Individual and Family Plans (IFP) Agent Guide

UnitedHealthcare®

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This Guide is intended for agent use only.

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Section 1: Introduction

Welcome to UnitedHealthcare

Using this Guide

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Welcome to UnitedHealthcare

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

Here to help you succeed

We are committed to providing you with tools that help you succeed. The *Agent Guide* is a resource providing information you need to conduct business with UnitedHealthcare efficiently and compliantly.

Compliance and integrity

We expect our agents to share our commitment to compliance and to act with integrity by putting the best interest of consumers first in everything they do on behalf of the company.

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.

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

Sincerely,

Marcus Robinson
CEO of Individual and Family Plans
UnitedHealthcare Individual and Family Plans

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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 Individual and Family Plans (IFP) agents. Throughout the guide, the words “agent”, “agent/broker”, “broker”, and “you” are used to refer to any IFP agent, agencies, or solicitor unless otherwise indicated.

The Producer Help Desk (PHD) can be reached at **1-866-235-4095** (normal hours of operation are 8 a.m. – 7 p.m. Central Time, Monday – Friday) or at acabrokersupport@uhc.com for agent, Jarvis, or other technology related issues.

Section 2: On-Boarding and Readiness

On-Boarding

Agent/Solicitor Level, Alignment, or Channel Change Requests

Conflict-of-Interest

Pledge of Compliance

Agent Profile

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On-Boarding

You must be appropriately contracted, licensed, appointed (as required by the state), and have completed registration and training required by UnitedHealthcare or the applicable exchange (Federally-facilitated Marketplace (FFM) or State-based Marketplace (SBM)), based on your designated roles in order to represent UnitedHealthcare in the marketing, selling, and/or servicing of UnitedHealthcare products.

Active Non-Employee Agents and Agencies

Agents must be licensed, appointed (as required by the state), and have completed the registration and training required by UnitedHealthcare or the applicable exchange FFM or SBM at the time of the enrollment application received date. To receive commissions or renewals on an eligible enrollment, in addition to being licensed, appointed (as required by the state), and appropriately trained as of the enrollment application received date, agents must be contracted with UnitedHealthcare. Agents not contracted at the time of the enrollment application received date must be contracted with UnitedHealthcare no later than the member's plan effective date.

On-Boarding

Contracting

You may align under a Field Marketing Organization (FMO), Key FMO, General Agency (GA), or eAlliance organization approved and contracted with UnitedHealthcare. You may only align in one hierarchy at any given time. There is no contractual relationship between the solicitor and UnitedHealthcare. All commissions earned for sales made by the solicitor are paid directly to the contracted entity to which the solicitor is linked. The contracted entity is responsible for compensating the solicitor agent appropriately.

Your up-line initiates the contract submission process by providing contracting paperwork (via electronic copies or a link to either an internal or an external on-line contracting system) to you to obtain necessary on-boarding information and documentation. The parties involved are responsible for verifying the accuracy and completeness of the contracting packet paperwork. Signature dates must be within 30 days of the date received by ALM. A complete contracting packet contains:

- Agreement (not applicable for solicitor) – First and signature pages, at a minimum, must be submitted.
- Appointment Application – signed and dated.
- Background Check Authorization Form – signed and dated.
- Errors and Omissions Attestation of Coverage within the Appointment Application – signed and dated.
- W-9 Form (not applicable for solicitor) – signed and dated.

Direct Entity

Entities may enter a direct contract with UnitedHealthcare. Contact your UnitedHealthcare Market Manager or Sales Leader for additional information.

UnitedHealthcare Direct to Consumer (DTC) Sales Vendor Telesales Agent

UnitedHealthcare Direct to Consumer (DTC) Sales vendor telesales agents must not simultaneously in an active contractual relationship with UnitedHealthcare or another carrier to market/sell IFP products.

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Section 2: On-Boarding and Readiness

Licensing
You must be licensed in your resident state and in all states for which you have requested appointment (as required by the state). ALM will verify license status using NIPR (National Insurance Producer Registry). Failure to maintain valid licensing is grounds for not-for-cause termination.

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

- ALM must receive a complete contracting packet in order to assign a Party ID. If an incomplete contracting packet is received, ALM will suspend the contracting process and notify your up-line via email, identifying the missing, incomplete, or outdated items. The contracting process will resume when the packet is complete.
- Upon receipt and review of a complete contracting packet, ALM will assign the Party ID and an Agent ID (Writing Number) and email you and your up-line a Party ID Notification Letter.

Registration and Training
You must complete registration and training required by UnitedHealthcare or the applicable exchange (FFM or SBM) and is your responsibility to complete before conducting any marketing or selling on behalf of UnitedHealthcare.

Background Investigation
Initial On-Boarding
You must pass a background investigation in order for ALM to process the appointment request. The investigation is ordered at the time the Party ID is issued and may be ordered when a new contract packet is received based on when the last investigation occurred. A background investigation collects information regarding your history of criminal charges, insurance licensing history, Office of Inspector General records, and General Service Administration excluded party records. IFP background investigations do not include a financial information check. Results are examined against predefined criteria. A Pass-Fail scoring methodology is employed:

- Pass – the contracting process continues
- Fail – the results of the background investigation are reviewed by a senior ALM analyst. If the review supports the initial result, the contracting process terminates and you receive notification that the appointment is declined due to background investigation. The notification letter includes appeal submission instructions. (Refer to the Agent Appeal of Denied Appointment Due to Background Investigation section below.)

Periodic Investigation
On a periodic basis, a background investigation is ordered for all non-employee agents (all levels), solicitors, and principals who have an active Party ID.

- A notification letter is sent to you informing you of the upcoming background investigation. The notification letter provides instructions on how to notify ALM if you do not authorize the investigation.
- If you do not authorize the background investigation, you will receive a 30-day termination notice. Refer to the Termination Section for details.
- The periodic background investigation review follows the same process outlined in the Initial On-Boarding Section above (except credit history information is not collected). If you fail the periodic background process, you will receive a 30-day termination notice,

regardless of channel or level (solicitors included). Refer to the Termination Section for details.

- Proactive Background Review
  To expedite the periodic background investigation process, an investigation may be paused temporarily in order to obtain clarification of data reported by the background investigation vendor.
  - A communication is sent to you requesting the necessary documentation for you to pass the review. You must respond to the request within ten days to complete the background review process.
  - If you miss the deadline or choose not to participate in the process, the background review will proceed as usual, which may result in a failed background review.
  - If you do not pass the review, you are entitled to the standard two-tiered appeal process. (Refer to the Agent Appeal of Decline Due to Background Investigation section below.)
- On a monthly basis, ALM accesses the Office of Inspector General (OIG) –U.S. Department of State Health & Human Services website (www.oig.hhs.gov/exclusions) and downloads the list of excluded individuals/entities. The list is analyzed against the active agent population to ensure active agents have not appeared on the list since the previous month. Any agent or agency appearing on the list is terminated in accordance with their agreement.
- On a monthly basis, ALM accesses the US General Services Administration (GSA) housed in the System for Award Management (SAM) website to download a list of excluded individuals/entities. The list is analyzed against the active agent population to ensure active agents have not appeared on the list since the previous month. Any agent or agency appearing on the list is terminated in accordance with their agreement.

Agent Appeal of Denied Appointment Due to Background Investigation

A two-tier appeal process is offered to agents who are denied appointment due to background investigation results. Appeals must be in writing, include the agent's name and address, and provide detailed information explaining the mitigating circumstances regarding the findings of the background investigation, including correction of errors or explanation of extenuating circumstances. An optional Background Appeal Form, available on Jarvis, may be used to submit the appeal documentation. All appeal documentation is uploaded to the agent's file in the document management system. Appeals may be emailed to ALM via Email: big.notifications@uhc.com

- First-Level Appeal – Tier I
  Initial, Tier I appeals are reviewed and determinations made by designated ALM staff specifically trained to review background investigation results. If the same ALM analyst who made the original decision to deny appointment of the agent based on the background investigation results also conducts the Tier I appeal review, in order to obtain an impartial decision the analyst will solicit input from other analysts trained in background investigation reviews or a review by leadership will be requested, in order to obtain an impartial decision.
  - The ALM specialist reviews the background investigation results, appeal letter and attachments, and other pertinent documents and makes a determination to approve or deny the appeal.
  - If the appeal is approved, the contracting process resumes. New documents may be required if they no longer meet signature date requirements.

