Employee Agent Guide

United Healthcare®

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This Guide is intended for agent use only.

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Welcome to UnitedHealthcare

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

Here to help you succeed

We are committed to providing you with tools that support your success. The *Agent Guide* is a comprehensive resource providing 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 the company. To help, compliance guidelines are integrated into each section of this guide.

Easy access

An electronic version of this guide is available on ***Jarvis*** and is updated regularly. We welcome your comments, suggestions and recommendations for additional content. Please submit feedback to your UnitedHealthcare sales leader.

Consider this guide your resource to serve consumers. We are honored to be 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 Employee Sales agents. Throughout the guide, the words “agent” and “you” are used to refer to any Employee Sales agent.

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Section 2: How do I Get Started?

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Employee Individuals

All employees in a sales role must be appropriately licensed, appointed (as required by the state), and certified. Failure to meet licensing, appointment (as required by the state), and certifications requirements may result in disciplinary action up to and including termination. Employees are not responsible for any applicable licensing fines.

Note: 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.

Writing Agents

The individual whose writing number is entered on the enrollment application must be appropriately licensed, appointed (as required by the state), and certified in the product in which the consumer is enrolling at the time of sale.

Employee Field Sales Agent

- You must have an active insurance license in Life, Accident, and Health (or similar as determined by the state) with appropriate lines of authority for their state of residence, plus non-resident licenses for any other states where they will be active in marketing or sales.
  - ALM verifies license status using the NIPR.
  - UnitedHealthcare may assist you through the resident state licensing application and exam process. You must attend all required pre-licensing education and pass the resident state license exam.
  - UnitedHealthcare may assist you through non-resident state licensing application requests as applicable.
  - Failure to obtain a license within 90 days of hire is grounds for termination from sales and marketing positions.
- You must be appointed (as required by the state) in any state where you will be active in marketing or sales.
  - If at the time of hire, you have a current resident state license, ALM:
    - Validates that you have not been flagged Review Before Contract (RBC) in the contracting system.
    - Submits the appointment request to the states selected on the Internal Agent Request form.
    - For JIT states, appointment requests will be submitted after the first enrollment in the state.
    - 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.
    - If a request to appoint is denied, you are terminated according to UnitedHealthcare policies and procedures.
    - Sends a Welcome Letter communicating your writing number to you and your UnitedHealthcare manager/supervisor.

- ~ If at the time of hire, you **do not** have a current state license, ALM:
  - Assigns the Party ID and emails the Party ID Notification Letter to you and your UnitedHealthcare manager/supervisor.
  - When you have received your resident state license, validates you have not been flagged RBC in the contracting system, and sends a Welcome Letter communicating your writing number to you and your UnitedHealthcare manager/supervisor.
  - Submits an appointment request for the resident state and non-resident state license applications in all other designated states in which you will market or sell UnitedHealthcare Medicare Plans products.
  - For JIT states, appointment requests will be submitted after the first enrollment in the state.
  - 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.
- You are responsible for maintaining an active resident state license, including all educational requirements.
  - ~ You must provide ALM with current License Application information at the time of renewal.
    - ALM monitors the status of state licenses and submits renewal applications prior to expiration for agents that have provided a completed License Application.
    - If a License Application is not on file, ALM sends a request to the agent and continues to monitor license status until the license shows as renewed on NIPR.
    - In the event ALM does not receive a current License Application, your UnitedHealthcare manager/supervisor is contacted for assistance.
  - ~ UnitedHealthcare provides you access to online Continuing Education (CE) courses 90 days prior to resident state license expiration.
  - ~ Upon completion of the required CE hours, ALM submits the renewal application on the agent's behalf.
  - ~ ALM verifies license status using NIPR.
  - ~ Failure to maintain valid licensing or loss of licensing is grounds for termination from sales and marketing position.
- You must be appropriately certified.

Senior Community Care Sales Field Agent

- Must have an active insurance license in Life, Accident, and Health (or similar as determined by the state) with appropriate lines of authority for their state of residence, plus non-resident licenses for any other states where they will be active in marketing, sales, or management capacity.
- Must be appointed (as required by the state) in any state where they will be active in marketing, sales, or management capacity. Depending on the product type and state, the appointment request may be submitted after the first enrollment in that state.
- Must be appropriately certified.

