax must be sent to the correct UnitedHealthcare enrollment center.
  - ~ The enrollment application must be submitted within 24 hours.
  - ~ If the enrollment application is submitted past the enrollment cutoff date, the agent must advise on the fax cover sheet why the enrollment application submission was delayed.
  - ~ A Health Assessment (HA) is not able to be completed with this paper enrollment application.
- **Enrollment of Consumers into a New Jersey Highly Integrated Dual Eligible (HIDE) SNP**
  - ~ You must explicitly inform the consumer that all their benefits (Medicaid benefits will be coordinated with the plan) will be provided by the plan upon the effective date of their enrollment. You must obtain explicit confirmation that the consumer understands.
  - ~ You must inform the consumer (except under rare circumstances) that all services, items, and drugs must be obtained from in-network providers and explain that the anticipated change in their Medicaid coverage may result in some of the providers they

may use to no longer be in-network. You must obtain explicit confirmation that the consumer understands.

- ~ You must offer to assist the consumer with the following:
  - Checking whether their current PCP is in-network and assisting in finding a new in-network alternative if necessary.
  - Looking up the consumer's specialist and pharmacies and assisting in finding a new in-network alternative if necessary. Particular attention should be given to providers of ongoing care or continuing courses of treatment, as well as, facility-based providers.
  - Look up the consumer's medications to determine if the medications are on the formulary.

- **Enrollment of Consumers into Massachusetts UHC One Care (HMO DSNP)**
  UnitedHealthcare participates in UHC One Care in Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Plymouth, Suffolk, and Worcester counties. Note: Eligibility is different for both UHC One Care and Senior Care Options (SCO) because of the age requirement. UHC One Care eligible members individuals are not eligible for SCO unless they turn 65 and want to become part of SCO.
  - ~ Agents must Authorized agents must be UHC One Care product certified and have competed the UHC One Care specific training prior to conducting any marketing/sales activities for UHC One Care.
  - ~ Only authorized agents may enroll consumers into UHC One Care.
  - ~ Eligible individuals must be:
    - Aged 21 through 64 at the time of enrollment
    - Eligible for Medicare and MassHealth Standard or MassHealth CommonHealth
    - Not enrolled in a Home and Community-Based Services (HCBS) Waiver
  - ~ Unless it is in the member's best interest, agents must not enroll UHC One Care or SCO members into a MA plan.

- **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 04/01/2021, 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 or an Optum-provided confirmation form (filled in by the SNF) signed by one of the following: Nursing Home Administrator, MDS Coordinator, Director of Admissions, Director of Nursing, Social Services (Director or Social Worker) or Business Manager that indicates that the SNF expects the consumer to require a stay of 90 days or longer. For select states, you may use the Medicare & Medicaid Verification (MMV) tool in ***Jarvis*** or by contacting the Producer Help Desk (PHD) during normal hours of operation to validate the Level of Care for a consumer who has not resided in the contracted SNF for at least 90 days

    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 Beneficiary Identifier (MBI), 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 UHC 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.
  - You must follow state-specific guidelines for determining plan eligibility as it relates to the "Level of Care" requirement.
  - The Optum Products Team will maintain the state-specific requirements and makes them available upon request.
  - For select states, you may use the MMV tool in ***Jarvis*** or by contacting the PHD during normal hours of operation to validate the consumer's Level of Care.
  - Some states require "Level of Care" assessments and these documents are retained by an outside identified entity. Documentation is retained by the entity/local site for 10 years and made available upon request within 48 business hours.
  - 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 community to access the plan.

Institutional and Institutional Equivalent Special Needs Plan Enrollments
JarvisEnroll is the primary enrollment method used to complete enrollments for UnitedHealthcare Institutional and Institutional Equivalent Special Needs Plans. Residents may reside in contracted Skilled Nursing Facility (SNF) or IE-SNP residents may reside in the service area. In addition to all federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules, the following guidelines apply:

- The agent/Sales Account Manager must ensure that no provider or SNF or assisted living community employee is present during the marketing/sales appointment, facilitates the enrollment, and/or acts on behalf of the consumer unless appropriately authorized.
- The agent/Sales Account Manager must follow established processes for obtaining a Scope of Appointment (SOA) agreement and completing an enrollment via JarvisEnroll.

Enrollments
Enrollment Guidelines
If the sales presentation turns into an enrollment, the agent must inform the consumer they are transitioning to the enrollment phase. In addition to all federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules, the following guidelines apply:

- The consumer or the consumer's authorized legal representative must sign the enrollment application.
- For MA plan and PDP, the agent must provide required plan materials (i.e. Summary of Benefits, Star Ratings, and Pre-Enrollment Checklist) at the time of a field agent assisted

enrollment. Materials may be provided in any available format; however, if the consumer requests the materials in a specific format, the agent must provide the materials in the requested format. For field agents, the Pre-Enrollment Checklist must be provided in the same format (e.g., paper, digital) as the Summary of Benefit and must be reviewed with the consumer prior to enrollment. For telephonic enrollments, the items contained within the Pre-Enrollment Checklist must be reviewed prior to the completion of an enrollment. For telephonic enrollments, the consumer must be verbally told where the Summary of Benefit and Star Ratings can be accessed.

- For a Medicare Supplement enrollment, the enrollment kit must be made available to the consumer.
- For Standalone Dental, Vision, Hearing plan enrollments, the enrollment materials (i.e. plan brochures and application) must be made available to the consumer.
- The agent 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. However, you must not deny completing an enrollment request if a consumer does not have a PCP or refuses to designate a PCP. Otherwise, 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 applicant's email address, you must not enter your own email address or a dummy email address. If the applicant does not have an email address or refuses to provide one, the you must leave it blank. For MA plans and PDP, an email address must not be required. For Medicare Supplement Insurance plans and Standalone Dental, Vision, Hearing plans, if the signature method requires an email address and the applicant does not have an email address or refuses to provide one, you must choose a different signature method.
- The agent must determine and enter the proposed effective date, election period, and election period reason code (if applicable).
- The agent must 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 plan 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 (HA) 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.)
  - ~ After Standalone Dental, Vision, Hearing plan enrollment, a copy of the enrollment application, a plan acceptance Welcome email, a dental insurance membership identification card, and a policy of insurance.
- **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.
- **Field agents** completing a paper enrollment application must leave a receipt of the paper enrollment application.
- All agents using an electronic enrollment method (e.g., JarvisEnroll, Multi-Carrier Enrollment Tool, or Online Enrollment (OLE) Tool) must provide the confirmation number, generated upon completion of the enrollment application.
- The consumer must be provided with the agent's 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, unless an exception applies. For call centers that have a process approved by UnitedHealthcare, the agent that presented the plan may be different from the agent that completes the enrollment, affixes their writing number, and signs 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.
- Agents must submit the enrollment application within 24 hours of receipt.
  Within seven calendar days of receipt of the MA plan 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 plan 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 plan 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., JarvisEnroll) must upload the enrollment application within 24 hours of receipt.
  - ~ MA plan 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.

Electronic Enrollment Mechanisms
JarvisEnroll

- For field agents using JarvisEnroll, a consumer/authorized legal representative may sign an enrollment application in-person, remotely via email or text message using remote signature (a secure electronic signing process), or via voice signature.
- Once the consumer or authorized legal representative has signed the application, it is automatically submitted for processing and may be viewed by you.
- In-person signatures may be obtained in JarvisEnroll using a computer mouse, stylus, or finger for touch screen.
- Remote Signature
  - ~ An access code must be created by you and provided to the consumer or authorized legal representative in order to access the enrollment application for review and signature. For Medicare Supplement, the access code is chosen by the consumer or authorized legal representative and provided to the agent to enter into JarvisEnroll allowing the consumer or authorized legal representative to access the application for review and signature. In order to provide an enrollment receipt via email, you must select the option prior to launching remote signature.
  - ~ The consumer or authorized legal representative is required to sign the enrollment application within 24 hours of when the “Launch Remote Signature” button is enabled by the agent. The access code expires after three failed attempts to enter the correct code.
  - ~ For field agents using JarvisEnroll, you may use a UnitedHealthcare approved HIPAA-compliant screen sharing application during a remote one-on-one appointment. The enrollment must be completed using JarvisEnroll and all federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules apply.
- Voice Signature
  - ~ For field agents using JarvisEnroll, a consumer or authorized legal representative may sign an MA plan or PDP enrollment application remotely using voice signature. The use of JarvisEnroll voice signature must only be used at the request of a consumer or in the best interest of the consumer, for example a consumer who does not want to meet in-person (who otherwise could) and does not have access to email or text capabilities to complete a JarvisEnroll remote signature.
    - The consumer or authorized legal representative will receive a phone call from you in order to record a voice signature to complete the enrollment application in JarvisEnroll.
    - You must merge a call with the applicable 1-800 number to record the call.
    - You must read all required disclaimers, Statement of Understanding, and the application in their entirety.
    - You must complete the voice recording on the call. If the call is interrupted or disconnected, a new call will need to be made and a new enrollment application completed. You cannot restart a recording if it has been stopped.
    - Once the consumer’s or authorized legal representative’s voice signature has been obtained, the JarvisEnroll application is submitted automatically for processing and may be viewed in JarvisEnroll.
    - If the consumer opts-in to receive, you and consumer will receive via email an enrollment receipt.
- Medicare Supplement or DVH JarvisEnroll Signature Options – Field Agents
  In addition to the enrollment and electronic enrollment mechanism guidelines above, the following guidelines applies for Medicare Supplement or DVH enrollments:

- ~ For Medicare Supplement and Standalone Dental, Vision, Hearing plan applications, agents using JarvisEnroll may offer an option for the consumer to complete/sign their enrollment application in-person, via remote signature, or via electronic security code from a location of their choice.
- ~ If the consumer chooses remote signature or electronic security code, agents 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.
- ~ JarvisEnroll signature options include:
  - Electronic Signature
    Signatures may be obtained in-person using touch screen or Topaz signature pad.
  - Electronic Security Code Signature
    - Electronic security code is only available when the applicant is completing the enrollment.
    - The consumer must provide a valid email address and agree to the Security Code – Applicant Signature Terms and Conditions.
  - Remote Signature
    Agents must follow the remote signature guidelines above.

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 plan 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.
- Enrollments completed using an online enrollment tool approved by UnitedHealthcare must be completed in the manner approved (e.g., face-to-face or remotely) and only for approved products.
- You must abide by all applicable enrollment guidelines defined within this policy, including but not limited to conducting a thorough needs analysis, presenting all aspects of the plan, review networks, providers, medications, and eligibility, and provide an enrollment application for the selected plan.
- Enrollments completed remotely using an online enrollment tool approved by UnitedHealthcare
  In addition to all other regulations, rules, policies, and procedures, the following guidelines apply:
  - 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.
  - You may complete an enrollment using the online enrollment tool. You must email the online enrollment application link to the consumer and direct the consumer to complete the enrollment information, including the listing of their providers and prescriptions.
  - You may complete an enrollment using a telephonic enrollment tool approved by UnitedHealthcare.

Section 6: How do I take an Enrollment Application?