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- If the appeal is denied, a denial notification letter is sent via email and postal mail to you that describes your right to a second appeal and the process. Your up-line receives a copy of the notification letter.

- Second-Level Appeal – Tier II
  An appeal submitted following a Tier I denial is considered by the Background Tier II Appeal Committee. The committee includes senior-level distribution operations and field sales representatives; meets, as needed; and maintains meeting notes (used to document relevant aspects of the meetings including attendees, appeals reviewed, decisions rendered and by whom).
  - Tier II appeals must contain additional information explaining what was missed in the initial reviews and/or errors regarding the background investigation not revealed previously.
  - The Background Tier II Appeal Committee reviews the appeal and pertinent documents, renders a decision, and forwards the appeal documentation with noted decision to ALM.
  - ALM facilitates processing and documenting the appeal, including the communication of the final decision to you and your up-line.
  - If the appeal is approved, the contracting process resumes. New documents may be required if they no longer meet signature date requirements.
  - If the appeal is denied, a denial notification letter is sent via email and postal mail to you. Your up-line receives a copy of the notification letter.
  - The decision of the Background Tier II Appeal Committee is final and may not be appealed.

Waiting Period to Submit a New Contract Packet
If you are declined due to background investigation results, you must wait one year from the date of your notification letter to submit a new contract packet. If you appeal the decline, you must exhaust both appeal level options and wait one year from the date of your original background decline date to submit a new contract packet.

Errors and Omissions (E&O)/Professional Liability Insurance
Each non-employee agent representing UnitedHealthcare must carry and maintain continuous E&O/Professional Liability insurance coverage and provide proof of coverage (e.g., carrier's declaration page) upon request. Failure to carry and maintain proof of E&O/Professional Liability coverage is grounds for termination. The following guidelines apply:

- The policy must specifically state "Errors and Omissions" or Insurance Agent/Broker Professional Liability.
- The declaration page or certificate of insurance must state the policy number, policy limits, policy period (issue and expiration dates), and carrier.
- Minimum insurance is required. E&O/Professional Liability insurance is required at a minimum of $1,000,000 per claim and/or $1,000,000 aggregate.
- E&O/Professional Liability for a corporation should state who is covered by the policy (e.g., the corporation, principal, and/or its employees or subcontractors).
- Blanket E&O/Professional Liability coverage must explicitly state who the policy covers:
  - Entities that have blanket E&O coverage for their down-line agents may provide a non-carrier produced listing of those covered, as long as the down-line is classified as an agent or at the solicitor level. The listing must be on the entity's letterhead, provide the agent's or solicitor's full legal name and be signed by the entity's

principal. Agents or solicitors can be added by providing either an update to the original listing or a separate letter.
    - General Agent level and above producers must have their own E&O coverage or their name must appear as the certificate holder (or similar) on the confirmation of insurance of a blanket policy.
    - Contracted entities may provide E&O/Professional Liability coverage by submitting a non-carrier produced listing of covered individuals. The listing must be on the business entity's letterhead, provide covered individual's full legal name and signed by the entity's principal. IFP entities may provide coverage for their down-line employees, affiliated producers, agents, and/or subcontractors who are contracted at the individual agent level.
- E&O/Professional Liability for a principal covers the corporation, but not specifically the employees or subcontractors of the corporation.
- If you are not insured by a corporate policy, you may have individual E&O/Professional Liability insurance. The policy should be in your name.
- Submission of E&O/Professional Liability coverage documentation is not required unless specifically requested and may be sent to exchangescontracting@uhc.com. See the Contracting section above regarding the attestation requirement.

Appointment

You must be appointed (as required by the state) in the state in which the consumer resides and each state in which you represent UnitedHealthcare in the marketing and/or sale of UnitedHealthcare products.

- UnitedHealthcare may submit appointment requests during on-boarding.
- UnitedHealthcare may submit appointment requests after receipt of the first enrollment in that state.
    - UnitedHealthcare may use Just-in-Time appointing (including back-dating appointments when available).
    - 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.
- UnitedHealthcare may use current appointment in another UnitedHealthcare product to satisfy the appointment requirement.

In order to be eligible for a commission, you must be appointed (as required by the state) in the state in which the consumer resides at the time of the enrollment application received date. In addition to requesting appointment during on-boarding, UnitedHealthcare may use Just-in-Time appointing (including back-dating appointments when available), or current appointment in another UnitedHealthcare product to satisfy the appointment requirement. If the appointment is not verifiable at the required time, an enrollment application and any future renewals will not be commission eligible.

Writing Number (Agent ID) Notification

You receive a writing number (Agent ID) as part of your on-boarding process. An active writing number allows you to access marketing and sales materials on Jarvis. Once the appointment request is submitted to the state, you are set to active status in the contracting system, a writing number is issued, and your Agent Agreement is in force executed with the Chief Executive

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Officer (CEO) IFP signature. A Welcome Letter, which contains your writing number and a copy of the executed signature page of your Agent Agreement, if applicable, is available in your agent performance file. A copy of the Welcome Letter sent to your up-line or to UnitedHealthcare sales leadership. You are expected to confirm state appointment approval via Jarvis prior to marketing/selling any product unless the state is indicated as a "Just in Time" appointment and the appointment will be submitted after the first enrollment.

UnitedHealthcare Telesales Sales Agents
UnitedHealthcare Telesales sales agents must be appropriately licensed, appointed (as required by the state), and certified based on their role.

UnitedHealthcare Telesales Sales Agents 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 market or sell UnitedHealthcare products. Telesales agents are responsible for all educational requirements to maintain an active state license.
- Be appointed (as required by the state) in each state where they will market or sell UnitedHealthcare products.
- Complete all applicable FFM and/or SBM exchange training, certification, and registration requirements prior to marketing/selling for the applicable selling season. Telesales agents must complete all trainings/certifications themselves.

Agent/Solicitor Level, Alignment, or Channel Change Requests

For all changes in contracting level, hierarchy, or channel, residual override commissions are retained by the hierarchy in place at the time of the original sale and do not follow the moving agent/agency. An agent's up-line is prohibited from contacting a down-line agent's UnitedHealthcare member(s) once the agent (i.e. agent of record) is released from the up-line's hierarchy or has submitted to UnitedHealthcare a Notice of Intent to Move to move hierarchy. Contact includes but is not limited to telephone, email, text message, voice message, and postal mail. This provision does not apply to solicitors.

Release and Notice of Intent to Move Requirements
When an agent/solicitor contracted with UnitedHealthcare wants to align under a new hierarchy a Letter of Release or Notice of Intent to Move is required unless the change results in an employment relationship with UnitedHealth Group or its affiliate or a telesales vendor contracted with UnitedHealthcare. An agent/solicitor/agency is prohibited from changing levels or hierarchy while in a suspended status.

Release Process

- For an agent/solicitor, only the highest contracted entity (e.g., FMO, Key FMO, GA, or eAlliance) in the agent/solicitor's current hierarchy (or UnitedHealthcare if applicable) may, at its discretion, provide the agent/solicitor with a full release to leave the hierarchy (even if the agent/solicitor self-terminated within six months of submitting new contract paperwork).
- Upon receipt of the release, you may move to a new hierarchy. While there is no waiting period to contract under a new hierarchy, ALM does not process contracting change

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requests during a blackout period that runs annually October 1 through January 31. The new contracting packet, which must include the Letter of Release, must be received by ALM no later than September 30 in order to align under the new hierarchy by the start of the Open Enrollment Period (OEP).

- You may only move to a contracting level equal to or lower than your current contract level and must stay at that level for a minimum of one year.
- If your current FMO, Key FMO, GA, or eAlliance (or highest upline agency or UnitedHealthcare, if applicable) will not provide a release, you may terminate your agreement with UnitedHealthcare and contract under a different FMO, Key FMO, Key GA, GA, eAlliance, or as a direct agent, at the same or lower contract level no less than six months after your termination effective date or you may use the Notice of Intent to Move process. Normal contracting rules apply.