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, the individual must 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, and Medicare Supplement Insurance 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 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 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 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, 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

- Employee Sales Agents
  - ~ Must be portfolio certified for the plan year within 30 days of hire or prior to conducting marketing/sales activities, whichever comes first, and annually thereafter.
  - ~ Employee sales agents authorized to market/sell SCO must be SCO product certified for the plan year and complete MA SCO specific training prior to conducting marketing/sales activities for SCOs.

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).

Requests for Certification Related Information

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

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.

- 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.

Restriction on Distribution of Policies and Procedures

- Policy and procedure documents are confidential and proprietary property of UnitedHealth Group and are only available for external distribution upon request to Compliance_Questions@uhc.com. They are not to be distributed, reproduced, republished, transmitted, displayed, broadcast, or otherwise exploited in any manner to any external entity including, but not limited to, National Marketing Alliances (NMA), and their down-line agencies and brokers, Independent Career Agents (ICA), and Independent Marketing Organizations (IMO) without the express prior written permission of UnitedHealthcare.

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

Materials

Websites and Social Media

Media Engagements

Materials

It is UnitedHealthcare policy that agents 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.

Communication Materials

Communications means activities and use of materials to provide information to current and prospective consumer/member. This means that 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 any material or activity, CMS will consider objective information including, but not limited to, the audience, timing and other context of the material or activity, as well as other information communicated by the material or activity.

- 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;
    - o Any material or activity that meets intent and content standards that is distributed via any means that mentions any benefits will be considered marketing.
    - o High level mention of plan benefits (e.g., vision, dental, and hearing) will be considered marketing.
    - o 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.

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

- 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
    - Institutional Sales Agents (Selling the Institutional Special Needs Plan only): Sales Account Manager, Sales Implementation Manager
  - 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.

Employee Sales Agent

- You must work through your UnitedHealthcare Sales Leader to request a material exception to UnitedHealthcare. If approved by a UnitedHealthcare Sales Leader, the Sales Leader will submit the request to their contact within 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

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.

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

- 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.

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.

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

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.

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.

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

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

Marketing/Sales Event Reporting

Marketing to Consumers with Impairments or Disabilities

Permission to Contact (PTC)

Lead Generation

Field Sales Expense Payment Process

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.

Communications
Communications means activities and the use of materials to provide information to current and prospective consumers/members.

Marketing
Marketing is a subset of communications and includes activities and use of materials with the intent to draw a consumer/member's attention to a plan or plans and to influence a consumer/member's decision-making process when selecting a plan for enrollment or deciding to stay enrolled in a plan (that is, retention-based marketing). Additionally, marketing contains information about the plan's benefit structure, cost sharing, measuring, or ranking standards.

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.

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.

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

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:

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.

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

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.

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

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 a 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.
- 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 requests information regarding a different plan 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).
- 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.

Written Required Materials (Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP))

- 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:
  - ~ If you are not fluent in the applicable language, you 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 prohibited from using individuals who are not employees of UnitedHealthcare 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)

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/indivdual 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). DTC Sales Agents who are direct employees of UnitedHealthcare are permitted to send unsolicited emails that appear to be coming from or on behalf of UnitedHealthcare when using the permitted email functionality within Mira and/or Salesforce Marketing Cloud. 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.

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.

Authorization for Institutional Contact (for agents authorized to market/sell the UHC Nursing Home Plan)
You may initiate contact (e.g., call, schedule appointments) in the following situations:

- A compliant ISNP – Authorization for Disclosure of Contact Information form has been received from the contracted skilled nursing facility. The ISNP – Authorization for Disclosure of Contact Information form is retained and securely stored. To be compliant, the form* must be a UnitedHealthcare provided form and/or contain **all** of the following:
  1. A description of the personal health information required (e.g., name, telephone number, and address),
  2. A description of entities to which the information is to be released (e.g., contracted health plan, UnitedHealthcare),
  3. An expiration date or expiration event,

4. A description of the purpose of the disclosure (i.e. marketing),
5. Language indicating that the individual may revoke at any time,
6. Language indicating that the authorization is voluntary,
7. Language that the provision of health care services is not a condition of the signing of the Enrollment Application,
8. Authorization must have been signed within the previous twelve month period,
9. Language clearly informing the individual that someone will contact them, **and**
10. Language clearly informing the individual that the information will be given to a health care plan contracted with the nursing home in which they reside.