Online Enrollment (OLE) Tool (eAlliance only)
Enrollments completed using an Online Enrollment (OLE) tool approved by UnitedHealthcare must be completed in the manner approved and only for approved products.

Consumer Facing Website
A web-based MA plan 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 enter information or fill in an enrollment via screen sharing with the consumer through an internet connection (e.g., the consumer gives the agent control of the consumer's computer to complete a web enrollment via WebEx) unless agreed to by the Vice President Field Sales and the Compliance Officer.
- Completing a web-based MA plan or PDP enrollment using a public website or enrollment tool on behalf of a consumer may be considered fraud.

JarvisEnroll Office
JarvisEnroll Office may be used by authorized EDC offices to process MA and PDP enrollments.

Telephonic Enrollment
Telephonic enrollment is only permitted by an authorized telesales call center, such as a UnitedHealthcare call center, a contracted vendor call center, or a contracted multi-carrier call center.

Paper Enrollment
Upon receipt of a paper enrollment application, field agents must enter their agent writing number, and sign and date the enrollment application after verifying all information provided by the consumer is correct and that it is signed by the consumer or authorized legal representative.

Third-Party Marketing Organization (TPMO) Call Recording, Disclaimer, and Disclosure Requirements
TPMOs as defined by CMS must comply with TPMO call recording, disclaimer, and disclosure requirements. All entities and individuals contracted directly with UnitedHealthcare are considered first tier, downstream or related entities (FDRs) and, therefore, TPMOs. TPMOs also include any entity contracted or subcontracted by an FDR that provides services to UnitedHealthcare or UnitedHealthcare's FDR, including solicitors.

- TPMOs must record in their entirety all marketing, sales, and enrollment calls, including the audio portion of calls via web-based technology.
- TPMOs must retain recordings for a minimum of 10 years, and make the recordings available upon request. TPMOs must protect consumer/member PHI/ePHI/PII and the recording and storage of calls must meet UnitedHealthcare security requirements. Refer to the Privacy and Security section for guidelines.
- TPMOs must comply with all disclaimer and disclosure requirements, including but not limited to, the standardized TPMO disclaimers.
- TPMOs must use, where applicable, a standardized disclaimer that states:

  - If a TPMO does not sell for all MA organizations in the service area the disclaimer consists of the statement: "We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program to get information on all of your options."
  - If the TPMO sells for all MA organizations in the service area the disclaimer consists of the statement: "Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program for help with plan choices."
- The TPMO disclaimer must be as follows:
  - Used by any TPMO that sells MA plans on behalf of more than one MA organization unless the TPMO sells all commercially available MA plans in a given service area, and by any TPMO that sells Part D plans on behalf of more than one Part D Sponsor unless the TPMO sells all commercially available Part D plans in a given service area.
  - Verbally conveyed within the first minute of a sales call.
  - Electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication.
- TPMOs must disclose to UnitedHealthcare all subcontracted relationships used for marketing, lead generation, and enrollment activities. TPMOs must complete and submit the TPMO Subcontracted Relationship Submitting Form accessible via ***Jarvis*** for each subcontractor used for marketing, lead generation, and enrollment activities. TPMOs must disclose when a subcontracted relationship ends by completing a new Form that reflects the updated Contract End Date.

Force Majeure Resilience Program
The Chief Distribution Officer or their delegate may invoke at their 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 and ICA/IMO). 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 end of the Election Period (e.g., Annual Election Period (AEP), Initial Coverage Election Period (ICEP), Initial Enrollment Period for Part D (IEP for Part D), Medicare Advantage Open Enrollment Period (MA OEP), Open Enrollment Period for Institutionalize Individuals (OEPI), or Special Election Period (SEP)) 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, PDP, and AARP Medicare Supplement Insurance plan enrollment application by the applicable Election Period deadline.

Agent Notification and Approved Alternative Resources
If you reside and work in the impacted business market(s), you will be notified by your local sales leadership that if, because of the force majeure event, you are unable to meet in-person with a 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. 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 one-on-one marketing appointment over the phone, following all guidelines including permission to call and scope of appointment rules.
- If the consumer requests to enroll in a UnitedHealthcare Medicare plan, you must provide the consumer with the following enrollment method options:
  - **JarvisEnroll Remote Signature**
    The field agent may use JarvisEnroll remotely via email or text message and capture a signature using remote signature or the voice signature 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.
    - You should direct the consumer to enter your agent ID in the applicable field. Note: You must not enter your name and/or signature on the paper enrollment application prior to receipt of the paper application from the consumer. If the consumer submits the paper application directly to the company, the agent ID alone is acceptable.
    - You must advise the consumer that you or the company must receive the enrollment application on or before the last day of the month or applicable Election Period in order to receive their desired effective date.

Assisting a Current Member

Agents or delegates on an agent's staff may call customer service (MA plan, PDP, and Standalone Dental, Vision, Hearing plan) or the PHD (AARP® Medicare Supplement Insurance plan) to act limitedly on a member's behalf. You may call without the consumer being on the line. Delegates may call without an agent or the consumer being on the line.

- You or a delegate must provide to customer service or the PHD the member's first and last name, authentication numbers (e.g., Writing ID, Party ID), and required member information (e.g., MBI, Member ID, AARP® membership ID, DOB) for the member.
- For MA plans and PDP, at the member's request, you or a delegate may:
  - Order replacement ID cards or fulfillment items
  - Change the member's permanent and/or mailing address. You or a delegate must state that the member has authorized you or a delegate to make the change.
    - You or a delegate may only change an address for a member who is staying in the enrolled plan's service area. If the member has moved outside of the enrolled plan's service area, a new application would be needed.
    - You or a delegate must not act on behalf of a member if the member receives a letter from UnitedHealthcare requesting confirmation of their address. Only the member or authorized legal representative may confirm or update an address in this circumstance.
  - Change a Primary Care Physician (PCP)
  - Inquire about claims and billing issues
  - Assist with the UnitedHealth Passport® Program (e.g., activate/deactivate Passport, change the Passport stop date).
  - Cancel or withdraw an enrollment application.

- For Medicare Supplement plans, at the member's request, you or a delegate may:
  - ~ Order replacement ID cards and fulfillment materials
  - ~ Make an address change (some exceptions exist in New York and Florida)
    - o You or a delegate must state that the member has authorized you or a delegate to make the change.
  - ~ Receive information about the status of medical claims (must have the provider name and date of service at a minimum).
  - ~ Receive information related to billing
- For Standalone Dental, Vision, Hearing plans, at the member's request, agents or delegates may:
  - ~ Order replacement ID cards and fulfillment materials.
  - ~ Change the member's permanent and/or mailing address, email address or phone number.
  - ~ Change the member's name, date of birth or gender.
  - ~ Change the member's plan or plan effective date.
  - ~ Request to add a secondary (spouse) to the member's plan.
  - ~ Request to voluntarily terminate the member's plan during the 30-day free look period.
  - ~ Inquire about provider networks and claims.
  - ~ Receive information related to billing (e.g., rate changes, paid through date of member's plan, amount needed to make member's plan current, member's payment due date, date the member's premium payment received, and timing of member's electronic funds transfer withdrawal date.)

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 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.

- 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 or you must contact Customer Service or the PHD on behalf of the consumer to facilitate the withdrawal request. When contacting the PHD, you must attest to having permission from the consumer to request the withdrawal. 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. The you must direct the consumer to Customer Service or the agent/delegate must contact Customer Service or the PHD on behalf of the consumer to facilitate the cancellation request. When contacting the PHD, you must attest to having permission from the consumer to request the cancellation. 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 **(excludes standalone PDP, Medicare Supplement Insurance, and Standalone Dental, Vision, Hearing plans)**

You may assist a consumer in completing a Health Assessment (HA) at the time of the sale. Refer to the Health Assessment (HA) Payment Program section for HA payment program requirements.

Field Agents (includes Telephonic Addendum Call Centers)

- For applications with a 2024 effective date, a field agent (including telephonic addendum call centers) may complete an HA for a consumer enrolling in a MA plan, DSNP, or CSNP.
- For applications with an effective date on or after 1/1/2025, a field agent (including telephonic addendum call centers) may complete an HA for a consumer enrolling in a DSNP or CSNP.

General Guidelines

- The HA must not be completed prior to an enrollment or more than three calendar days after the consumer signature date on the enrollment application.
- You must not require or pressure a consumer to complete an HA.
- When completing an HA immediately after completing an enrollment application, the agent must make the consumer aware that the enrollment application is complete and the HA process is beginning.
- The agent must advise the consumer that answers provided for the HA do not impact the consumer's enrollment.
- If an HA is completed in-home, the field agent must disclose at least two prescription drug safe disposal locations in the consumer's area using the Drug Enforcement Administration (DEA) website. The disclosure must include a written copy using the approved Disclosure Form (available on ***Jarvis***) with the disposal location addresses and a verbal summary of the disclosure. HA completed telephonically (i.e. not in-home) are exempt from this requirement.

- Agents may complete an HA electronically through JarvisEnroll or third-party enrollment platform approved by UnitedHealthcare. If completing an HA, the HA must be completed using the same platform as that used to complete the enrollment application. You must not complete a paper HA (or any other HA format) with a consumer and transfer the information to the JarvisEnroll or third-party enrollment HA.
- You must not share their log-on credentials with another individual.

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 2022 for a January 2023 effective date, the agent must be certified for 2023 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.
  - ~ 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.

Section 6: How do I take an Enrollment Application?

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
- *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.

Section 7: How am I Paid?

Commission Overview

A writing agent who submits an enrollment application is only eligible for a commission if they are properly credentialed (i.e. contracted, licensed, appointed (as required by the state), and certified (refer to the certification requirements section for details)) 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 appropriately credentialed at the time of sale will be compensated. Up-line entities that are not appropriately 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 appropriately credentialed at the time of sale. If a writing agent is not appropriately 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 the sections below.

Agent Compensation Eligibility Requirements

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, you (including solicitors) must be appropriately 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 (as required by the state).
  - ~ For MA plan/PDP applications must be certified in the product in which the consumer enrolled for the applicable effective year.
  - ~ For AARP Medicare Supplement and Standalone Dental, Vision, Hearing plans, applications must be certified in the product at the time of sale (i.e. not based on the plan year). Note: The writing agent is considered certified for Standalone Dental, Vision, Hearing plans if certified for AARP Medicare Supplement plans.

- **Monthly Renewals (Year Two and Subsequent Years)**
  To be eligible to receive renewal commissions for year two and beyond, the first year commission must be processed and paid and you must be appropriately credentialed as outlined below:
  - ~ For MA plan/PDP applications effective prior to 01/01/2014, to receive monthly renewal commissions, you (or immediate up-line if writing agent was solicitor level) must not be termed for-cause or deceased.
  - ~ For MA plan/PDP applications effective 01/01/2014 and later for you to be eligible to receive monthly renewals, you (or immediate up-line if writing agent was solicitor level) must be appropriately credentialed, credentialing requirements for you are noted below.
    - o Must be actively contracted (including servicing status contract) or in suspended status with UnitedHealthcare as of the first of the renewal month.
    - o Must be actively licensed and appointed (as required by the state) in the state of sale (or agent's resident state for servicing status contract) as of the first of the renewal month.