Notice of Intent to Move Process

- All eligible agents or agencies may use the Notice of Intent to Move process.
- You must be under your current Agency and/or in your current hierarchy level for at least six months prior to submitting a Notice of Intent to Move and can only change agency hierarchy once every 12 months from the effective date of your current agreement or hierarchy change, whichever occurred most recently.
- You must email your Notice of Intent to Move to UnitedHealthcare at exchangescontracting@uhc.com and the top level of your current hierarchy, indicating the name of the hierarchy under which you intend to move.
- Upon receipt of the Notice of Intent to Move, UnitedHealthcare will send a reply letter to you, with a copy to the current hierarchy and intended hierarchy or applicable UnitedHealthcare sales leader, indicating the date when the 90 day waiting period expires.
- A 90 day waiting period begins on the date UnitedHealthcare receives the email. During the waiting period, you and your down-line, if applicable, may continue to write UnitedHealthcare business. If, during the 90 day waiting period, you decide to move to a different hierarchy than indicated in the Notice of Intent to Move, you must submit a new Notice of Intent to Move, which begins a new 90 day waiting period.
- Once the Notice of Intent to Move is submitted to the current up-line, the current up-line may not make changes to the transferring agent/solicitor's hierarchy unless the transferring agency/agent/solicitor provides written notice to make changes.
- ALM must receive required contracting paperwork (i.e. Appointment Application and only if moving level a new contract agreement) within 30 days of the expiration of the waiting period except as noted below:
  - ALM does not process contracting change requests during the Blackout Period (October 1 through January 31). Therefore, in order to move to a new hierarchy by the start of an Open Enrollment Period, the new contracting packet must be received by ALM before the blackout period begins October 1.
  - If ALM does not receive required paperwork within the required timeframe, you must submit a new Notice of Intent to Move, which begins a new 90 day waiting period.

Successor Programs

- Successor Agent Program – Renewal Eligible Non-Employee **(eAlliance agencies excluded)**

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

- Eligible products include all UnitedHealthcare IFP plans.
- eAlliance agencies are not eligible for the Successor Agent Program (except in limited circumstances as determined by UnitedHealthcare).
- Original Agent Eligibility and Terms of Agreement requirements:
  - Original Agent must be in active status with UnitedHealthcare.
  - Original Agent must not be the subject of an open complaint investigation. Open complaint investigations must be closed prior to requesting a successor Agent Agreement.
  - Original Agent must be in the FMO (solicitors are ineligible) or Direct Agent channel.
  - Original Agent must sign the "UnitedHealthcare Individual & Family ACA Marketplace Plans Successor Agent Agreement" which includes without limitation the following terms:
    - Original Agent's current Agent Agreement and Writing ID(s) will be terminated.
    - Original Agent acknowledges that the transfer of their book of business is contingent on their down-line hierarchy, if any, also being transferred to the successor agent. Standard release rules apply.
    - Original Agent's rights related to their entire current UnitedHealthcare business, including renewal commissions and up-line payments, if any, will cease upon the effective date of the transfer.
    - Original Agent's liabilities and obligations related to their business that is not eligible to be transferred will continue and survive the termination of their Agent Agreement.
    - Original Agent's current debt related to the transferred business is to be paid in full or transferred to the Successor Agent upon transfer of the book of business. Debt repayment plans are not allowed.
    - If Original Agent is the assignee of another agent's commission, the assignment of commissions agreement will be terminated.
    - Original Agent agrees to comply with applicable state and federal rules and requirements related to the transfer of their book of business, including, but not limited to, member notice and consent requirements.
- Successor Agent/Agency Minimum Eligibility and Terms of Agreement
  - Successor Agent/Agency must have an active contract with UnitedHealthcare. Standard release rules apply.
  - Successor Agent/Agency must be licensed and appointed (as required by the state) in each state in which a currently enrolled IFP plan member resides and complete registration and training required by UnitedHealthcare or the applicable exchange (FFM or SBM).
  - Successor Agent/Agency must be of an equal or higher level than the highest level at which the original agent had been contracted to receive the original agent's full book of business.

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- ~ Successor Agent/Agency must not be the subject of an open complaint investigation. Open complaint investigations must be closed (refer to policy IFP-112 for details) prior to requesting a successor agent agreement.
- ~ Successor Agent/Agency Principal must sign the "UnitedHealthcare Individual & Family ACA Marketplace Plans Successor Agent Agreement" and agree to the following terms:
  - Successor Agent/Agency agrees to accept and service Original Agent's entire eligible book of business and oversee, where applicable, down-line agents transferred to Successor Agent's/Agency's hierarchy to receive renewal commission/up-line payments.
  - Successor Agent/Agency will take on any future charge back debt related to the transferred book of business.
  - Successor Agent/Agency agrees to comply with applicable state and federal rules and requirements related to working with new clients, including, but not limited to, member notice and consent requirements.

- o Upon transfer, the Successor Agent's Agent Agreement with UnitedHealthcare will govern the book of business.

- Successor Agent Program Approval Process
  - o All requests to transfer Original Agent's UnitedHealthcare book of business to Successor Agent/Agency are subject to prior review and approval by UnitedHealthcare.
  - o UnitedHealthcare approves or disapproves a request to transfer within approximately 30 days of receipt of the signed Successor Agent Interest Form. If approved, a "UnitedHealthcare Individual & Family ACA Marketplace Plans Successor Agent Agreement" between Original Agent and Successor Agent/Agency may be executed.
  - o Successor Agent Agreements are effective immediately upon full execution (i.e. the date UnitedHealthcare signs the agreement).
  - o UnitedHealthcare reserves sole discretion to deny any agreement up until it is a fully executed contract.
  - o UnitedHealthcare reserves sole discretion to remove Successor Agent/Agency as Agent of Record (AOR) and to discontinue paying the agent if it determines that Successor Agent/Agency is not servicing the members or overseeing down-line agents, if any, as required by the Agent Agreement.
  - o UnitedHealthcare, at its sole discretion, reserves the right to rescind the Successor Agent Program at any time without notice.
- Deceased Agent Successor Program – Renewal Eligible Non-Employee (eAlliance agencies excluded)

  When all eligibility requirements are met, UnitedHealthcare will work with a deceased contracted non-employee agent's next of kin, estate, and/or up-line to establish a successor agent/agency, who agrees to accept and service the members within the deceased agent's book of business and oversee down-line agents, as applicable. In all cases, transfer of a deceased agent's book of business is subject to UnitedHealthcare's prior review and approval.
  - o Eligible products include all IFP plans.
  - o eAlliance agencies are not eligible for the Successor Agent Program (except in limited circumstances as determined by UnitedHealthcare).

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- Deceased Agent Successor Program Qualifications and General Considerations
  - ~ Deceased Agent must have been a renewal eligible agent (solicitors are ineligible) in active status with UnitedHealthcare at the time of death.
  - ~ Deceased Agent must have been in the FMO or Direct Agent channel at the time of death.
  - ~ Under normal operations, the following occurs upon notification of an agent death:
    - Deceased Agent's Writing ID(s) will be termed for death.
    - If Deceased Agent's book is the assignee of another agent's commission, the assignment of commissions agreement will be terminated.