- A compliant UnitedHealthcare provided Written Consent to Contact Form (WCCF) has been received from an employee of the contracted skilled nursing facility. The WCCF must be completed in its entirety.

***Notes:**

- If the HIPAA authorization is not a UnitedHealthcare provided document, you are responsible for assessing the form's content to ensure it contains items 1-10 above before presenting to the agent's Director of Sales Operations for review and sign-off on the content of the form. Until the Director of Sales Operations has provided written attestation that the alternative form is an acceptable substitute for the UnitedHealthcare form, you may not contact the prospect.
- If the HIPAA authorization is missing any element in 1-7, you are **not** permitted to use any of the information provided on the authorization.
- If the HIPAA authorization contains items 1-7, but is missing 8, 9, and/or 10 and the Director of Sales Operations has provided written attestation; you are only permitted to direct mail the individual until affirmative PTC is received from the consumer or responsible party.

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 by the sales office.
- 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
    - 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.

Field Sales Expense Payment Process

UnitedHealthcare employees, including but not limited to agents and sales support coordinators, must refer to and comply with any and all applicable UnitedHealth Group corporate policies related to obtaining and paying for services and materials (e.g., venue rent, refreshments and/or supplies, catering services, entertainment services, audio/visual equipment purchase or rental, furniture/tent purchase or rental) or reimbursing non-employee agents/agencies for services and materials used in the conducting of educational and/or marketing/sales events and/or activities.

UnitedHealth Group Vendor Process

Enterprise Procurement provides end-to-end support to help employees identify a supplier, negotiate pricing, and contract for needed goods and/or services. You are required to engage Enterprise Procurement when engaging a supplier or buying goods or services as set forth in the UnitedHealth Group Enterprise Procurement policy. Enterprise Procurement engagement is not required for Entertainment & Meeting Expenses (such as meeting space, catering, decorations, A/V production) where:

- Expenditures are less than $100,000
- Risk is not present (i.e. not engaging suppliers that present potential legal liability to the Company)

Note: When possible, you must use suppliers whom UnitedHealth Group has established agreements or catalogs for most other goods and services regardless of cost, including office supplies, promotional items advertising and print fulfillment when expenses are $100,000 or above or where a contract is required or risk is present. Refer to UnitedHealth Group Enterprise Sourcing and Procurement policy for details.

Approved Payment Methods

Prior to using any approved payment method, you must verify if using a UnitedHealth Group vendor is required and/or if a contract has already been established with a particular vendor. A UnitedHealth Group vendor should be used if one is available. The following payment methods may be used for the following types of expenses used to support field sales operations activities and events: venue rent, refreshments and/or supplies, catering services, entertainment services, audio/visual services or equipment rental, furniture/tent purchase or rental.

- UnitedHealth Group Travel and Expense Corporate Card (preferred method)
  - ~ The card holder must comply with all corporate policies related to the UnitedHealth Group Travel and Expense Corporate Card, including transaction limits, monthly purchase limit, allowed/not allowed purchases, and expense reconciliation/reporting.
  - ~ You should work with your manager to determine what items and services are appropriate for purchase using a UnitedHealth Group Travel and Expense Corporate Card.
  - ~ The cardholder must create an expense report in Concur Expense for the transaction within 20 days of the transaction date.

- Third-Party Payment Processing Service (PayPal, Venmo)
  Third-party payment processing services, such as PayPal and Venmo, may be used if a vendor does not accept credit cards. The PayPal or Venmo account must be linked to a UnitedHealth Group Corporate Credit Card and not to your personal financial account or credit card. A detailed receipt must be obtained that includes the actual vendor name, date of purchase/payment, amount paid, and details of services/materials purchased.
- UnitedHealth Group Purchasing Card (PCard)
  - ~ A UnitedHealth Group PCard is not a preferred method for paying for expenses related to field sales operations activities and events and should be issued on an exception basis for this use.
  - ~ The card holder must comply with all corporate policies related to the UnitedHealth Group PCard, including transaction limits, monthly purchase limit, allowed/not allowed purchases, and expense reconciliation/reporting.
  - ~ The UnitedHealth Group PCard must not be used for personal-use items and services, including but not limited to, computer hardware or software not approved by Technology Procurement, travel related expenses, business meals, capital goods, leased equipment, personal services (e.g., laundry services, flower shops, salons), amusement and entertainment (e.g., theatre, bowling alleys, golf courses, betting), telecommunications services (e.g., cell phone, DSL, cable or cell phone equipment), sponsorships or charitable expenses, tuition reimbursement, gift cards, or payment of wages for services rendered.
  - ~ UnitedHealth Group's Delegation of Authority Policy applies; therefore, prior approval for some items may be required. You should work with your manager to determine what items and services are appropriate for purchase using a UnitedHealth Group PCard.
  - ~ The cardholder must create an expense report in Concur Expense for the transaction within 20 days of the transaction date.