- Active status agents must be certified in the product of sale for the renewal year as of the first of the renewal month and the servicing status agent must be appropriately certified according to the terms of servicing agreement.

~ For AARP Medicare Supplement and Standalone Dental, Vision, Hearing plan applications with all plan effective dates, to receive renewal commissions:
- You (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.)

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, and awards.

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 you for selling Medicare products. However, if plan sponsors do compensate you, such compensation must comply with CMS and other regulatory guidance.

- Plans must establish a compensation structure for new enrollments and renewals effective in a given plan year. The compensation structure:
  ~ Must be reasonable and reflect fair market value for services performed.
  ~ Must comply with fraud and abuse laws, including the anti-kickback statute.
  ~ Must be in place by the beginning of the plan year marketing period, October 1.
  ~ Must be available upon CMS request for audits, investigations, and to resolve complaints.
- If plans pay commissions they must abide by CMS guidance by paying commissions for initial year (i.e. new to Medicare) enrollments as well as renewal compensation. CMS determines if an enrollment qualifies as an initial year or renewal year enrollment and directs the plan sponsor on which compensation level should be paid. The following rules pertain to the compensation cycle:
  ~ The commission amount paid to you for enrollment of a Medicare consumer into an Medicare Advantage (MA) plan or Prescription Drug Plan (PDP) 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 your 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 difference between the renewal rate and initial rate commission will be paid. 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 you are paid so long as you are in good standing according to the terms of your 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 2020 effective date will begin January 2021 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, the difference between the commission paid and the number of months the member was in the plan will be charged back.
- If a member terminates coverage involuntarily in months 1 to 11 (for example due to a plan exit), the difference between the commission paid and the number of months the member was in the plan will be charged back.
- 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, and awards are examples of compensation. The value of all forms of compensation must be included in the total compensation amount paid to you 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 and Standalone Dental, Vision, Hearing Plans

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, commissions; bonuses, gifts, prizes, and awards.

Commission
Commission is a form of compensation given to you 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 or Standalone Dental, Vision, Hearing products. However, if plan sponsors do compensate you, 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 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 or Standalone Dental, Vision, Hearing 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.

Charge Backs

Commissions are earned on the duration of a member's enrollment. Any unearned commission paid on an AARP Medicare Supplement or Standalone Dental, Vision, Hearing policy will be charged back to all levels that were paid for that policy.

- Charge backs will be recovered from the next available commission payment of any UnitedHealthcare product.
- If there is not enough new or renewal commissions to offset the charge back, the balance of the charge back is rolled to the next commission statement. This continues until the charge back is repaid in full.

Miscellaneous Forms of Compensation

Commissions, bonuses, gifts, prizes, and awards are examples of compensation. The value of all forms of compensation must be included in the total compensation amount paid to you for an enrollment and may not exceed the limits under state laws and regulations.

Commission Payment Schedule

Commission Payment Schedule

- MA Plan and PDP
  - ~ New Business – paid twice weekly
  - ~ Renewals – paid monthly, Per Member Per Month, MA plan and PDP renewals are processed the third 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 typically paid a nine-month advance in most states (as noted here or in the contract), unless an agent has specifically requested to have no advance period. 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.
  - ~ 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.
- Standalone Dental, Vision, Hearing Plans
  - ~ New business – paid monthly, in the month following the effective date of the policy.
  - ~ Renewals – paid monthly, payments will occur the month following the premium month.

Direct Deposit (Does not apply to SecureHorizons Medicare Supplement products)

You may follow the instructions below to request direct deposit.

- Access ***Jarvis*** (www.uhcjarvis.com)
- Under "Manage Profile" tab, 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, contact the PHD at 888-381-8581 or via ***Jarvis*** Chat.

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 hierarchy. For each enrollment, an entity/agent within a hierarchy is entitled only to the appropriate amount listed on the UnitedHealthcare 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 **(update effective 02/24/2020) (applies to MA only (excludes standalone PDP, Medicare Supplement Insurance, and Standalone Dental, Vision, Hearing plan))**

UnitedHealthcare will pay the contracted amount for the completion of a Health Assessment (HA) when all of the following requirements are met:

- All "Agent Assisted Health Assessment (HA) Process" (refer to earlier section) requirements must be met.
- For applications with an effective date on or after 1/1/2024:
  - ~ The enrollment is for a new member; or

  - The member completes a plan change moving from one UnitedHealthcare MA, DSNP, or CSNP to another UnitedHealthcare DSNP or CSNP.
- For applications with an effective date on or after 1/1/2025:
  - The enrollment is for a new DSNP or CSNP member; or
  - The member completes a plan change moving from UnitedHealthcare DSNP or CSNP to another UnitedHealthcare DSNP or CSNP.
- The enrollment must be accreted (i.e. the application was approved and the member enrolled).
- The plan in which the consumer is enrolling is commissionable.
- You must pass credential validation for the submitted enrollment application (refer to the Agent Compensation Eligibility Requirements section).

An HA payment:

- Will generally occur during the month that follows the plan effective date month (e.g., the HA payment for a 2/1 plan effective date will occur in late March).
- For applications with an effective date on or after 1/1/2024, an HA payment will be charged back due to a rapid disenrollment from the plan.
- May be charged back if it is determined that payment requirements were not met or due to payment corrections or abuse of the HA payment program.
- Will be reported on the 1099 for the year in which it was paid.

Agent of Record (AOR) Retention

In select circumstances, an agent's status as AOR and associated entitlement to commission payments will be retained for a Qualifying Plan enrollment when eligibility requirements have been met. The AOR remains responsible for servicing the member. AOR retention is at the discretion of UnitedHealthcare. UnitedHealthcare reserves the right to deny an agent AOR retention or remove an agent as AOR.

- AOR eligibility requirements
  - For non-eAlliance Qualifying Plan enrollments, the current agent associated to the member, or immediate up-line if the original agent was a solicitor, must be an active selling EDC, ICA, or IMO agent/agency (non-solicitor) at the time the Qualifying Plan enrollment occurred (i.e. not terminated or in servicing status).
  - For eAlliance, any plan change not executed by an eAlliance with a signature date on or after 9/1/2023 are not eligible for AOR retention except as otherwise allowed by UnitedHealthcare (e.g., retaining AOR to ensure member access to HRA funds).
  - A Direct to Consumer (DTC) Sales agent must conduct the enrollment in the new Qualifying Plan or the impacted member may self-enroll via CMS, web or paper enrollment application without the involvement of a non-DTC Sales agent.
  - The member enrolls from a Qualifying Plan into Qualifying Plan. Qualifying Plans include UnitedHealthcare MA plan, MAPD plan, DSNP, or CSNP. Any other type of plan switch does not qualify for AOR retention, including Medicare Supplement Insurance, and Individual PDP.
- Service Area Reduction (SAR) Impacted Qualifying Plan Member Enrolls in a New Qualifying Plan
  - A member's current Qualifying 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 Qualifying 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;
- Non-SAR Qualifying Plan Members Enrolls in a New Qualifying Plan
  - ~ The current member must be currently enrolled in a Qualifying Plan;
  - ~ The current member must switch from the current Qualifying Plan to another Qualifying Plan with no gap in coverage.
- Commission Payment
  - ~ For Qualifying Plan enrollments with a signature date prior to 1/1/2024, a new commission will process if the plan change is within the first year and renewals will continue in year two and forward to the agent associated to the member, or immediate up-line if the original agent was a solicitor, at the time the Qualifying Plan enrollment occurred, if eligible.
  - ~ For Qualifying Plan enrollments with a signature date on or after 1/1/2024, the retained AOR as determined in this section will receive commission at the current renewal year rate for the new enrollment.
  - ~ For non-Qualifying Plan 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 commission/incentive payments per standard rules.

Assignment of Commission (applies to all products (excluding SecureHorizon Medicare Supplement Insurance))

Agent Assignment to an Individual or Entity

- The assignee, an individual or entity represented by a principal, must also be actively contracted for the sale of Medicare products.
- The assignor and the assignee must belong to the same line of business. For example, a Medicare & Retirement Writing ID (WID) cannot assign to an IFP WID or a Medicare & Retirement WID cannot assign to an agent only selling IFP products.
- Assignment to an estate, widow(er), or heir: Under the Agent Agreement, death of the agent is an automatic termination. UnitedHealthcare 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%.
- SecureHorizons Medicare Supplement Insurance Plans are not eligible for Assignment of Commission.

Assignment of Commission Process

You 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 > Assignment of Commissions.

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 appropriate 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.

Held Commission Process

Commissions are paid to eligible, non-employee agents for enrollment applications that are complete, legible, and accurate. Commission will be held if you fail 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 can review commission status and statements under the Commissions tab on ***Jarvis***. If a commission is held, the reason(s) for payment ineligibility is provided.

Review and Resolution Process

The primary goal of the review process is to determine whether a held commission is eligible for payment or is legitimately held due to an issue with agent credentialing and/or enrollment application quality. The process for held commission review and resolution includes the following steps:

Appeals Process:

- The communication outlines a clear appeal process that you may use if you feel a transaction has been held inappropriately.
  - ~ You have 30 days from receipt of the communication to appeal to the PHD at 888-381-8581 or via ***Jarvis*** Chat.
  - ~ The ALM, Certification, and/or Commissions team reviews the appeal and approves or denies it.
  - ~ For appeals that are specifically related to your certification, the following requirements must be met:
    - o You may request exception process review under one of the following circumstances:
      - You knew, in good faith, that they 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, was not provided with the appropriate certification requirements or online development plan.
    - o 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 you 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 "forfeit" status indicating no further appeal is available.
- The appeals process can take up to 14 business days, and you are contacted via email, phone, or letter with the final decision on the appeal.

Plan Changes

MA plan/MA-PD plan or PDP

- Any MA plan/MA-PD plan or PDP and/or plan benefit package change is a commissionable event and may result in a new commission paid on a Per Member, Per Year (PMPY) basis. (See the "Agent of Record (AOR) Retention" 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.
- 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. Rapid disenrollment rules apply.
- 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

- For plan changes, if there is no break in coverage, the original writing agent will retain commission eligibility. Plan changes include:
  - ~ Changes from one AARP Medicare Supplement Plan to another under the same Insurance Company, including:
    - o Changes from an AARP Medicare Supplement Plan, insured by UnitedHealthcare Insurance Company to another AARP Medicare Supplement Plan insured by UnitedHealthcare Insurance Company.
    - o Changes from an AARP Medicare Supplement Plan, insured by UnitedHealthcare Insurance Company of New York to another AARP Medicare Supplement Plan, insured by UnitedHealthcare Insurance Company of New York, and

- Changes from an AARP Medicare Supplement Plan, insured by UnitedHealthcare Insurance Company of America to another AARP Medicare Supplement Plan, insured by UnitedHealthcare Insurance Company of America.

~ Changes from an AARP Medicare Supplement Plan, insured by UnitedHealthcare Insurance Company to an AARP Medicare Supplement Plan, insured by UnitedHealthcare Insurance Company of New York (and vice versa).

~ The writing agent on the plan change, if different from the original writing agent, will not receive commissions.