- Successor Agent/Agency Eligibility and Terms of Agreement
  - Successor Agent/Agency must have an active contract. Standard release rules apply.
  - Successor Agent/Agency must be licensed and appointed (as required by the state) in each state in which a currently enrolled IFP plan member resides and complete registration and training required by UnitedHealthcare or the applicable exchange (FFM or SBM).
  - Successor Agent/Agency must be of an equal or higher level than the highest level at which the Deceased Agent was contracted to receive the Deceased Agent's full book of business,
  - Successor Agent/Agency must not be the subject of an open complaint investigation. Open complaint investigations must be closed (refer to policy IFP-112 for details) prior to proceeding with a successor agent agreement.
  - Successor Agent/Agency Principal must sign the "UnitedHealthcare Individual & Family ACA Marketplace Plans Successor Agent Agreement" and agree to the following terms:
    - ~ Successor Agent/Agency agrees to accept and service Deceased Agent's entire eligible book of business and accept and oversee, where applicable, down-line agents transferred to the Successor Agent's/Agency's hierarchy to receive a renewal commission/up-line payments. UnitedHealthcare reserves sole discretion to remove Successor Agent/Agency as AOR and to discontinue paying Successor Agent/Agency if it is determined that Successor Agent/Agency is not servicing the member.
    - ~ Successor Agent/Agency agrees that outstanding debt related to the transferred business will also be transferred to the Successor Agent/Agency. They also will take on any future charge back debt related to the transferred book of business.
    - ~ Successor Agent/Agency agrees to comply with applicable state and federal rules and requirements related to working with new clients, including, but not limited to, member notice and consent requirements.
  - Upon transfer, Successor Agent's Agent Agreement with UnitedHealthcare will govern the book of business.

- Deceased Agent Successor Program Approval Process
  - UnitedHealthcare must approve all requests to transfer a Deceased Agent's UnitedHealthcare book of business to a successor agent/agency.
  - UnitedHealthcare must receive notification, including a death certificate and/or obituary, within 6 months of Deceased Agent's death. If UnitedHealthcare is not properly notified within 6 months of Deceased Agent's death, UnitedHealthcare

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may take on the role of servicing Deceased Agent's book of business or find a successor agent/agency.
  - Upon notification of death, next of kin/estate/up-line has 7 months from the date of death to identify a potential Successor Agent/Agency who agrees to the terms of and submits the "UnitedHealthcare Individual & Family ACA Marketplace Plans Successor Agent Agreement".
  - UnitedHealthcare will work first with Deceased Agent's next of kin/estate to identify a Successor Agent/Agency.
  - If next of kin/estate does not wish to help identify a Successor Agent/Agency, UnitedHealthcare will next work with Deceased Agent's up-line to identify a successor agent/agency.
  - If no Successor Agent/Agency is established and/or no Successor Agent Agreement is signed within 7 months from the date of death, UnitedHealthcare may take on the role of servicing Deceased Agent's book of business or find an alternate Successor Agent/Agency.
  - UnitedHealthcare will approve or disapprove the request to transfer within approximately 30 days of receipt of the signed Successor Agent Interest Form. If approved, a "UnitedHealthcare Individual & Family ACA Marketplace Plans Successor Agent Agreement" may be executed with the Successor Agent/Agency and the original agent's estate representative.
  - Successor Agent Agreements are fully executed as of the date UnitedHealthcare signs the Agreement and effective the date noted on the Agreement. UnitedHealthcare, at its sole discretion, reserves the right to deny any agreement up until it is a fully executed contract.
  - UnitedHealthcare, at its sole discretion, reserves the right to rescind the Deceased Agent Successor Program at any time without notice.
- Successor Agent Program Appeal Process
  An appeal process is offered to agents who are declined for the Successor Agent program.
  - Appeals must be in writing, include the agent's/agency's name and address, and provide detailed information explaining the rationale for appeal, including information on how the members will be serviced by engaging in the Successor Agent program. Appeals may be mailed, faxed, or emailed to Commissions:
    UnitedHealthcare Attention: Commissions – Successor Agent
    MN006-E800 9800
    Health Care Lane
    Minnetonka, MN 55343
    Fax: 1-866-761-9162
    Email: sh_commissions_administration@uhc.com (preferred method)
  - Appeals are forwarded for consideration to the Successor Agent Approval Board (SAAB), which includes senior-level distribution operations and field sales representatives.
    - The SAAB reviews the appeal and pertinent documents, renders a decision, and forwards the appeal documentation with noted decision to Commissions.
    - Commissions facilitates processing and documenting the appeal, including the communication of the final decision to the applicable agent(s).

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- If the appeal is approved, the Successor Agent/Agency process resumes. New documents may be required if they no longer meet signature date requirements per the Successor Agent process.
- If the appeal is denied, a denial notification letter is sent via email to the agent(s)/agency.
- The decision of the SAAB is final and may not be appealed again.

Conflict-of-Interest

Conflict-of-Interest Definition

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.

Common Types of Conflicts

Most conflicts covered by policy fall into one of the following categories:

- 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. * No conflict exists for non-employee agents who own an agency. It is a conflict when a UnitedHealth Group employee owns an agency.
- 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 a Product Requiring State License: An employee of UnitedHealth Group or its affiliate is involved in the sale of a product that requires a state license (e.g., health, life, financial services, and property/casualty), that may or may not compete with UnitedHealthcare insurance products. * Does not include employees in a sales role selling the product(s) they are authorized to sell.

Conflict-of-Interest Disclosure and Requirement

Individuals with an active Party ID who receive compensation based on sales and/or enrollments (e.g., commission, incentive, bonus, override) must complete a conflict-of-interest disclosure and attestation interview annually and as conflicts arise thereafter.

- Annual Disclosure and Attestation
  You will receive an email on your Party ID anniversary date (or issue date for newly onboarding individuals) directing you to complete the conflict-of-interest disclosure and attestation process.
    - You must complete the disclosure and attestation process in Sircon.

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  - Failure to complete the disclosure and attestation process by the due date or failing to disclose a conflict during the process may result in corrective and/or disciplinary action up to and including termination and a Corrective Action Plan (CAP) for employees.

- Disclosing Conflicts Outside of the Annual Process
  Conflicts that arise after the completion of the annual disclosure and attestation processed must be disclosed promptly.
  - Within three business days of a new conflict-of-interest arising, email Agent_COI@uhc.com and request an off-cycle disclosure and attestation interview. If an off-cycle interview is requested in error, email Agent_COI@uhc.com and request that the interview request be closed.
  - Failure to complete the disclosure and attestation process by the due date or failing to disclose a conflict during the process may result in corrective and/or disciplinary action up to and including termination for non-employees and a Corrective Action Plan (CAP) for employees.

Conflict-of-Interest Disclosure Evaluation and Determination Outcomes
UnitedHealthcare evaluates conflict-of-interest disclosures and determines the outcome for each, which may include developing a management plan, requiring the individual to 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.

Pledge of Compliance

United HealthCare Services, Inc. and its affiliated companies (collectively referred to herein as UnitedHealthcare) are committed to excellence in providing health insurance coverage to its members and in conducting its business affairs. UnitedHealthcare's reputation and value in the marketplace depend upon the integrity of all the individuals who represent it. Subscribing to this Pledge of Compliance is an expression of your personal commitment to ethical and compliant conduct in the marketing and sale of UnitedHealthcare products.

In this guide, "product" means Qualified Health Plans (QHPs) offered through the Health Insurance Marketplace available from UnitedHealthcare, "consumer" means a person who may purchase a product and "member" means someone who has purchased or is enrolled in such product.

1. I will act in an ethical manner and with integrity; treat consumers, members, and colleagues with courtesy, respect, and dignity at all times and never intentionally put the consumer/member or UnitedHealthcare at risk.
2. I will comply with all applicable federal and state regulations and guidelines, federal and state laws, and company rules, policies, and procedures that govern the marketing and sale of UnitedHealthcare products, including, but not limited to, telephone solicitations, consumer prior express written consent, opt-out, do-not-call lists, and similar requests and requirements under the Telephone Consumer Protection Act (TCPA) and the Telemarketing Consumer Fraud and Abuse Prevention Act (TCFAPA).
   a. I will comply with all regulations, guidelines, rules, policies, and procedures related to the use of marketing materials, logos, websites, and brand, product, and entity names.