Payment Methods Requiring Sales Leadership Approval

- Cash
  You are discouraged from using cash to pay for expenses for which you expect reimbursement from the company and should be the exception used in circumstances when the vendor will not accept a UnitedHealth Group issued credit card or payment via a third-party payment processing service. You must get approval from a senior sales leader prior to making any cash payments. You must use Concur to request reimbursement and provide a detailed receipt that includes the actual vendor name, date of purchase/payment, amount paid, and details of services/materials purchased.
- Personal Checks
  With prior approval from a senior sales leader, you may use a personal check to procure approved items or services only in circumstances when the vendor will not accept a UnitedHealth Group issued credit card or payment via a third-party payment processing service. You must use Concur to request reimbursement and provide a detailed receipt that includes the actual vendor name, date of purchase/payment, amount paid, and details of services/materials purchased.

Payments Requiring Legal Approval

The following types of payments require legal approval. You should talk to your manager about engaging one of the UnitedHealthcare attorneys that supports Medicare & Retirement Sales.

- Any type of payment to a provider, including payments to rent the provider's space for an educational or marketing/sales event. NOTE: CMS prohibits plans from paying providers for marketing or enrollment activities (refer to provider activities section for guidelines).
- Any agreement to share in the cost of marketing expenses with an agent/agency must follow the Focused Marketing Agreement (FMA) process, which requires Legal approval of the FMA. Approval from Legal must be obtained prior to committing to and or paying any marketing related expense.

Other Payments that Require Advance Approval

- A venue may request or require a "contribution" or "donation" or "sponsorship" in exchange for using space in its venue to conduct an educational or marketing/sales event. When the payment is in exchange for the use of space, it is considered venue rent, is characterized as a business expense, should be of an amount that does not exceed similar costs, and should be expensed accordingly. A charitable contribution or donation can only be made to a 501C3 organization, and they are generally permitted. To determine if an organization is a 501C3 charity, confirm the organization is listed on GuideStar.com (no cost to register and use). Refer to UnitedHealth Group enterprise policy in eGRC Policy Center for charitable contribution guidelines.
- Prior to entering into a sponsorship agreement, engage the regional marketing director and local sales leadership. Refer to item 4 below if the sponsorship has the potential to involve a politically-related charity or public official.
- Payments to Government Officials and Political Contributions. You must refer to UnitedHealth Group enterprise policy in eGRC Policy Center or contact GovCompliance@uhg.com for details.
- Politically-related charitable and community giving may potentially raise legal and reputational issues for UnitedHealth Group. As a result, the following contributions must be reviewed and approved by UnitedHealth Group Compliance & Ethics prior to making a commitment to give the politically related contribution:
  - ~ Contributions made at the request of a local, state, or federal government official or employee
  - ~ Contributions made to a charity controlled or founded by a public official
  - ~ Contributions made to a Public Sector client
  - ~ Contributions made in connection with an event at which a federal, state, or local government official or employee will be honored or recognized.

Invoices and Company Liabilities

Invoices and company liabilities may not be paid by you using your personal cash, personal credit arrangements or personal credit cards. Company obligations such as vendor invoices, marketing events, season tickets, and other liabilities must be contracted with UnitedHealth Group entities in accordance with Purchasing policies, billed to UnitedHealth Group entities and paid by UnitedHealth Group entities.

Section 6: How do I take an Enrollment Application?

Enrollment Methods

MA Plan and PDP Cancellation, Withdrawal, or Disenrollment Requests

Agent Assisted Health Assessment 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 wants 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.
- 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, 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. 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), 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 UnitedHealthcare Nursing Home Plan.

~ Institutional Equivalent Special Needs Plan (IESNP)
You must determine eligibility, as it relates to the "Level of Care" requirement, at the point-of-sale.
  - 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 a Medicare Supplement enrollment, the enrollment kit 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, 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.)
- **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.
- 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.
  - ~ Agents 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, an agent 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.