- For internal replacements

~ If there is no break in coverage and original writing agent was active and appropriately credentialed for the replacement policy at the time of application, the original writing agent will be commission eligible. The replacement policy writing agent, if different from the original writing agent, will only be commission eligible if the original writing agent was not active and the new writing agent was appropriately credentialed for replacement policy at the time of application (for UHICA plans, new writing agent must also have been authorized to sell such plans by way of separate notice from UnitedHealthcare). Internal replacements include:

- An AARP Medicare Supplement Plan insured by UnitedHealthcare Insurance Company of America replaces an AARP Medicare Supplement Plan insured by UnitedHealthcare Insurance Company or UnitedHealthcare Insurance Company of New York; or
- An AARP Medicare Supplement Plan insured by UnitedHealthcare Insurance Company or UnitedHealthcare Insurance Company of New York replaces an AARP Medicare Supplement Plan insured by UnitedHealthcare Insurance Company of America.

~ For subsequent internal replacements, the agent that was “commission eligible” on the immediately prior internal replacement will be evaluated for commission in accordance with the internal replacement sub-section above.

Standalone Dental, Vision, Hearing Plans

- For any plan change, 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 they disagree with a payment amount, including instances when you have not been paid, but feels 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.

- You must contact the PHD at 888-381-8581 or via ***Jarvis*** Chat to provide 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 you by the Commissions Audit department.
- Responses will be stored within the PHD Service Request.
- Follow-up calls associated with the request from you or your up-line should be directed to the PHD at 888-381-8581 or via ***Jarvis*** Chat 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 MA plan or PDP.

- 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, you may request a debt repayment plan by submitting an appeal by contacting the PHD at 888-381-8581 or via ***Jarvis*** Chat. Debt repayment options are only available for charge backs for the sale of MA plans and PDPs 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:
  - ~ You must be in good standing (i.e. you are not the subject of an open complaint investigation and/or open corrective and/or disciplinary action outreach),
  - ~ You 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

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

Individuals representing UnitedHealthcare (including but not limited to agents (including active, servicing, and solicitors), agency principals, contractors, employees, and sales leaders) 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 competing with the interests of UnitedHealthcare or its consumer/members unless approved by management and in accordance with the Conflict of Interest policy.

A conflict of interest occurs when an individual's interests or activities, or in some cases those of their immediate family member (spouse/domestic partner, child, parent, or sibling, including step-relations and in-laws), could affect or appear to affect the individual's decision making on behalf of UnitedHealthcare or because the individual's objectivity could be questioned because of those interests or activities.

Types of Conflict of Interest
UnitedHealthcare categorizes conflicts by the following types:

Relationship with a Health Care Provider or UnitedHealthcare Business Partner
- An individual representing UnitedHealthcare, or their immediate family member, has a direct or indirect ownership interest in AND/OR is an employee, contractor, or consultant of AND/OR holds a position of influence with a health care provider or UnitedHealthcare business partner.

Relationship with an Organization that Interacts with Medicare Beneficiaries
- An individual representing UnitedHealthcare has a direct or indirect ownership interest in AND/OR is an employee, contractor, or consultant of AND/OR holds a position of influence with an organization that has any interaction with Medicare beneficiaries.

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.

Simultaneous Employment and Contract with UnitedHealthcare or another insurance carrier
- An employee of UnitedHealth Group or its affiliate is simultaneously in a non-employee contractual relationship with UnitedHealthcare or another insurance carrier.

Relationship between Non-Employee Agent/Agency and a UnitedHealthcare Competitor
- A non-employee agent is contracted and appointed with multiple carriers, including direct competitors of UnitedHealthcare. While this is a conflict of interest, UnitedHealthcare does not require the disclosure and management of this conflict type.

UnitedHealth Group Employee Sells Non-UnitedHealthcare Products Requiring State License
- An employee of UnitedHealth Group or its affiliate is involved in the sale of a non-UnitedHealthcare insurance product, which requires a state license (e.g., health, life, financial services, and property/casualty), that may or may not compete with UnitedHealthcare Medicare insurance products.

Conflict of Interest Status Attestation and Disclosure
Individuals with an active Party ID who receive compensation based on sales and/or enrollments (e.g., commission, incentive, bonus, override) must disclose their conflicts of interest and attest to their conflict of interest status annually and as they are discovered thereafter.

Section 8: What are Expected Performance Standards?

Annual Disclosure and Attestation
Individuals will receive an email on their Party ID anniversary date (or issue date for newly onboarding individuals) inviting them to complete their conflict of interest disclosure and attestation.

- Individuals must complete the disclosure and attestation process within 90 calendar days of the date of the email.
- Failure to complete the disclosure and attestation process by the due date may result in a not-for-cause termination for non-employees (refer to the Termination Process section) and for employees, being placed on a Corrective Action Plan (CAP).

Disclosing Conflicts Outside of the Annual Process
Conflicts of interest that arise after the completion of the annual disclosure and attestation must be disclosed promptly.

- Within three business days of discovery of a new conflict of interest, email Agent_COI@uhc.com and request an off-cycle conflict of interest disclosure and attestation interview.
- Complete the disclosure and attestation process within 90 calendar days of receiving the email invitation.
- Failure to complete the disclosure and attestation process by the due date may result in a not-for-cause termination for non-employees (refer to the Termination Process section) and for employees, being placed on a Corrective Action Plan (CAP). Once an invitation is sent, it must be completed to avoid termination or a CAP. If an off-cycle interview is requested in error, email Agent_COI@uhc.com and request that the interview request be closed.

Conflict of Interest Disclosure Evaluation and Determination Outcomes
UnitedHealthcare evaluates conflict of interest disclosures and determines an outcome for each. Outcomes include developing a management plan, requiring the individual divest of the conflict, or referring the individual for termination. Failing to agree to or comply with a management plan or failing to divest of a conflict may result in corrective and/or disciplinary action up to and including termination.

Privacy and Security Incidents
You are required to act in compliance with all of the Centers for Medicare & Medicaid Services (CMS) regulations and guidelines and other applicable federal and state laws. UnitedHealthcare expects agents to act with the highest degree of ethics and integrity and in the best interest of its consumers and members. UnitedHealthcare does not tolerate unethical behavior and our policies and procedures strictly prohibit activities that are not in the best interest of those we serve. Federal law requires Medicare plan sponsors to implement and maintain a Compliance Program that incorporates, measures to detect, prevent, and correct compliance related issues that include fraud, waste, and/or abuse.

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides requirements for the protection of health information. There are two pertinent provisions that guide the use of member/consumer information:

- Privacy Provisions
  - The HIPAA Privacy Rule outlines specific protections for the use and sharing of Protected Health Information (PHI).
- Security Provisions

- The HIPAA Security Rule defines how PHI should be maintained, used, transmitted, and disclosed electronically.

Under HIPAA, if member information is disclosed to an unintended recipient, the UnitedHealthcare Privacy Office may have to:

- Notify the member
- Post the disclosure on the Health and Human Services (HHS) website
- Notify the Centers for Medicare and Medicaid Services (CMS)
- Notify state Attorney General (AG) or Department of Insurance (DOI) and/or other state agency as required by state law
- Notify the media
- In addition, individuals, including employees and business associates, may be criminally liable for intentional disclosures, privacy, and/or security incidents involving a potential or actual disclosure of member/consumer information

If you become aware of an inappropriate HIPAA/PHI disclosure, it **must** be reported within 24 hours of discovery.

You are responsible for protecting our consumers, members, our brand, and our company. Failure to protect PHI/PII may result in corrective and/or disciplinary action up to and including termination. You can report suspected privacy or security incidents through:

- Incidents should be reported to one of the following:
  - The UnitedHealthcare Program Privacy Office at UHC_Privacy_Office@uhc.com
  - Your supervisor or manager
  - The Segment Compliance Officer/Compliance Lead
  - The UnitedHealth Group Compliance & Ethics HelpCenter 800-455-4521 or www.uhghelpcenter.ethicspoint.com (available 24 hours a day, 7 days a week.)
- 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.

Fraud, Waste, and Abuse

You are accountable for complying with all applicable laws, rules, regulations, policies, and procedures regarding fraud, waste, and abuse. UnitedHealthcare relies on your integrity, good judgment, and values to ensure we remain compliant.

Fraud is intentionally obtaining something of value through misrepresentation or concealment of facts. The complete definition of fraud has many components including:

- Intentional dishonest actions or misrepresentation of fact,
- Committed by a person or entity, and
- With knowledge the dishonest action of misrepresentation could result in an inappropriate gain or benefit.

This definition applies to all persons and all entities.

Waste and abuse are generally broader concepts than fraud. Waste includes inaccurate payments for services, such as unintentional duplicate payments, and can include inappropriate

utilization and/or inefficient use of resources. Abuse describes practices that, either directly or indirectly, result in unnecessary costs to health care benefit programs. This includes any practice that is not consistent with the goals of providing services that:

- Are medically necessary
- Meet professional recognized standards for health care, and
- Are fairly priced

Generally speaking, waste and abuse can be identified by the following concepts:

- Over-use of services
- Practices or activities – whether by providers, members, vendors, employees or contractors – that are inconsistent with sound business, financial, or medical practices
- Practices or activities that cause unnecessary costs to the health care system

In most cases, waste and abuse are not considered to be caused by careless actions but rather the misuse of resources.

You can report suspected fraud, waste, and abuse to the UnitedHealthcare Fraud Tip Line at 866-242-7727 (Monday – Friday from 8:00 a.m. – 6:00 p.m. or 24 hours a day, 7 days a week for recorded messages.

Ethics and Integrity

Being ethical is much more than knowing the difference between right and wrong. It is being able to recognize and find your way through an ethical dilemma.

Merriam-Webster's Dictionary defines ethics as:

- The discipline dealing with what is good and bad and with moral duty and obligation.
- A theory or system of moral values
- A guiding philosophy.
- A set of moral issues or aspects.

Promoting an ethical and honest environment involves all agents embracing the values of honesty and integrity.

The following are several tips that should aid you in your daily activities:

- Understand the Centers for Medicare & Medicaid Services (CMS) regulations and UnitedHealthcare rules, policies, and procedures
- Report misconduct
- Ask if you don't know the answer. Remember there are plenty of resources to help you make ethical decisions, so don't feel reluctant about asking advice.
- Take responsibility for your actions.
- Remember the 3Bs of Ethics and Integrity:
  - ~ Be Informed
  - ~ Be Aware
  - ~ Be Vocal

Ethical issues arise in most aspects of marketing and selling and encompass three main components disclosure, competency, and suitability.

Disclosure

- You must disclose to consumer all information needed to make an informed decision

- You must inform consumers of the advantages, as well as, the limitations of the products you present
- 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

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 plans and ensure all agents are conducting marketing, selling, and enrollment activities compliantly. Agents must adhere to all federal and state laws and regulations and Centers for Medicare & Medicaid Services (CMS) and UnitedHealthcare ethical and business standards, policies, procedures, and rules.

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 agency representative is responsible for completing the following oversight and development activities:

Your NMA must manage and monitor your agent performance by:
- Ensuring you complete all required UnitedHealthcare training.
- Communicating all product and regulatory information from UnitedHealthcare.
- Ensuring you participate in any UnitedHealthcare required remedial training.
- Ensuring any corrective action plan is completed and reported back to UnitedHealthcare.