   b. I will not engage in selective marketing or any marketing activities that disguise the true intent of the solicitation or outreach.
   c. I will adhere to UnitedHealthcare event requirements when hosting an event. I will comply with all regulations, guidelines, rules, policies, and procedures related to events.
3. I will adhere to all contracting, licensing, appointment, and all applicable Marketplace training, registration, and certification requirements and will not present any UnitedHealthcare product for which I am not properly contracted, licensed, appointed (as required by the state), or for which I have not completed the registration and training required or required certification at the time of marketing or sale.
4. If I am a contracted agent, I will adhere to all the terms and conditions of my agent contract.
5. I will not misrepresent my relationship with UnitedHealthcare, any federal or state agency including the Centers for Medicare & Medicaid Services (CMS), state regulatory or oversight body, or any third-party affiliation.
6. I will not imply to consumers or members that their enrollment is in any way sponsored, endorsed, or shared by any particular federal or state agency or third party.
7. I will not intentionally disparage UnitedHealthcare or its products, any competitor or competitor's products, or any government entity or program.
8. I will treat all UnitedHealthcare-provided resources and property, including leads, with respect and for the use intended or provided. Additionally, I will not share my personal log-in information or use another agent's log-in information nor will I sell a lead provided by UnitedHealthcare.
9. I will adhere to and comply with all anti-discrimination regulations and guidelines.
10. I will adhere to and comply with all regulations related to protecting the privacy of consumers and members, including their health and personally identifiable information, and the appropriate reporting of suspected or actual disclosures. This includes the appropriate use and safeguarding of documentation including consumer consent forms, Enrollment Applications, lead and business reply cards, and any other document containing a consumer or member's health and/or personally identifiable information.
11. I will comply with all regulations, guidelines, rules, policies, and procedures related to the enrollment process including obtaining consumer consent, confirming consumer eligibility, eligibility application accuracy confirmation, service area and election period requirements, and agent-assisted enrollment guidelines. This includes adhering to the appropriate use of all enrollment mechanisms including telephonic, electronic, and internet-based.
12. I will only use my agent identification number (National Producer Number (NPN) or state insurance license number, as applicable) on Marketplace Enrollment Applications for which I assisted the consumer in the enrollment process. UnitedHealthcare will not share or split commission payments between agents.
13. I will <u>not</u>:
   a. Lead a consumer to believe their signature on an Enrollment Application is for any purpose other than to enroll in an ACA Marketplace plan;
   b. Enroll a consumer into a plan that they or their authorized legal representative did not authorize; or
   c. Fraudulently alter, complete, and/or sign an Enrollment Application or any other business document using a consumer's identifying information such as name and/or Social Security number.

14. I will work with the consumer's authorized legal representative if the consumer has mental or physical limitation issues that prevent the consumer from fully understanding the plan.
15. I will not engage in any form of inducement, including the giving or accepting of gifts or financial incentives, coercion, deception, or abuse of fiduciary trust in conducting business on behalf of UnitedHealthcare. This includes any arrangements to share or split any payment or commission with the consumer or member.
16. I will respond as directed and in a timely manner to any inquiry received from UnitedHealthcare related to my sales activities and actions to support investigation of any complaints or concerns, will produce all related documentation within the timeframe requested, and will complete any assigned corrective and/or disciplinary action within the indicated timeframe.
17. I will accept and read all notices from UnitedHealthcare, regardless of communication method, including newsletters and email notifications, that may contain contractual and/or compliance information and updates related to marketing/sales activities. I will ensure my valid email address is on file (in my agent profile) at all times.
18. I will comply with HIPAA Privacy and Security Rules and UnitedHealthcare requirements related to the protection of Protected Health Information (PHI), including encryption requirements that apply to any electronic device that stores and/or transmits PHI (e.g., laptops, smart phones, tablets). I understand that it is my responsibility to ensure all PHI that is stored or transmitted electronically is secured through a valid encryption process (e.g., secure delivery via encrypted email). I also agree to comply with and respond timely if I am randomly selected for virtual and or telephonic audits UnitedHealthcare performs related to the protection of PHI. I will comply with the reporting requirements for privacy and security incidents.
    a. I will report to UnitedHealthcare any potential HIPAA, PHI, or PII incidents immediately upon discovery.
    b. I will report privacy incidents to one of the following:
        i. The UnitedHealthcare Privacy Office at UHC_Privacy_Office@uhc.com.
        ii. UnitedHealthcare sales leader
        iii. The Segment Compliance Lead
        iv. The UnitedHealth Group Compliance and Ethics HelpCenter at 800-455-4521 or www.uhghelpcenter.ethicspoint.com (available 24 hours a day, 7 days a week), or compliance_questions@uhc.com.
    c. I will report immediately security incidents (e.g., unauthorized access to UnitedHealth Group data/systems, laptop theft) to UnitedHealth Group Support Center at 888-848-3375 (available 24 hours a day, 7 days a week).
19. I attest that I have read, understand, and will abide by UnitedHealth Group's Code of Conduct: Our Principles of Ethics and Integrity (accessible at https://www.unitedhealthgroup.com/investors/standards.html). I will maintain professional relationships, act with integrity, exercise the highest standards of business and personal ethics in the conduct of duties, respect human rights, and will not engage in any form of discrimination, harassment, or intimidation.
20. I attest that I have read, understand and will abide by the IFP Pledge of Compliance. I understand that it is my obligation to comply with the law, this Pledge, and all applicable UnitedHealthcare policies, including the Conflict-of-Interest policy, and contractual obligations. I further understand that I have an affirmative duty to report all suspected illegal or unethical conduct, including violations of law, this Pledge, Company policies and contractual obligations, or any concerns about accounting, internal controls, auditing

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matters, or suspected fraud and abuse. UnitedHealthcare maintains a strict non-retaliation policy for good faith reporting of actual or potential illegal or unethical conduct.

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 email at exchangescontracting@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 numbers can be added/updated via Jarvis.

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Section 3: Sales Communications

Sales Communications

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Sales Communications

UnitedHealthcare provides you with information related to the product portfolio, applicable federal and state laws and regulations, and UnitedHealthcare policies, procedures, rules through a variety of means. All communication methods must be conducted in compliance with federal and state laws and regulations governing business data use and consent requirements for calls/text where applicable.

Communication Methods
Email and Jarvis are the primary methods of communication used by UnitedHealthcare.

Other Communication Methods
- Postal mail
- Manager meetings
- Conference Calls
- Telephonic Messaging (e.g., text and voice)

Communication Management
IFP Connect
IFP Connect is a newsletter distributed to agents bi-weekly and all articles will be available on ***Jarvis***.

Emails
Sales Communications maintains and uses email distribution lists to send targeted emails.

IFP Sales Communications Review
IFP internal sales communications must go through the communication review process. Contact your IFP sales leader for additional details.

Disclosing Proprietary Information and External Opportunities
- 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 does not include any UnitedHealth Group or its affiliate's name, logo, or trademark, the permission to participate requirement does not apply.

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Section 4: Marketing Activities and Materials

Marketing Activities

Materials General Requirements

Websites and Social Media

Consumer Contact

Lead Generation

Book of Business

Accessibility and Non-Discrimination

Privacy and Security

Field Sales Expense Payment Process

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Marketing/Sales Activities

You must comply with all federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules related to marketing/sales activities and the development and use of materials. Failure to comply with any laws, regulations, rules, policies, or procedures may result in corrective and/or disciplinary action up to and including contract termination.

You must be appropriately contracted, licensed, appointed (as required by the state), and have completed the registration and training required by UnitedHealthcare or the applicable exchange (Federally-facilitated Marketplace (FFM) or State-based Marketplace (SBM)) in order to conduct marketing/sales activities on behalf of UnitedHealthcare.