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.

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.

Section 6: How do I take an Enrollment Application?

- 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 and PDP) 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)
    - 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

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.

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.

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.

Section 6: How do I take an Enrollment Application?

- 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.

Section 7: How am I Paid?

Compensation Overview

Compensation Overview

You are paid an incentive starting with the first eligible enrollment based on the terms of your Sales Incentive Plan (SIP).

Incentive Eligibility Requirements

To be eligible for an incentive:

- You must meet all requirements set forth within your Sales Incentive Plan (SIP) in effect at the time.
- You must be a participant in a SIP and satisfy any signature requirements. Note: incentive payments may be held until signature requirements have been met.
- You must be appropriately credentialed (i.e. licensed and appointed (as required by the state) in the consumer's resident state, and certified in the product in which the consumer is enrolling) at the time of sale.

For an enrollment application to be eligible:

- It must have been written by an active agent, who at the time of sale was appropriately credentialed.
- The company must receive revenue for the enrollment from the applicable entity (e.g., the Centers for Medicare & Medicaid Services (CMS), state Medicaid agency, or member premium).
- The consumer must be enrolling in a product covered by this policy.
- The member must be actively enrolled in the plan on the fourth month effective date following the original effective date (e.g., if the original effective date is 1/1, the member must be actively enrolled on 4/1), unless an exception applies.

Incentive Payment Calculation – Medicare Advantage (MA) and Prescription Drug Plan (PDP) Products

Incentive payments are calculated monthly, and, if earned, are processed for payment in the employee's last paycheck of the month. Payments are withheld if the employee did not meet eligibility requirements at the time the enrollment application was written. Enrollments eligible for incentive payment may vary by plan year and sales role. The SIP participant should refer to their SIP for eligibility specifics.

UnitedHealthcare Government Programs Employee Agent

- The enrollment application is validated for eligibility.
- The writing agent is validated for eligibility. If you do not pass credential validation, the enrollment is not incentive-eligible.
- If the enrollment application and you are eligible, incentive payment is calculated based on information reported in DART.
- The Sales Employee Incentive Compensation team will make available to you a monthly enrollment data report.
  - ~ You and your sales director/supervisor are responsible for reviewing your enrollment data report each month on a timely basis.
  - ~ If you find a discrepancy, you must submit an adjustment request using the Agent Enrollment Tracker (AET) tool. UnitedHealthcare sales leader must submit an adjustment request to the Government Programs employee incentive email box at GP_employeeincentive@uhc.com. Adjustment requests submitted after the deadline will be processed during the next incentive payment cycle.

- ~ The adjustment request is reviewed by the Sales Employee Incentive Compensation team and the requestor is notified of the request's approval or denial (with explanation).

Optum Institutional/Institutional Equivalent Special Needs Plan Employee Agent
The SIP document is stored and maintained with the Optum Compensation Team. Incentive payment information is based on information gathered and reported in GPS. On a monthly basis, an enrollment sales detail report derived from the Incentive Compensation Management (ICM) system is made available to the you for review of enrollment data. If an enrollment discrepancy is found, you must submit an adjustment request using the sales inquiry functionality through the ICM system.

Chargeback Calculation – MA and PDP Enrollments (including Optum)
Chargebacks generally are the result of a member's rapid disenrollment, but can occur for other reasons. Not all instances of rapid disenrollment results in a chargeback (e.g., member death).

- Amounts are deducted from a SIP participant's incentive payment for previously paid advances on sales that are not earned.
- Chargebacks due to rapid disenrollment are calculated and processed as they occur against available incentive payments the month it is determined and on a go-forward basis until it is recouped. For example, if in February it is determined that a member with a January 1 effective date voluntarily disenrolled in January, the charge back is calculated and taken in February.
- The Optum Compensation Team follows Optum's definition of chargeback. Chargebacks due to "loss of eligibility" are waived and do not result in a chargeback against compensation.