Field Sales Agents authorized to sell UHC Senior Care Options
Your UnitedHealthcare Senior Care Options sales manager must manage and monitor performance by:

- Ensuring you complete and pass all UnitedHealthcare required training.
- Ensuring you attend meetings with UnitedHealthcare SCO sales managers for continuing education, training, case reviews and best practices.
- Completing ongoing monitoring activities.
- On an annual basis, conducting and documenting a minimum of one evaluation. A Coaching Request (CR) will be generated automatically in the Producer Contact Log (PCL) for each agent and assigned to the direct manager. The CR due date will be 30 days from date of creation. Within the 30-day period, the direct manager must:
  - Observe you while you conduct a personal/individual marketing appointment (an exception may apply), complete the applicable evaluation form accessible in PCL, and conduct a coaching session with you.
  - Document the observation and coaching session in the evaluation form and complete the CR documentation.
- Your UnitedHealthcare SCO sales manager will perform 30, 60, and 90 day follow-up for continuing education, training, and case reviews upon certification in the UnitedHealthcare Senior Care Options Plan product.
- Your UnitedHealthcare SCO sales manager will perform periodic ride-alongs to observe you during marketing/sales appointments.
- Your UnitedHealthcare SCO sales manager will conduct additional field observations and coaching sessions when you exhibit less than satisfactory performance. Each observation must be documented in PCL by creating a manual CR. If you do not show consistent performance improvement within an agreed upon timeframe, you may be subject to corrective action up to and including termination.
- DTC Sales agents authorized to sell UHC Senior Care Option plans will be monitored by their DTC sales leadership.

Activities 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 Conflict of Interest Committee (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 and state laws and regulations and UnitedHealthcare policies, procedures, and rules. 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 Sales Management Reporting Tool (SMRT) Agent Oversight include:

- Telephonic and Digital Interaction Monitoring
- Cancelled Enrollment Applications
- Complaints
- Late Enrollment Applications
- PCP Auto-Assign
- Rapid Disenrollment

Other monitoring programs are not reported through SMRT Agent Oversight and include:

- Unqualified Sales
- Suspicious Sales
- Event Related Infractions
- Use of a Public Web Enrollment Portal

UnitedHealthcare reserves the authority to monitor additional issues and circumstances as deemed warranted. At its discretion, UnitedHealthcare may discontinue or suspend CR creation and required coaching requirements for monitoring programs.

For questions regarding the compliance monitoring program and thresholds, contact your NMA or up-line.

Telephonic and Digital Interaction Monitoring
Telephonic and digital interaction monitoring program evaluates consumer and Telesales agent (Direct to Consumer (DTC) Sales, and DTC Sales vendor, and external call center partners) telephonic and digital interactions that resulted in an enrollment to ensure compliance with CMS guidelines.

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 Agent Oversight (see the Agent Complaint Process section for details). If you are assigned a CEC or CEC2, you must participate in assigned outreach and complete all assigned coaching. If you are referred to a CAR process, you must participate in assigned outreach and successfully complete the assigned sales remediation training course(s) and corresponding assessment, with a minimum score of 80% within six attempts, by the indicated due date. 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) plan enrollment application. Effective 03/01/2018, monitoring will be limited to paper and JarvisEnroll Office enrollment applications for MA HMO plans (some exceptions apply) submitted by you. Sales Oversight maintains the list of included plans.

Section 8: What are Expected Performance Standards?

Rapid Disenrollment
Rapid Disenrollment monitors voluntary member disenrollment from a MA plan or Prescription Drug Plan (PDP) within three months of the effective date.

Unqualified Sales and Corrective/Disciplinary Action
An unqualified sale is a sale by an agent who, at the time the enrollment application was written, was not appropriately licensed and/or appointed (as required by the state) or certified in the product in which the consumer enrolled.

- For the first two instances 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 third unqualified sale is validated within a rolling 12-month period subsequent to completed corrective actions for the first two instances 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 an agent's activities 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 marketing/sales events as indicated in the event reporting section. Prior to reporting and/or conducting an event, the presenting agent must have received credit for Events Basics.

- **Failure to Report**
  - ~ A failure to report infraction, results in a formal Operational Issues complaint against the presenting agent and a CAR.
    - o You will be assessed two complaint points
    - o 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
    - o You will receive Agent Coaching & Policy Specialist (ACPS)/BA coaching
    - o 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 Receive Credit for Events Basics**
  - ~ A presenting agent who did not receive credit for Events Basics 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).

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 internal UnitedHealthcare systems are utilized 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 enrollment 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.

Third-Party Marketing Organization (TPMO) Reporting Requirements
TPMOs must report monthly to UnitedHealthcare any staff disciplinary actions or violations of any requirements that apply to UnitedHealthcare associated with consumer/member interaction. As applicable, each monthly report must be provided to sales_oversight@uhc.com no later than the last day of the following month.

Agent Non-Compliance Reporting
UnitedHealthcare will, no less than monthly, submit agent offenses to CMS consistent with CMS reporting requirements.

Outreach and Coaching
Outreach and progressive engagement, including coaching, training, corrective action, and/or termination will occur when performance in one or more areas reaches an unacceptable level or at UnitedHealthcare's discretion. Agent outreach is generally conducted by an Agent Coaching & Policy Specialist (ACPS).

Agent Responsibilities
- You must participate in assigned outreach.
- You must complete assigned coaching, corrective action plan, and/or remediation activities within the required timeframe.
- If you fail to participate in and/or complete assigned coaching, corrective action plans, and/or remediation activities may be subject to disciplinary action up to and including termination.

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 forwarded to the Agent Issue Management (AIM) team via the agent issue management tool within 10 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 AIM team will complete the entry of each complaint as needed into the agent issue management 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 and the case documented accordingly if the following conditions exist:
  - No UnitedHealthcare sales agent is involved in the complaint
  - The product identified in the complaint is not a UnitedHealthcare product
  - The issue in question is not a violation of UnitedHealthcare policies, CMS guidelines, or federal or state rules or laws
  - The basis for the complaint is due to an internal business operational issue and submitted through the agent issue management tool
- If the complaint is in scope of the agent complaint process, it moves to the pre-disposition stage

Pre-Disposition

The AIM 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 issue management 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 CEC process includes the following steps:

- The AIM team uses the approval Referral Criteria Grid to determine appropriate outreach.
- If you are an active agent, the AIM team creates a Coaching Request (CR) in PCL and assigns it to the appropriate Agent Coaching & Policy Specialist (ACPS).

- If you are an inactive agent, a CR is not created. The AIM team updates the complaint status in the agent issue management tool and notifies ALM to flag you Review Before Contracting (RBC), 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 products. Complaints referred to the CIU are repeat issues or severe allegations of misconduct. At any point during the investigation, the AIM team or CIU may determine by using a severity grid that a recommendation to suspend your ability to market and sell UnitedHealthcare products is justified. The CIU will forward the suspension recommendation to the Director or Agent Issue Management.

Initial Review and Assignment of Case
Upon receipt of a complaint referral from the AIM 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 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 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 federal and state laws and regulations, CMS Medicare Communications and Marketing Guidelines (MCMGs), UnitedHealthcare policies, procedures, and rules, 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 federal and state laws and regulations, MCMGs, UnitedHealthcare policies, procedures, and rules, or other authority, a reasonable person would conclude that the allegation is unfounded.
- Inconclusive: There was insufficient evidence, facts, or corroborating evidence that existed at the time the investigation was conducted that would lead a reasonable person to conclude the allegation is neither substantiated nor unsubstantiated.
- Insufficient Information: The complaint lacked the minimum amount of information necessary to determine the identity of the agent, member, or other information necessary to conduct a complex investigation.
- No Allegation: The complaint is determined not to have been a complaint against the agent for sales or marketing misconduct in accordance with federal and state laws and regulations, MCMGs and UnitedHealthcare policies, procedures, and rules.
- 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 issue management tool. The case is updated as 'Refer for Disposition' in the tracking tool and is referred back to the AIM team. Supporting documentation, including exhibits, are provided to the AIM team within the tracking tool. Effective 05/05/2021, the CIU may refer for disposition, cases that no longer meet the requirement for CIU investigation back to the AIM team.

Assignment of Final Disposition

The AIM 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 issue management 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.

Section 8: What are Expected Performance Standards?

Referral to the Corrective Action Referral Process
For allegation outcomes of Inconclusive or Substantiated, the AIM team uses the CEC-CEC 2-CAR-DAC Referral Criteria Grid to determine if a referral to the Corrective Action Referral (CAR) process is appropriate. The following situations result in a CAR process referral:

- You **have not** had outreach for the same allegation(s) within the past twelve months and the CEC-CEC 2-CAR-DAC Referral Criteria Grid recommends referral to the CAR process.
- You have exhausted all CEC/CEC2 opportunities for the same allegation family (-ies) within the past twelve months and the event/enrollment application for the current allegation took place after those previous CEC/CEC 2 outreaches occurred.

Referral to the Disciplinary Action Committee
For allegation outcomes of Inconclusive or Substantiated, the AIM 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 AIM team creates a Coaching Request (CR) in PCL and assigns it to the appropriate Agent Coaching & Policy Specialist (ACPS) 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 AIM team updates the complaint status in the agent issue management tool and notifies ALM to flag you RBC, 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 Issue Management, is comprised of 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.
- 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 issue management 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 AIM 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 or the agency if the issue is best addressed at the agency level.
- 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 RBC. (Refer to the Agent Termination Process section for termination process details.)

Complaint point System

Points will be assessed 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. Effective 06/01/2021, complaint points will not be assigned to CAR cases that meet eligibility criteria. 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, an Agent Coaching & Policy Specialist (ACPS)/Team Lead/Agent Oversight Supervisor may request from AIM an extension to the required CR completion date.

Contact your Agent Coaching & Policy Specialist (ACPS)/Team Lead/Agent Oversight Supervisor for process details.

Revocation of Authority to Sell

Agent Performance Standards and Thresholds

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.

Failure to Comply with or Maintain Performance Standards in a Specific Product

If your failure 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 your performance against monitoring program threshold(s), UnitedHealthcare may process a revocation 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 up-line 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 email, with a read receipt, to your address in ICM. A copy is sent to your highest level up-line.
- 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.
- Contact your up-line for additional appeal process details.

Demotion of Authorize to Offer (A2O) Elite Status of AARP Medicare Supplement Insurance Plans

Agent Performance Standards and Thresholds

To retain active Authorized to Offer (A2O) Elite status of Authorized to Offer AARP Medicare plans you must meet certification requirements. There are sales minimums to retain access to A2O Elite marketing materials. The sales 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 sales. The following quality production guidelines apply to obtain/retain active statuses:

A2O Elite (also known as Level 2) Status:

- To obtain/retain A2O Elite (also known as Level 2) status, you must meet the annual sales minimums by submitting at least twenty-five commission-eligible accepted and paid enrollment applications of AARP Medicare Supplement plans during the annual production measurement period or maintain a book of business of 150 or more active AARP Medicare Supplement plan members.
- If you fail to meet the annual sales minimum or do not maintain at least 150 active Medicare Supplement plan members in your book of business, you will be demoted to A2O (also known as Level 1) status. If you are demoted to A2O, you may continue to offer AARP Medicare Supplement plans, however, you will not have access to A2O Elite (also known as Level 2) marketing materials. Notification of demotion will be sent to you as well as your highest level up-line. The letter will include an effective date (30 days from the notification date), and reinstatement and appeal rights.