Marketing/Sales Activities

You must:

- Provide consumers with correct information, without omission of material fact, regarding the Exchanges, Qualified Health Plans (QHPs) offered through the Exchanges, and insurance affordability programs.
- When providing information to Exchanges that may result in a determination of eligibility for a special enrollment period in accordance with regulations, obtain authorization from the consumer to submit the request for a determination of eligibility for a special enrollment period and make the consumer aware of the specific triggering event and special enrollment period for which the agent/broker will be submitting an eligibility determination request on the consumer's behalf.
- Obtain and document consumer consent prior to assisting with or facilitating an enrollment for coverage through the Federally-facilitated Exchanges, State-based Exchange using the Federal Platform, or Classic Direct Enrollment (DE)/Enhanced Direct Enrollment (EDE) website, or assisting with applying for Advance Payment Tax Credit (APTC) or Cost-Sharing Reduction (CSR). Examples of situations where prior consumer consent must be obtained and documented, include but are not limited to:
    - Collecting or using any consumer Personally Identifiable Information (PII)
    - Conducting a person search for consumer eligibility applications using an approved Classic Direct Enrollment (Classic DE) or Enhanced Direct Enrollment (EDE) website
    - Actively helping a consumer apply for Marketplace coverage or financial assistance by completing an eligibility application on their behalf
    - Actively enrolling a consumer in a Marketplace QHP
    - Making updates to a consumer's eligibility application throughout the year via an approved Classic DE or EDE website
    - Checking the status of a consumer's coverage or their eligibility application, including their eligibility for financial assistance
- Compliantly document the consumer consent. The consumer consent documentation must:
    - Have the consumer or authorized representative take an action to produce the documentation (i.e. provide a signature or record a verbal confirmation).
    - Contain, at a minimum, the following information:
        - ~ A description of the scope, purpose, and duration of the consent provided by the consumer or their authorized representative;
        - ~ The date the consent was given;
        - ~ The name of the consumer or their authorized representative;

- ~ The name(s) of the agent, broker, web-broker, or agency being granted consent (note: all individuals who assist with or facilitate the consumer's enrollment must be granted consent); and
- ~ The process through which the consumer or authorized representative may rescind the consent.
  - o Be retained and made available upon request for a minimum of 10 years.
- Keep agent and non-agent activities separate when participating in non-agent events/activities (e.g., volunteering at a food bank).
- Use UnitedHealthcare provided materials for the intended purpose and without modifications.
- Provide required materials to the consumer at the time of enrollment.
- Be aware of and sensitive to the needs of the consumer related to language barriers and physical or cognitive impairments/disabilities and must comply with all applicable accessibility requirements.

You may wear a UnitedHealthcare branded shirt and/or badge (e.g., purchased from the UnitedHealth Group Merchandise eStore accessible via Jarvis) when representing UnitedHealthcare.

You must not:

- Begin marketing activities for the upcoming plan year until directed by UnitedHealthcare. Specifically, marketing of exchange plans must not begin in a given market and for a given year until forms and rates have been approved by the state and UnitedHealthcare has received QHP Certification and/or fully executed QHP Certification Agreement from the exchange.
- Obtain credentials (username and password) for a consumer's/member's exchange account or associated email account.
- Login to or otherwise access a consumer/member's exchange account.
- Withhold access to a consumer/member's exchange account and login information.
- Engage in any intimidating or high-pressure tactics.
- Engage in marketing or conduct that is misleading (including by having a direct enrollment website that HHS determines could mislead a consumer into believing they are visiting HealthCare.gov), coercive, or discriminates based on race, color, national origin, disability, age, or sex.
- Knowingly and willfully provide or receive money or other compensation to induce or in return for purchasing or arranging for the purchase of items or services covered.
- Give or receive anything of value from a consumer in exchange for an enrollment.

Events

You must:

- Comply with state and federal laws and regulations and UnitedHealthcare policies, procedures, and rules related to conducting an event.
- Obtain permission from the venue or applicable authority to conduct an in-person event.

You may have a compliant banner or table cloth with the plan name and/or logo displayed.

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You must not:

- Conduct an event in any location where the reputation of the agent or UnitedHealthcare could be compromised, such as a casino in an area 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.
- Wear UnitedHealthcare apparel when not representing UnitedHealthcare at an event (e.g., volunteering at a food distribution event outside of a licensed sales agent role).
- 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.

Materials General Requirements

Materials Must

- Comply with federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules regarding materials. You must ensure that all materials you create and/or use are compliant. You are solely responsible for the compliance of the materials you create and/or use.
- Be appropriately filed/approved with the state (as required by the state). You must ensure that materials are appropriately filed/approved with a state and submitted/reviewed by UnitedHealthcare as necessary.
- Provide accurate information.

You must use a title or designation that accurately reflects your role as a licensed insurance agent/producer marketing/selling health insurance. Using a title or designation that has the potential to confuse or mislead a consumer is prohibited.

Materials Must Not

- Include any UnitedHealthcare name, logo, brand element, or plan name or information (e.g., benefits or costs) without prior approval from UnitedHealthcare. All materials featuring the UnitedHealthcare brand must be submitted to UnitedHealthcare for review and approval prior to use. Refer to the Exception Process section for details.
- Use scare tactics or statements.
- Provide misleading information, including misleading information through omission.

UnitedHealthcare Branded Materials

UnitedHealthcare Brand Name, Elements, and Logo

- Other than the materials and preapproved templates (e.g., logo) provided by UnitedHealthcare, you have no authority to use any UnitedHealth Group, UnitedHealthcare, or its affiliates brand names, brand derivatives, trademarks, service marks, logos, or domain names in any agent/broker created or used content or material, or on any website and/or social media without the proposed use being submitted, reviewed, and approved prior to use.
- You must not use any UnitedHealthcare owned or provided content or materials in the creation of content or materials.
- Additionally, you are not permitted to incorporate in an email address or register or operate internet domain or social media names incorporating the name of any UnitedHealth Group, UnitedHealthcare, or its affiliates brand name or brand derivatives.

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

You must
- Be active and appropriately contracted, appointed (as required by the state), and completed registration and training required by UnitedHealthcare or the applicable exchange (FFM or SBM) in order to access and order preapproved materials through Jarvis. Access is limited to the products and/or plans in which you are licensed and certified to sell.
- Use your secure log on to access, download, and/or order materials through Jarvis.
- 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).
- When using pre-approved materials, you must use current versions.

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/broker who is not appropriately contracted, licensed, appointed, and completed registration and training required by UnitedHealthcare or the applicable exchange (FFM or SBM).
- Alter preapproved materials in any way, including handwritten notes (e.g., writing your contact information or marking 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 UnitedHealthcare Brand, Name, Logo, and/or Plan Related Information
Every effort must be made to use preapproved materials and templates. Requesting a custom branded material 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/broker-created materials featuring a UnitedHealthcare brand, plan information or logo without prior written approval by UnitedHealthcare is prohibited.

Requests for approval of agent/broker created branded material, the development of custom branded material, or the modification of preapproved materials are processed as follows:
- You must work through their highest level up-line to request a branded material exception to UnitedHealthcare. The up-line needs to submit the request to a UnitedHealthcare Sales Leader. If approved by a UnitedHealthcare Sales Leader (Agency Manager or Regional Vice President), the Sales Leader will submit the request to the UnitedHealthcare Marketing team for consideration.
- The UnitedHealthcare Marketing team 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/brokers,
  - 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 Marketing team will coordinate all requests with Compliance, Legal, and other internal reviewers as required. The requestor will be notified if the piece is approved for distribution. Meeting all criteria does not guarantee the request will be approved.
- Approval for the use of UnitedHealthcare brand elements will be granted only for the material submitted and may not be taken generally as blanket approvals. Approval or denial is generally provided within 10 business days. Approval may also be limited to one-time use.
- If applicable, the requester must abide by any additional usage guidelines provided by UnitedHealthcare.
- Both the requesting and the approving parties must keep a written record of all approvals granted.

Websites and Social Media

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

You Must

- Be actively contracted, appointed (as required by the state), and completed registration and training required by UnitedHealthcare or the applicable exchange (FFM or SBM) in order to announce their affiliation with UnitedHealthcare on their website.
- Be active with UnitedHealthcare in order to feature any UnitedHealthcare brand elements or branded resources. Agents/brokers who are inactive must remove all brand elements or branded resources no later than their termination date.

You Must Not

- Feature UnitedHealthcare brand elements (e.g., brand name, logo, or plan information), including but not limited to any reference to UnitedHealthcare, without prior approval from UnitedHealthcare.
- Post or repost any UnitedHealthcare owned or provided content or material, such as, materials available on UnitedHealthcare websites or social media, Jarvis, or distributed by UnitedHealthcare via email, postal mail, or instructional or informational sessions (in-person or virtual).

You may feature compliant non-UnitedHealthcare branded materials and content.