Incentive Payment Calculation for Medicare Supplement Products (Excludes plans sold by Optum CSS Direct to Consumer (DTC) Sales Agents)
Employee Agent

- You complete and submit an enrollment application for a Medicare Supplement Insurance product.
- On a monthly basis, the Sales Employee Incentive Compensation team:
  - ~ Receives a membership activity report derived from COMPAS (OIS);
  - ~ Compiles a report of all incentive-eligible sales determined by agent writing number and member status; and
  - ~ Makes the report available to you.
- You and your sales director/supervisor, are responsible for reviewing the report every month.
  - ~ If a discrepancy is found (e.g., missing sale, incorrect or invalid writing number), you must submit an adjustment request using the Agent Enrollment Tracker (AET) tool.
- The Sales Employee Incentive Compensation team will research and then notify the requestor of the request's approval or denial.
- Application corrections that result in an incentive eligible sale will be credited and paid to you during the next incentive payment cycle. No manual adjustment will be made.

Chargeback Calculation for Medicare Supplement Products
Chargebacks are calculated and processed for you as they occur against available incentive payments the month it is determined and on a go-forward basis until it is recouped.

Compliance and Ethics
No sales incentive payment will be made for enrollments that are determined to have occurred as a result of fraudulent, incomplete or inaccurate information provided by the sales agent. It if it is determined that a participant of the sales incentive program has engaged in inappropriate behavior, disciplinary action may be taken, up to and including termination.

Employee Legacy Book of Business
You may retain and be paid renewal commissions on your legacy book of business. Eligible employees generally consist of formerly contracted External Distribution Channel (EDC) agents or Independent Career Agent (ICA) hired into an employee role such as Field Sales Management or Field Sales Operational Management role. A legacy book of business consists of current UnitedHealthcare MA plan and/or PDP members enrolled by you when you were a contracted agent in the EDC or ICA channel. You are prohibited from writing any new business using your EDC or ICA writing number. Renewal commissions are paid as a 1099, not as part of your incentive payment, if applicable. (Refer to the non-employee commission section for details related to commission payments.)

- You will remain the Agent of Record (AOR) and receive a renewal commission on a member's enrollment in your legacy book of business if:
  - The member remains enrolled in the plan in which you enrolled them while a contracted agent; and
  - You remain appropriately licensed, appointed (as required by the state), and certified per the terms of your agreement at the time of sale and all applicable amendments.
  - You continue to service the member and supports an on-going relationship.
- Your status as AOR and associated entitlement to renewal payments will be retained for a qualifying enrollment facilitated by a non-renewal eligible agent.

Section 8: What are Expected Performance Standards?

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Suspension of Agent Marketing and Sales Activities

Termination – Disciplinary Action

Termination – Due to Unqualified Sale

Termination Process

Request for Reconsideration

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

Field Sales Agents authorized to sell UHC Senior Care Options
Your UnitedHealthcare Senior Care Options sales management is responsible for ensuring that agents authorized to sell UnitedHealthcare Senior Care Options plans complete required product specific training, attend periodic meetings, and complete ongoing monitoring activities. Your UnitedHealthcare SCO sales manager will monitor and enforce your attendance at meetings and trainings.
- You will receive 30, 60, 90 day follow-up for continuing education, training, and case review upon certification in the UnitedHealthcare Senior Care Options Plan product.
- On an annual basis, your manager will conduct and document a minimum of one evaluation.
- You are required to attend quarterly meetings with UnitedHealthcare SCO sales manager for continuing education, training, and case reviews and best practices.
- You will receive periodic ride-alongs to observe you during marketing/sales appointments.
- Your manager will conduct additional field observations and coaching sessions when you exhibit less than satisfactory performance. 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.

Employee Performance Management

Field Sales Employee
It is your sales management's responsibility to communicate your monthly production expectation within 90 calendar days of hire. For established agents, your monthly production standard required is determined by the sales office via the budget process. Sales management will manage your performance compared to business objectives.

Senior Community Care Field Sales Agent
Optum Compliance is responsible for managing, monitoring, and oversight for Senior Community Care Field Sales Agents. You may refer to the Senior Community Care (SCC) Quality and Performance Program policies for additional details.

Performance that may result in Immediate Termination

In some circumstances a recommendation for immediate termination (for-cause or not-for-cause) may occur.

Engaging in the following activities may result in a recommendation for immediate termination (refer to the Agent Termination section for details):

- Any occurrence of fraud, forgery, payments, inducements, deception, or coercion
- Creating a hostile work environment by employee agent
- Sale of a non-UnitedHealthcare product by an employee agent
- 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 regulations and UnitedHealthcare rules, policies, and procedures. Calculation methods and thresholds have been established for all compliance monitoring programs and are periodically reviewed. Deficient performance is categorized as Yellow (Complaint Monitoring only) or Red depending upon severity and patterns of performance. Monitoring programs reported in Sales Management Reporting Tool (SMRT) Agent Oversight include:

- 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 UnitedHealthcare sales leader.