Demotion Appeal Process

You may appeal an A2O Elite level demotion. UnitedHealthcare Insurance Plans 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 the PHD chat via Jarvis 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.

Suspension of Agent Marketing/Sales Activities

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 plans.

- 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 sent via email to you with a copy sent to your highest level upline.
- 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 plans while on a suspension status.

- New business written during the suspension period will not be eligible for commission. UnitedHealthcare reserves the right to hold any or all commissions, while on suspension status.
- Contact your up-line for additional details regarding a suspension of marketing and sales activities.

Termination of Non-Producing EDC Agent/Agency

UnitedHealthcare may at its discretion terminate agent/agency (not including solicitors or eAlliance) that do not meet minimum production requirements during the recurring annual evaluation period.

You will be sent a termination notification letter 30 days prior to the termination effective date, which includes the reason for termination, the effective date of termination, and instructions for submitting an appeal. A copy of the notification letter is sent to your highest level up-line and is uploaded to your agent sales file.

You may submit an appeal of the termination within the 30-day termination notification period if one of the following conditions can be met:

- Proof of at least one sale during the evaluation period (e.g., a copy of commission statement or a screen shot from ***Jarvis***).
- Proof you are solely in a non-selling role (e.g., training, operations, administrative). The highest level up-line must provide a signed letter verifying your role and include a request to move you to a solicitor level.
- Proof you are the principal and use the writing number of your 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.)

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 the PHD. A copy of the notification letter is sent to your highest level up-line 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.

Termination – Disciplinary Action

Refer to the Complaints section for termination determinations made by the DAC. The M&R DAC may review for determination agents that are disciplinary termed by other UnitedHealth Group lines of business.

Termination – Administrative

Administrative terminations are disciplinary, not-for-cause terminations initiated by the AIM 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 AIM team sends you a notification of termination letter detailing the reason for termination, the termination effective date, and the appeal process via email, with a read receipt, to your address in ICM. A copy of the notification is sent to your highest level up-line and to ALM.
- ALM will process the termination 30 days from the termination notification date and add a Review Before Contracting (RBC) 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 AIM team and a retraction to the notification of termination letter will be sent via email with a read receipt. A copy is sent to your highest level up-line 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 – Agent Coaching & Policy Specialist (ACPS)
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 AIM team sends you a notification of termination letter detailing the reason for termination, the termination effective date, and the appeal process via email, with a read receipt, to your address in ICM. A copy of the notification is sent to your highest level up-line and to ALM.
- ALM will process the termination 30 days from the termination notification letter and add a RBC flag to your file.
  - ~ If within 30 days from the date of the letter, your ACPS provides notice that you have completed all coaching and corrective action requirements, your ACPS will alert the AIM team and a retraction to the notification of termination letter will be sent via email with a read receipt. A copy is sent to your highest level up-line 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 and/or appointed (as required by state) and/or certified (refer to the Certification Requirements section for details).

- 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
  You will be terminated not-for-cause when a third unqualified sale is validated within a rolling 12-month period subsequent to completed corrective action for the first two instances 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.

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 highest level up-line (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 RBC 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 email, with a read receipt if applicable, to your address in ICM.
- 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 email, with a read receipt, to your address in the contracting system.
- Agent and/or highest level up-line 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.
- If you have down-line agents and the termination is requested by the highest level up-line, the entire down-line is terminated or reassigned to the next hierarchy.
- You are flagged RBC in the contracting system upon the DAC referral for disciplinary termination, directed by Legal, AIM team (for administrative terminations), field sales leadership, unaddressed complaint, failure to complete coaching, 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 RBC in the contracting system. UnitedHealthcare will report for-cause terminations to the appropriate state Department of Insurance (DOI) and the Center for Medicare and Medicaid Services (CMS).

For-Cause Termination Process
- You will receive a for-cause termination letter, detailing the reason for termination, the termination effective date, and the appeal process via email, with a read receipt, to your address in ICM.
- ALM is notified of the termination request by the AIM 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 RBC 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)

State and CMS Notification Process
UnitedHealthcare will comply with all regulatory requirements regarding state and CMS notification of appointment termination of agents.
- Contact your up-line for additional details.

Request for Reconsideration

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 AIM 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 documented in the DAC minutes and written notification of the DAC's decision is sent to you via carrier for expedited delivery and by email, with a read receipt, to your address in ICM.
- 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 RBC 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 senior UnitedHealthcare 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 AIM team via business_monitoring@uhc.com.
- The AIM 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 allegation family, 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 highest level 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 Chief Distribution Officer will cast the final approval/rejection vote and may consult with the market Senior Vice President and/or request additional information to make their decision.
- The RBC flag will be removed and you must address any outstanding member complaints following the reappointment.
- If the DAC denies the re-contracting request, the RBC 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 AIM team via business_monitoring@uhc.com.
- The AIM 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 allegation family, 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 highest level 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 RBC flag will be removed and you must address any outstanding member complaints following the reappointment.
- If the DAC denies the re-contracting request, the RBC 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 request, complete, and email a Request for Reconsideration of Appointment form and all supporting documentation to the AIM team via business_monitoring@uhc.com.
- The AIM 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 allegation family, 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 RBC flag will be removed, the AIM team will disposition the investigation findings following the reappointment.
- If the DAC denies the re-contracting request, the RBC flag will remain and you are prohibited from future contracting opportunities.

Administrative Termination - Agent Coaching & Policy Specialist (ACPS)

- A minimum waiting period of 12 months from your termination effective date is required.
- You must request, complete, and email a Request for Reconsideration of Appointment form and all supporting documentation to the AIM team via business_monitoring@uhc.com.
- The AIM 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 allegation family 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 RBC 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 RBC flag will remain and you are prohibited from future contracting opportunities.

Section 9: Glossary of Terms

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. The entire glossary was updated on 04/01/2024.

Term	Definition
A	
AARP	AARP is a nonprofit, nonpartisan organization dedicated to empowering people 50 and older to choose how they live as they age.
Accreted	An enrollment that was approved by CMS and the member enrolled in the plan.
Age-In	An individual that turned 65 and meets the age eligibility requirement for Medicare.
Agency	A global term to refer to the entity level contracted with UnitedHealthcare to market and sell UnitedHealthcare products. Agencies may include a network of downline contracted, licensed, appointed (as required by the state), and certified agents and/or solicitors.
Agent	A global term to refer to any contracted (if applicable), licensed, appointed (as required by the state), and certified individual marketing and selling UnitedHealthcare products. When referenced, agent may include the individual, up-line entity, or solicitor. See also solicitor.
Agent Agreement	The contract document that details the relationship between UnitedHealthcare and an individual agent.
Agent Issues Management (AIM)	The team that manages the intake, review, and disposition of agent related complaints.
Agent Lifecycle Management (ALM)	The team that manages the agent on-boarding and readiness process and maintains data, including but not limited to, contracting, licensing, and appointment data.
Agent of Record (AOR)	The agent on file associated to the member or immediate up-line if the original agent was a solicitor who continues to service the member once enrolled.
Annual Election Period (AEP)	An annual period when consumers and members can make new plan choices. Consumers may elect to join, drop, or switch a Medicare Advantage (MA) plan (or add or drop drug coverage), switch from Original Medicare to a MA plan or vice versa, or join, drop, or switch to another Medicare drug plan. AEP runs from October 15 to December 7. Elections made during this period will become effective January 1st of the following year.
Appeal (member)	Appeal means any of the procedures that deal with the review of adverse organization determinations on the health care services the enrollee believes they are entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service, as defined by CMS.
Appointed	When UnitedHealthcare has submitted an appointment request to that state (if applicable) and the agent has been granted authority by the

	state to market and sell UnitedHealthcare insurance products within that state.
Appointment (agent)	A procedure required by states that grants limited authority to an individual to market and sell UnitedHealthcare insurance products within that state.
Assignment of Commission	Assignment of Commission allows an agent/agency (assignor) to still service their member but direct their payments to another agent/agency (assignee).
Authorized Legal Representative	An individual that has authority under state law to make health care decisions on behalf of another individual.
Authorized to Offer (A2O) Elite Agent	Agents that have met and continue to meet all certification and performance requirements and adhere to all contractual provisions and requirements for AARP Medicare Supplement Plans.
Auto-Dialer	Equipment which has the capacity to store or produce telephone numbers to be called, using a random or sequential number generator and to dial such numbers.
Average Speed to Answer	The time it takes for calls to be answered from the instant a customer is placed in a queue to the moment an agent answers the call.
B	
Base Level Certification	Part of the UnitedHealthcare certification program that consists of the Medicare Basics (MA Non-SNP), PDP, and Medicare Supplement), Ethics and Compliance, and AARP assessments.
Blanket Approval	A term where a single approval covers all other use.
Business Reply Card (BRC)	A paper or electronic (eBRC) lead generation document completed by the consumer as a response/request for information about a plan or to provide permission to contact to an agent/agency/plan.
C	
Call Abandon Rate	the proportion of inbound calls to a call center where the customer disconnects before their call is answered by an agent.
Captive	A global term for an agent/agency/entity that has a contract agreement to only market/sell UnitedHealthcare for identified products.
Carrier	A global term that refers to the organization (e.g., UnitedHealthcare) that contract with CMS to provide coverage to beneficiaries.
Certification	The process required by CMS that all agents marketing/selling Medicare products are annually trained and tested on CMS rules and regulations and UnitedHealthcare policies, procedures, and rules specific to UnitedHealthcare products the agent intends to sell.
Certified	When an individual has completed the UnitedHealthcare certification requirements based on their role and/or products they market/sell.
Channel	The part of the UnitedHealthcare Sales Distribution structure where the individual/entity is contracted or an employee (e.g., External Distribution Channel (EDC), Independent Career Agent (ICA), Independent Marketing Organization (IMO), and Direct to Consumer (DTC) Sales).
Chargeback	The process where UnitedHealthcare recovers an amount of commissions paid to an agent/agency.
Chronic Condition Pre-Assessment	A CMS assessment model that is used and discussed pre-enrollment to verify eligibility into a CSNP.