Agent/Broker Website

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/broker-facing websites, which might be password protected, that are directed to agents/brokers for

recruitment activities, education, and communication. In addition to abiding with all policy guidelines, the following guidelines apply:

You Must

- Register with UnitedHealthcare any agent/broker created website prior to announcing your affiliation with UnitedHealthcare. Registration requests must be submitted to the compliance_questions@uhc.com mailbox and minimally contain:
  - First Name
  - Last Name
  - Email address
  - Phone Number
  - National Producer Number (NPN)
  - Website URL
- 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. The use of the UnitedHealthcare name may only be used to announce an affiliation. The correct spelling of UnitedHealthcare must be used and the trademark must be included the first time the name appears.
  - UnitedHealthcare-provided logo. The logo may be requested when registering the website with UnitedHealthcare. Agents/brokers must comply with all terms of use.
  - Hyperlink to a UnitedHealthcare-approved website homepage.
- Place within their website hyperlinks to official government websites 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.
- On agent/broker-facing websites only, include a link to www.uhcjarvis.com as a convenience for UnitedHealthcare contracted agents/brokers.

You Must Not

- Announce your affiliation with UnitedHealthcare through any means unless you have registered the website.
- Use any UnitedHealthcare logo except the one provided by UnitedHealthcare and in accordance with the logo request process. Copying and pasting or using a logo from a UnitedHealthcare website, material, or publication is prohibited.

Agent/Broker Social Media

Agent/broker 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 all state and federal laws and regulations and UnitedHealthcare policies, procedures, and rules. 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.

- For employees of UnitedHealth Group or its affiliates, abide by UnitedHealth Group corporate social media guidelines.

You May

- Link to a compliant agent/broker created business website.
- 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

- Use a social media platforms interactive functionality (or equivalent service) to engage in unsolicited direct contact with consumers/members.
- Feature the UnitedHealthcare brand name, logo, or branded material.
- Feature any hyperlinks to any UnitedHealthcare company or affiliate website.

Materials, Websites, and Social Media Monitoring and Oversight
Agent/broker materials are monitored to ensure they are compliant and used in a compliant manner.

- Materials created and/or used by an agent/broker may be reviewed retrospectively by UnitedHealthcare.
- UnitedHealthcare monitors the use of UnitedHealthcare brand elements. Non-compliant or unapproved use of the UnitedHealthcare brand may be subject to corrective and disciplinary action up to and including termination and/or a cease and desist order.
- Materials, websites, and social media accounts created and/or used by agents/brokers may be monitored by CMS and/or state Department of Insurance (DOI).
- Corrective Action
  - Agents/brokers 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/brokers who do not comply with corrective action may be referred to the IFP Disciplinary Action Committee (DAC) or subject to progressive discipline including corrective and/or disciplinary action, up to and including termination.

Consumer Contact

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

You must comply with federal and state laws and regulations regarding telephonic contact (e.g., calling, text message, automated telephone dialing system, and pre-recorded or artificial or voice), including but not limited to, state and federal Do-Not-Call (DNC) Registry, the Telephonic Consumer Protection Act (TCPA), federal and state calling hours, and telephonic recordings of consumers/members. Contact by email and other electronic means (e.g., social media interactive functionality, direct messaging, and smart phone applications) must comply with applicable state and federal laws and regulations, including but not limited to, applicable CAN-SPAM requirements.

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Lead Generation

You are responsible for ensuring any lead, including those obtained from a third-party lead generation vendor and/or their up-line, comply with all federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules.

Lead Referral Programs

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

- Agent Initiated Programs
  You may choose to use a third-party lead generating option but are responsible for ensuring the leads are obtained compliantly, within compensation limits, do not violate any applicable fraud and abuse laws, including the federal anti-kickback statute, and are compliant with all applicable state and federal regulations and UnitedHealthcare policies, procedures, and rules.

Compensation in Exchange for Lead

- You must comply with applicable federal and state laws and regulations regarding any compensation or other financial arrangement provided in exchange for a referral/lead.
- You must comply with state and federal laws and regulations related to compensation limits, commission splitting, and/or payments to non-licensed/appointed agents. UnitedHealthcare recommends you consult with local legal counsel to determine the compliance of any compensation arrangements you make with referrers.

Book of Business

UnitedHealthcare at its discretion may provide you or an agency access to your 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 other rules, regulations, policies, and procedures 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.

Accessibility and Non-Discrimination

Agents must be aware of and sensitive to the needs of the consumer related to language barriers and physical or cognitive impairments/disabilities and must comply with all applicable accessibility requirements.

Upon request or becoming aware of a situation requiring special accommodations, the agent must take appropriate actions based on the consumer's linguistic barrier or disability (e.g., obtaining language translation/interpreter 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 protections to consumers. Agents may not discriminate based on race, ethnicity, national origin, religion, gender, sex, age, mental

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or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, or geographic location.

Information Requirements

- Information must be provided to applicants and enrollees, including but not limited to individuals living with disabilities and/or individuals who are limited English proficient, in plain language and in a manner that is accessible and timely.
- UnitedHealthcare must provide all information that is critical for obtaining health insurance coverage or access to health care services through the Qualified Health Plan (QHP), including applications, forms, and notices, to qualified individuals, applicants, qualified employers, qualified employees, and enrollees in accordance with the CMS regulatory standards. Information is deemed to be critical for obtaining health insurance coverage or access to health care services if the issuer is required by law or regulation to provide the document to a qualified individual, applicant, qualified employer, qualified employee, or enrollee.
- UnitedHealthcare must make language assistance notice taglines available in at least the top 15 languages spoken by the limited English proficiency population of the relevant states.

Consumers with Linguistic Barriers

Written Materials

Agents may refer consumers to member services, UnitedHealthcare IFP Telesales, or the Language Assistance page on www.uhc.com for guidance on requesting materials in alternate languages or large print.

Translation/Interpreter Services

When a consumer speaks a non-English language and is having difficulty understanding or maintaining a conversation in English and the agent is not fluent in the non-English language, the agent 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. The agent 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:
  - UHOne Telesales agents not fluent in the applicable language must either transfer the consumer according to department protocol to an appropriately skilled agent fluent in the applicable language or conference in an interpreter with an internal or external vendor interpreter service according to department protocol.
  - eAlliance agents not fluent in the applicable language must either transfer the consumer to an appropriately skilled agent fluent in the applicable language within the same eAlliance or conference in an interpreter with an interpreter services vendor contracted by their eAlliance entity.
  - A field agent not fluent in the applicable language must do one of the following:
    - Refer the consumer to UHOne Telesales call center.
    - Refer the consumer to a field agent contracted with UnitedHealthcare who is fluent in the applicable language.
    - Agents are permitted to use employees of the same agency or up-line fluent in the applicable language or an interpreter services vendor contracted by

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their agency/up-line. Agents are prohibited from using individuals who are not employees of their agency/up-line or a contracted vendor.

Consumers with Disabilities
Basic plan information must be made available in alternate forms to consumers with disabilities, such as visual or hearing impairments, upon request.

Hearing Impaired
UnitedHealthcare makes available a TDD/TTY line to respond to marketing and membership questions from hearing impaired individuals.

- An agent who encounters a hearing-impaired consumer may:
  - Provide required materials 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 required materials directly to the consumer's authorized legal representative for review and enrollment purposes.
  - Provide closed captioning upon request for online event presentations.
- Upon consumer request, a sign language interpreter must be provided at an in-person or online event or an in-person or online personal/individual marketing appointment at no charge to the consumer. Agents must not use a third-party individual who is not an employee of UnitedHealth Group or an approved sign language interpreter vendor.
  - American Sign Language (ASL) Interpreter Requests
    Agents must complete an ASL interpreter request form (located on Jarvis).
  - Non-ASL Interpreter Requests
    Agents must complete an interpreter request form (located on Jarvis).

Vision Impaired
A visually impaired consumer may request materials in alternate formats through Customer Service at 1-844-386-7491 (TTY/RTT 711). An agent who encounters a visually impaired consumer may:

- Read the materials verbatim to the consumer.
- Allow the consumer to be accompanied by an individual, of their choosing, who can read/interpret the information and/or materials.
- If the consumer has an authorized legal representative, provide required enrollment materials or information and/or where to obtain the information (e.g., UnitedHealthcare IFP plan options and costs for the enrollee, plan benefit details, government subsidies available to the enrollee, Open Enrollment Period (OEP) deadlines and coverage start dates, and other resources available on UHC.com for shopping purposes (FAQs, sample medical policy, etc.) 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.