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 referred to the CAR process, you must successfully complete the assigned sales remediation training course(s) and corresponding assessment, with a minimum score of 80% within six attempts, 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. 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.

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 occurs when you are not licensed and/or appointed (as required by the state) in the state in which the consumer resides and/or certified in the product in which the consumer is enrolling at the time of sale.

- For the first 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.)
- UnitedHealthcare will notify CMS when an enrollment is completed by an agent that was not licensed in the state in which the consumer resides at the time of enrollment.

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 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 UnitedHealthcare manager/supervisor coachin
    - 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.

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 the agent's UnitedHealthcare manager/supervisor.

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 any of 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 applicable Referral Criteria Grid to determine appropriate outreach.
- If you are an active agent, the AIM team creates a Coaching Request (CR) in the Producer Contact Log (PCL) and assigns it to your UnitedHealthcare sales leader/supervisor.
- 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 UnitedHealthcare sales 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 UnitedHealthcare sales 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.

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 UnitedHealthcare sales leader/supervisor and submits a request to certification operations to assign the applicable sales remediation module(s) to you.
- If you are an inactive agent, a CR is not created. The 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.

Section 8: What are Expected Performance Standards?

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, 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 recommends the termination of an employee agent. 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, a UnitedHealthcare sales leader may request from AIM an extension to the required CR completion date. Contact your UnitedHealthcare sales leader for 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 UnitedHealthcare manager/supervisor. 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 products.

- Prior to making a recommendation to suspend an employee's ability to market and sell, the DAC chair must consult with Human Capital. Human Capital will confer with your UnitedHealthcare manager/supervisor to discuss next steps.
- 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 UnitedHealthcare manager/supervisor.
- 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 products while on a suspension status.
- New business written during the suspension period will not be eligible for commission. UnitedHealthcare reserves the right to hold any or all Sales Incentive Plan (SIP) payments, while on suspension status.
- Contact your UnitedHealthcare sales leadership for additional details regarding a suspension of marketing and sales activities.

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 – 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 an incentive 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

You will receive notification from your UnitedHealthcare sales leader/supervisor to cease and desist from any marketing and selling activities. Contact your UnitedHealthcare sales leader/supervisor for additional details.

Termination Process

All terminations must be classified for-cause or not-for-cause.

Not-for-Cause Termination

A not-for-cause termination may be recommended for you by UnitedHealthcare or requested for any reason by an agent. Depending on the reason for termination, you may be flagged RBC in the contracting system.

For-Cause Termination

UnitedHealthcare may recommend a for-cause termination for you. Agents terminated for-cause will be flagged RBC in the contracting system. UnitedHealthcare may report for-cause terminations to other UnitedHealth Group lines of business. UnitedHealthcare will report for-cause terminations to the appropriate state Department of Insurance (DOI) and the Center for Medicare and Medicaid Services (CMS).

Termination Process

When your appointment is terminated, it may necessitate a termination of your employment as well. Therefore, when the termination of your appointment is under consideration, the following steps must be followed:

- If the DAC makes a recommendation to terminate an employee agent's appointment, your UnitedHealthcare management will confer with Human Capital to discuss the next steps when a recommendation to terminate your appointment necessitates the need to terminate employment.
- You will be sent a written notification of employment termination if requested through HRDirect, unless required by state law, in which case agent notification is automatic. You will be flagged RBC in the contracting system.
- A written notification of appointment termination will be sent to you when the appointment is terminated for-cause.
- ALM processes the employee not-for-cause or for-cause appointment termination and appropriate state Department(s) of Insurance (DOI) notification. (See the State and CMS Notification Process section).
- UnitedHealthcare reserves the right to suspend the agent from marketing and sales activities until the termination becomes effective.
- You may request a reconsideration of 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 UnitedHealthcare sales leader/supervisor for additional details.

Request for Reconsideration

Agent Request for Reconsideration - Employee Agent

You may file an Internal Dispute Resolution (IDR) with Human Capital to dispute your employment termination. If your termination status is reversed and you are going to assume duties that require an appointment, your manager must notify ALM to reappoint you to the appropriate entities.

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

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	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.

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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

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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.

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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.

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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.

Section 9: Glossary of Terms

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.

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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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