Chronic Condition Release of Information Form	The form permitting UnitedHealthcare to contact a consumer's provider to verify a chronic condition for eligibility into a CSNP.
Chronic Special Needs Plan (CSNP)	An MA plan that is designed to provide focused and specialized care for individuals with a qualifying chronic condition.
Code of Conduct	The UnitedHealth Group Code of Conduct provides essential guidelines that help the organization achieve the highest standards of ethical and compliant behavior in our work.
Coinsurance	The amount the member may be required to pay as their share of the cost of services or prescription drugs. Coinsurance is generally stated as a percentage (e.g., 25%).
Commercial Member	A member in a commercial UnitedHealthcare plan.
Commission	Commission is a form of compensation given to an agent for new enrollments of consumers into a plan or membership renewals.
Commissionable	A term used in commissions to describe when an enrollment or plan change meets the requirements in order for a commission to be paid.
Communication Materials	Communications means activities and use of materials to provide information to current and prospective consumer/member. This means all activities and materials aimed at prospective and current consumer/member.
Comparison Website	A website operated by an eAlliance or Telephonic Enrollment Capability Addendum entity that features UnitedHealthcare plan benefit information.
Continuing Education (CE)	Regular education and training requirements by state to maintain their license.
Contracted	A global term for an agent/agency/entity that has an executed contract agreement to market/sell UnitedHealthcare products.
Copayments	The amount the member may be required to pay as their share of the cost of services or prescription drugs. Copayment is generally stated as a fixed amount (e.g., $2.00).
Coverage Stages	The four stages (i.e. Yearly Deductible, Initial Coverage, Coverage Gap, Catastrophic Coverage) to Medicare Part D Standard Prescription Drug Coverage that defines the amount the member or Plan pays.
D	
Deductible	The amount the member must pay for covered services or prescription drugs before the Plan begins to pay.
Delegate	A term to describe an individual authorized to act limitedly on behalf of an agent in assisting a member.
Direct to Consumer (DTC) Sales (Formerly Telesales)	The distribution channel comprised of Telesales agents and agencies that market and sell UnitedHealthcare products. May be employee Telesales agents or contracted call center vendors.
Downline	The external hierarchy structure where the entity aligns under a higher contracted level entity in the External Distribution Channel.
Drug Tiers	The grouping of covered drugs for a Medicare Prescription Drug plan into tiers. The number of tiers may vary by plan and generally, the lower the tier, the lower the cost of the drugs in the tier.

Section 9: Glossary of Terms

DTC Sales Vendor	Call center vendors contracted by UnitedHealthcare DTC Sales to market and sell UnitedHealthcare products telephonically.
Dual Special Needs Plan (DSNP)	An MA plan that is designed to provide focused and specialized care for individuals who are eligible for both Medicare and Medicaid.
Dynamic URL	A term used in Permission to Contact documentation to describe a website URL that changes based on provided information.
E	
eAlliance	A contracted entity approved by UnitedHealthcare to operate a telephonic enrollment call center and/or electronic enrollment capability as part of the External Distribution Channel (EDC).
eAlliance Captive	eAlliance entities that are contracted to market and sell UnitedHealthcare plans exclusively for Medicare Advantage (MA) plans.
Effective Date	The date that a member's plan coverage begins.
Election Period	The time(s) during which an eligible individual may request to enroll in or disenroll from an MA/PDP plan. The type of election period determines the effective date of MA/PDP coverage as well as the types of enrollment requests allowed. The six types of election periods are: Annual Election Period (AEP), Initial Coverage Election Period (ICEP), Initial Enrollment Period for Part D (IEP for Part D), Open Enrollment Period for Institutionalized Individuals (OEPI), Special Election Period (SEP), and Medicare Advantage Open Enrollment Period (MA OEP).
Electronic Business Reply Card (eBRC)	See Business Reply Card
Employee Sales Agent	A UnitedHealthcare employee who is licensed and appointed to market and sell UnitedHealthcare Medicare Plans products in the field.
Enrollment Guide	A resource that contains an Enrollment Application, Summary of Benefit, Drug List, Star Rating information, and provides benefits and services the plan covers.
Enrollment Kit	A resource that provides general benefit information, rates, application, and required disclosures for the AARP Medicare Supplement Insurance plans.
Entities	A global term used to describe an organization or agency.
Errors and Omissions (E&O)/Professional Liability 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 Request	A request to use the UnitedHealthcare on a custom created material sent to UnitedHealthcare for review and approval.
Executive Leadership Team (ELT)	A global term used to describe the UnitedHealthcare leadership roles that report directly to the Chief Sales and Distribution Officer.
External Distribution	One of the sales distribution channels that market and sell UnitedHealthcare Medicare Plans products. The channel consists of

Channel (EDC)	contracted entities, agencies, agents, and solicitors (there is no contractual relationship between a solicitor and UnitedHealthcare). EDC entities, agencies, agents, and solicitors are not employees of UnitedHealth Group and are not captive to UnitedHealthcare.
External Vendor Certification Courses	Third-party certification programs (e.g., America's Health Insurance Plans (AHIP) and National Association of Benefits and Insurance Professionals (NABIP)) that satisfies the requirement for UnitedHealthcare Medicare Basics Assessment.
F	
Fast Track Assessment	Part of the UnitedHealthcare certification program that upon successful completion certifies an agent to market/sell MA plan, PDP, Medicare Supplement Insurance plan, Standalone Dental, Vision, Hearing plan, DSNP, CSNP, and report and conduct events
Field Agent	A global term referring to any licensed, appointed (as required by the state), contracted (as applicable), and certified agent that market/sell UnitedHealthcare products that is not in a call center environment.
Field Marketing Organization (FMO)	An entity that is contracted with UnitedHealthcare to market and sell UnitedHealthcare insurance products through its hierarchy of downline contracted agents and solicitors. Not the highest contract level in the EDC hierarchy structure.
Field-Based Channel	A global term to describe agents/agencies that market and/or sell UnitedHealthcare products not in a call center environment. Consists of EDC and IMO/ICAs.
First Tier, Downstream, or Related Entities (FDRs)	First Tier entity means any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program. Downstream entity means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. Related entity means any entity that is related to the MA organization by common ownership or control and (1) Performs some of the MA organization's management functions under contract or delegation; (2) Furnishes services to Medicare enrollees under an oral or written agreement; or (3) Leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.
First Year Commissions	The compensation given to an agent for the first-year a member is enrolled in a UnitedHealthcare plan. A plan year ends on December 31 regardless of the effective date of the enrollment and the first year may not mean the first 12 months.
Focused Marketing Agreement (FMA)	An agreement where UnitedHealthcare agrees to provide funds to support focused marketing activities to contracted agencies.

Formulary	A list of covered drugs selected by the Plan that must meet requirements set by CMS.
Fully-Integrated Dual Eligible (FIDE)	A dual-eligible special needs plan where specifically dually eligible individuals receive fully integrated Medicare and Medicaid benefits from a single managed care organization (MCO).
G	
General Agency (GA)	An entity that is contracted with UnitedHealthcare to market and sell UnitedHealthcare insurance products through its hierarchy of downline contracted agents and solicitors. Not the highest contract level in the EDC hierarchy structure.
Grace Period	The period of time where a DSNP member loses their Medicaid status but still may get care and services through the plan. However, the consumer will be responsible for cost sharing and/or may be involuntarily disenrolled.
Grievance	Grievance means any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of an MA organization's or provider's operations, activities, or behavior, regardless of whether remedial action is requested.
Grievance (member)	Grievance is the process and procedure for timely hearing and resolving of grievances between enrollees and the organization or any other entity or individual through which the plan provides health care services under any MA plan it offers.
H	
Health Assessment (HA)	An assessment questionnaire used to identify programs and resources that fit the member's needs.
Health Insurance Portability and Accountability Act (HIPAA)	HIPAA is a federal law that provides requirements for the protection of consumer health information and provisions to combat fraud, waste, and abuse.
Health Plan Management System (HPMS) portal	The CMS system for the collection, review, and storage of materials that must be submitted for CMS review.
Hierarchy	The structure of the highest level of a contracted external organization and their downline.
Highly Integrated Dual Eligible Special Needs Plan	A dual eligible special needs plan offered by an MA organization that provides coverage of Medicaid benefits under a capitated contract.
I	
Incentive	The compensation paid to a sales employee on an accreted, credentialed validated, and incentive eligible enrollment based on the terms of their Sales Incentive Plan (SIP).
Independent Career Agent (ICA)	A non-employee agent licensed, appointed, and contracted with UnitedHealthcare to market and sell UnitedHealthcare Medicare Plans. The ICA contract provides that they are exclusive for UnitedHealthcare Medicare Advantage products.
Independent Marketing	A non-employee agency licensed, appointed, and contracted with UnitedHealthcare to market and sell UnitedHealthcare Medicare

Organization (IMO)	Plans. IMO agencies are exclusive for UnitedHealthcare Medicare Advantage products and the agents are captive to UnitedHealthcare.
Individual and Family Plan (IFP)	Health insurance plans available to individuals who do not get their coverage through their employer or a government-run program. IFP plans can be enrolled in through the Health Insurance Marketplace (also called the Exchange).
In-Force Insurance Policy	An insurance policy, such as a life insurance policy, that is currently active.
Initial Year	The first year the consumer is enrolled in a plan as determined by CMS. A plan year ends on December 31 regardless of the effective date of the enrollment.
In-Network	A group of providers who have contracts with UnitedHealthcare to provide care/services to the plan's members.
Institutional Equivalent Special Needs Plan (IESNP)	An MA plan that is designed to provide focused and specialized care for individuals who require Nursing Home Level of Care (LOC) based on the state specific definition.
Institutional Special Needs Plan (ISNP)	An MA plan that is designed to provide focused and specialized care for individuals who resides in or expects to reside in a Skilled Nursing Facility (SNF) contracted with the plan for at least 90 days.
Intent to Service (ITS) Form	The form (delivered via a link in their 30-day termination notice) required to be electronically signed to enter into a servicing status.
J	
Jarvis	The agent portal that provides access to agent tools, product, commission, and resources information.
***Jarvis* Notification**	A communication mechanism published in the ***Jarvis*** Notification Center on ***Jarvis*** that alerts ***Jarvis*** users to important information such as regional updates, member status, plan updates, and more.
JarvisEnroll	An electronic enrollment tool that allows agents to enroll consumers. JarvisEnroll can be accessed using a computer or mobile device.
JarvisWrap	A communication mechanism used to communicate information related to tools, products, state and federal regulations, and UnitedHealthcare policies, procedures, and rules.
Just-in-Time (JIT) Appointment	Select states allow for appointment requests to be submitted after receipt of the first enrollment in that state. Select states may also allow for appointments to be considered valid if the appointment is active within a defined number of days (defined by the state) from the enrollment application.
K	
Knowledge Central	A system that contains information, materials, and documents for the DTC Sales channel.
L	
Late Enrollment Penalty (LEP)	An amount added to the plan premium when a consumer does not obtain creditable prescription drug coverage when first eligible for Medicare Part D or who had a break in creditable prescription drug coverage of at least 63 consecutive days. The LEP is considered a part of the plan premium.
Lead	The name and contact information of a consumer who might be contacted to market UnitedHealthcare Medicare products.

Section 9: Glossary of Terms

LeaderNav	An intranet-based site used to communicate with UnitedHealthcare Sales Leaders.
Learning Lab	The training platform where individuals access certifications and other learning and development resources.
Level, Alignment, or Channel Change	Requests to change contract level, hierarchy, or channel with UnitedHealthcare.
Licensed	An individual that has a license granted by a governmental entity authorizing them to act as an agent and sell insurance products within that state.
LivePerson	The agent console that allows DTC Sales agents to conduct co-browse live screen sharing sessions.
M	
Master General Agency (MGA)	An entity that is contracted with UnitedHealthcare to market and sell UnitedHealthcare insurance products through its hierarchy of downline contracted agents and solicitors. Not the highest contract level in the EDC hierarchy structure.
Medicare Advantage (MA) Plan	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 prescription drug benefits.
Medicare Beneficiary	An individual who is entitled to Medicare Part A and eligible for Medicare Part B. Also referred to as consumer or member.
Medicare Made Clear (MMC)	A communication material produced by UnitedHealthcare that provides general information on the Medicare program.
Medicare Supplement Insurance Plan	Medicare Supplement insurance sold by private health insurance companies to help pay some of the out-of-pocket costs for services covered by Original Medicare, like copayments, coinsurance, and deductibles. Also referred to as "Medigap".
Member Retention Activities	A term used as part of UnitedHealthcare Book of Business to describe activities conducted in an effort to keep the member enrolled in their UnitedHealthcare plan.
Migration	A term used in the DTC Sales channel to describe a proactive outreach campaign to Medicare and Retirement members to inform them of products in their county that provide both medical and prescription drug coverage.
MIRA	A program that allows the creation and storing of a consumer contact record and schedule marketing/sales appointments and/or events.
Multi-Carrier Agent	An agent that is contracted to market/sell UnitedHealthcare plans and plans offered by other carriers.
Multi-Carrier Enrollment Tool	An online enrollment tool that may be used to initiate an enrollment into an MA plan or PDP. Prior to making UnitedHealthcare plans available via the multi-carrier tool, the NMA request must be approved by UnitedHealthcare and submitted to CMS.
Multi-Carrier Pre-Assessment Form	A form that must be completed as part of the application process for an eAlliance agreement or Telephonic Enrollment Capability Addendum.
Multi-Carrier Program	A program that allows participating agents to conduct informal marketing/sales events at Walmart in-store kiosks.

N	
National Insurance Producer Registry (NIPR)	A database which contains information about insurance agents and brokers provided by state Departments of Insurance (DOI).
National Marketing Alliance (NMA)	An entity that is contracted with UnitedHealthcare to market and sell UnitedHealthcare insurance products through its hierarchy of downline contracted agents and solicitors. Can be the highest contract level in the EDC hierarchy structure.
Needs Analysis	A term used by UnitedHealthcare to describe the required questions and topics regarding a consumer's needs in a health plan choice that must be fully discussed and thoroughly reviewed with the consumer prior to an enrollment.
New Business	A term used in commissions to describe first year UnitedHealthcare enrollments.
Next Level Product Certification	Part of the UnitedHealthcare certification program that includes product and event assessments.
Non-Licensed Representative	A DTC Sales non-licensed individual that conducts allowed business activities.
Non-UnitedHealthcare Sanctioned Event	An event where the primary focus is not to educate or market/sell Medicare products (e.g., volunteering at a food distribution event).
Non-Writing Employee	A UnitedHealthcare employee that does not actively market/sell UnitedHealthcare products (e.g., Executive Leadership team, Sales Leadership Team, Sales Supervisors, Sales Support, and Sales Management)
Not-for-Cause Termination	A type of termination of an agent's contract and/or appointment for reasons other than breach of the for-cause provision of the agent agreement.
O	
Online Enrollment (OLE) Tool	An online enrollment tool that may be used by approved an eAlliance or Telephonic Enrollment Capability Addendum entity. Approval to use an OLE to market and sell UnitedHealthcare products is at the sole discretion of UnitedHealthcare.
Outbound Call Campaign	Outbound marketing/sales call campaigns by field agents on behalf of UnitedHealthcare or involving UnitedHealthcare products.
Out-of-Network	A provider or facility with which UnitedHealthcare does not have a contract to deliver covered services to member of UnitedHealthcare.
Overflow	A term to describe excess call volume for eAlliance or Telephonic Enrollment Capabilities Addendum call centers.
Override Entity	A contracted up-line that may receive payments for services other than enrollment of beneficiaries (for example, training, customer service, agent recruitment, operational overhead, or assistance with completion of health risk assessments).
P	
Part B Buy-Down	A benefit that may be offered by some Medicare Advantage plans that may help pay part of the Medicare Part B monthly premium.
Party Identification (Party ID)	An identification number that is assigned to an agent by UnitedHealthcare. An agent is only assigned one Party ID in their lifetime with UnitedHealthcare.

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Permission to Contact	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 (MA) plan, Prescription Drug Plan (PDP), or Medicare Supplement insurance products.
Personal/Individual Marketing Appointment	A face-to-face, telephonic, or online meeting with an individual or small group (e.g., married couple) to market/sell Medicare products.
Plan Change	A term used in commissions to describe a plan change from one UnitedHealthcare MA/MAPD, PDP, CSNP, or DSNP plan to another UnitedHealthcare MA/MAPD, PDP, CSNP or DSNP plan or from one AARP Medicare Supplement plan to another under the same insurance company.
Plan Year	The applicable year for a plan that runs from the effective date until December 31st.
Pledge of Compliance	A document that details an individual's personal pledge of compliance to commit to ethical and compliant conduct and adhere to CMS guidelines and regulations and UnitedHealthcare policies, procedures, and rules.
Pre-Enrollment Checklist	A standardized communications material that plans must provide to prospective enrollees with the enrollment form, so that the enrollees understand important plan benefits and rules.
Preferred Provider Organization (PPO)	An MA plan that has a contracted provider network. All benefits covered in-network are also available from out-of-network providers that accept Medicare, generally at a higher cost to the member. PPO can be a Local PPO that the service area covers set counties chosen by the plan or a Regional PPO that the service area is one of 26 regions set by Medicare.
Prescription Drug Plan (PDP)	Means prescription drug coverage that is offered under a policy, contract, or plan that has been approved as specified by CMS and that is offered by a PDP sponsor that has a contract with CMS that meets the contract requirements.
Prescription Drug Plan Education and Enrollment Representative (PDP E&E)	An individual in the DTC Sales channel that may conduct enrollment activities that do not require a license. Activities must not extend beyond the scope of their role and training.
Principal	The individual that is contracted with UnitedHealthcare as the responsible party for an agency/entity.
Prior Authorization	The pre-approval that a plan may require to cover a particular drug.
Private-Fee-For-Service (PFFS)	An MA plan where the member can seek services from any Medicare-eligible provider who agrees to accept the plan's terms, conditions, and payment rate. UnitedHealthcare only offers non-network PFFS plans.
Proctor	A term used to describe an individual that monitors an agent taking the UnitedHealthcare certification assessments.
Producer Contact Log (PCL)	A system used to document agent/agency interaction with the PHD, UnitedHealthcare Sales Leadership, or UnitedHealthcare Agent Coaching and Policy Specialist (ACPS).

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Producer Help Desk (PHD)	UnitedHealthcare contact center that provides support pertaining to the agent experience.
Q	
Quantity Limits	A limit on the quantity of a drug a member can receive at a time. Quantity limits may be set by the Plan and/or Medicare.
R	
Rapid Disenrollment	When a member voluntarily disenrolls from a MA plan or PDP within three months of the effective date.
Relationship Hierarchy Addendum (RHA)	Part of the contracting packet that documents the hierarchy structure for the applicable agent/agency.
Renewal Income	The compensation given to an agent for any year following the initial year enrollment the member remains in the same plan or a different plan that is a like plan type.
Renewal Year	All years following the initial enrollment year the member remains in the same plan or in different plan that is a like plan type as determined by CMS.
Rider	Additional coverage for specific medical benefits that may be available for consumers enrolling in an MA plan for an additional monthly premium.
S	
Sales Activity	A term to describe the activities conducted by an agent in an attempt to enroll a consumer into a UnitedHealthcare Medicare plan.
Sales Communication Team	The team that manages and distributes sales related communications to agents/agencies and UnitedHealthcare sales management.
Sales Incentive Plan (SIP)	The agreement that documents the requirements, sales goals, and conditions a UnitedHealthcare employees must meet in order to be paid an incentive.
Sales Management Personnel	A global term used to describe the UnitedHealthcare leadership hierarchy.
Senior Care Options (SCO) Plan	A Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) offered in Massachusetts. The plan combines all the benefits and coverage of Original Medicare and MassHealth under one plan.
Senior Community Care Sales Field Agent	Employee field sales agents that are part of the Optum Sales hierarchy that market/sell only I/IESNP.
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 contacts between the PHD and an agent.
Servicing Status	The UnitedHealthcare program where contracted non-employee agents terminated not-for-cause may enter into a servicing agreement in order to receive renewal commissions for MA plans and PDPs.
Solicitor	A licensed, certified, and appointed (as required by the state) agent who markets and sells UnitedHealthcare products through a contract with an EDC agency or eAlliance. There is no contractual relationship between the solicitor and UnitedHealthcare.

Star Rating	ratings that are calculated annually by CMS to rate the quality and performance of a MA plan and PDP on a scale of 1 to 5, with 5 being the highest rating. Star Ratings are published annually in October.
Static URL	A term to describe a website URL that does not change.
Step Therapy	When a plan may require a member to try a lower-cost alternate drug that treats the same health condition before covering the requested drug.
Strategic Marketing Organization (SMO)	An entity that is contracted with UnitedHealthcare to market and sell UnitedHealthcare insurance products through its hierarchy of downline contracted agents and solicitors. May be the highest contract level in the EDC hierarchy structure or align under an NMA.
Sub-Contracted	A third-party organization sub-contracted to provide services to UnitedHealthcare or an entity contracted with UnitedHealthcare.
Successor Agent	The active agent who becomes the Agent of Record (AOR) for the original agent's book of business.
Successor Program	The UnitedHealthcare program where contracted non-employee agents may request UnitedHealthcare transfer their entire UnitedHealthcare book of business to a successor agent, who agrees to accept and service the original agent's book of business and oversee down-line agents, where applicable.
T	
Telephonic Addendum (TA)	An addendum to an entity's contract that permits them to operate a call center to market and sell UnitedHealthcare insurance products.
Telephonic Enrollment	Enrollment requests that are completed telephonically and are only allowed to by authorized telesales call centers (e.g., UnitedHealthcare call center, a contracted vendor call center, contracted eAlliance, or Telephonic Addendum entity)
Telephonic Enrollment Script	A script to complete a telephonic enrollment that must contain all required elements and must be submitted and approved by CMS.
Third-Party Marketing Organization (TPMO)	Any organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA plan or plans to making an enrollment decision). All entities and individuals contracted directly with UnitedHealthcare are considered first tier, downstream or related entities (FDRs) and, therefore, TPMOs. TPMOs also include any entity contracted or subcontracted by an FDR that provides services to UnitedHealthcare or UnitedHealthcare's FDR, including solicitors.
UHC Agent Toolkit	The platform that provides access to UnitedHealthcare approved materials and assets.
U	
UnitedHealthcare Book of Business (BoB)	A collection of member information assigned to a particular agent that is maintained by UnitedHealthcare.
Up-Line	The contracted entities within the External Channel hierarchy that are above a specific agent/agency.
W	

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Writing Number	A UnitedHealthcare generated number assigned to a contracted, licensed, and appointed agent used for submitting business, to track commissions, and other agent-specific sales statistics.
X	
XM Discover	A voice analytics tool that analyzes call transcripts for keywords, topics, or emotions to help us better identify trends and understand how our organization is performing on the metrics we monitor.

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