Physically Impaired
The agent must select event sites that are accessible to a physically impaired individual. If the event site selected is not accessible to consumers with disabilities, the event must be rescheduled or cancelled until a site with appropriate accommodations is found. Agents should choose a meeting site that is compliant with the Americans with Disabilities Act (ADA). For

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guidance when evaluating the accessibility of a meeting site, review the ADA website: https://www.ada.gov/business/accessiblemtg.htm. Upon reasonable request, an agent must also provide a wheelchair to a disabled individual at an 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 Areas
- Routes to the Building Entrance
- Building Entrance
- Routes to the Meeting Space
- Meeting Space
- Restrooms

Cognitively Impaired

Agents should be aware that a cognitively impaired consumer might live independently or within a residential facility. If there is any question regarding a consumer's cognitive ability, the agent should ask whether the consumer has an authorized legal representative (e.g., Power of Attorney). If the consumer has an authorized legal representative, the agent should reschedule the appointment for a time when the consumer's authorized legal representative can be present.

Privacy and Security

Agents/brokers must act in compliance with all federal and state laws and regulations, CMS regulations and guidelines, and UnitedHealthcare policies, procedures, and rules related to privacy and security.

Health Insurance Portability and Accountability Act (HIPAA)

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 Provision
  The HIPAA Privacy Rule outlines specific protections for the use and sharing of Protected Health Information (PHI).
- Security Provision
  The HIPAA Security Rule defines how PHI should be maintained, used, transmitted, and disclosed electronically.

You must protect consumer/member Protected Health Information (PHI) and Personally Identifiable Information (PII) and report any potential incidents to UnitedHealthcare immediately upon discovery.

Agents/brokers 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/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

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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 (e.g., health plan) or a Business Associate of one (e.g., vendor, agent, etc.).

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

You 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 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/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).

You 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.

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- 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 Healthcare.gov (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 the agent (or agency, if the agent is employed by an agency) has a proper Business Associate Agreement in place with the cloud storage provider, and the cloud storage where PHI/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.

Telesales Agents (only)
In addition to the guidelines above, the following privacy and security guidelines apply:
You must not:

- Leave any paper call notes in an unsecure area (e.g., desktop, unlocked desk drawer, wastebasket) at any time and/or retain the notes beyond the end of the business day. Paper call notes must be disposed of the day the notes are taken and in an acceptable secure manner.
- Use any paper mechanisms for tracking production or commission/telephonic enrollment.
- UHOne Telesales Employee agents (only), may use an electronic method when tracking commission/telephonic enrollments. Electronic trackers must be saved securely, such as to the employee's UnitedHealthcare home directory (saving to a computer desktop or removable or portable device is not secure).

Privacy and Security Incidents

- You must report to UnitedHealthcare any potential HIPAA, PHI, or PII incidents immediately upon discovery.
- Suspected privacy incidents must be reported to one of the following:
  - The UnitedHealthcare Privacy Office at UHC_Privacy_Office@uhc.com.
  - UnitedHealthcare sales leader
  - The Segment Compliance Lead
  - The UnitedHealth Group Compliance and Ethics HelpCenter at 800-455-4521 or www.uhghelpcenter.ethicspoint.com (available 24 hours a day, 7 days a week), or compliance_questions@uhc.com.
- Security incidents (e.g., unauthorized access to UnitedHealth Group data/systems, laptop theft) must be immediately reported to UnitedHealth Group Support Center at 888-848-3375 (available 24 hours a day, 7 days a week).

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- 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.
- 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
- 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.

Field Sales Expense Payment Process

UnitedHealthcare employees, including but not limited to agents, sales leaders, and sales operations 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 field sales operations activities and events. UnitedHealthcare employees should contact their UnitedHealthcare Sales Leadership with questions.

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. Employees 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, employees 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 Procurement policy for details.

Approved Payment Methods

Prior to using any approved payment method, the employee 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.

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- 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.
  - Employees should work with their 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.
- 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, payment of wages for services rendered, or electronic medical or health records.
  - UnitedHealth Group's Delegation of Authority Policy applies; therefore, prior approval for some items may be required. Employees should work with their 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

  Employees are discouraged from using cash to pay for expenses for which the employee expects 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. Employees must get approval from a senior sales leader prior to making any cash payments. The employee 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, the employee 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. The employee must use Concur to request reimbursement and

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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

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 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 on the qualified organization list published by the Internal Revenue Service (IRS). Refer to UnitedHealth Group enterprise policy in eGRC Policy Center for charitable contribution guidelines.
- Prior to entering into a sponsorship agreement, engage the Regional Sales Vice President (VP) 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. Employees 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 employees using employee personal cash, personal rewards, miles, or gift cards, personal credit arrangements, using third-party mobile application payment tools such as Venmo, 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.

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Section 5: Enrollment Process

Enrollment and Plan Termination

Enrollment and Plan Termination

Agent Enrollment Requirements

- You must comply with federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules related to agent-facilitated enrollment of an individual into a Qualified Health Plan (QHP) sold via an exchange (Federally-facilitated Marketplace (FFM) or State-Based Marketplace (SBM)).
- You must be appropriately contracted, licensed, appointed (as required by the state), and have completed the registration and training required by UnitedHealthcare or the applicable exchange (FFM or SBM) at the time of the enrollment application received date.

Enrollment Requirements

You must:

- Provide consumers with accurate and correct information without omission of material fact(s).
- Provide all information that is critical for obtaining health insurance coverage or access to health care services through the QHP to qualified individuals, applicants, qualified employers, qualified employees, and enrollees in accordance with the Centers for Medicare and Medicaid Services (CMS) regulatory standards. Information is deemed to be critical for obtaining health insurance coverage or access to health care services if the issuer is required by law or regulation to provide the document to a qualified individual, applicant, qualified employer, qualified employee, or enrollee.
- Provide the Federally-facilitated Exchanges with correct information.
- Document that eligibility information has been reviewed by and confirmed to be accurate by the consumer or the consumer's authorized legal representative prior to submission of information. Required documentation includes but is not limited to:
  - Documentation must include the date the information was reviewed, the name of the consumer or authorized legal representative, an explanation of the attestations at the end of the eligibility application, and the name of the assisting agent.
  - Documentation must be retained and made available upon request for a minimum of 10 years.
  - Acceptable documentation includes but is not limited to obtaining the signature of the consumer or authorized legal representative (electronically or otherwise), verbal confirmation that is captured in an audio recording, written response (electronic or otherwise) to a communication sent by the agent, or other similar means or methods specific by the Department of Health and Human Services (HHS) in guidance.
- Ensure that the enrollment request is effectuated entirely by the consumer or authorized legal representative.

You must not:

- Market or engage in conduct that is misleading (including by having a direct enrollment website that HHS determines could mislead a consumer into believing they are visiting Healthcare.gov), coercive, or discriminates based on race, color national origin, disability, age, sex, or other protected classes.
- Solicit or accept an enrollment outside of a valid election period.
- Engage in fraudulent activities (e.g., forgery).
- Give or receive anything of value from a consumer in exchange for an enrollment.

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- Knowingly and willfully provide or receive money or other compensation to induce or in return for purchasing or arranging for the purchase of items or services covered.
- Misrepresent your role to consumers
- Imply they represent or are employed by CMS, the Marketplace or HealthCare.gov, or are contacting the consumer/member on behalf of these organizations.
- Provide consumers with inaccurate information or omit relevant information about the QHP, federal premium tax credits, enrollment timelines, or cost-sharing subsidies.

Enrollment Process

You are responsible for the compliance of any enrollment or enrollment application you assist a consumer with. An enrollment application should only be completed after you have obtained all required consent and documentation, completed a needs assessment and thoroughly explained to the consumer the plan benefits and associated costs, confirmed eligibility, verified providers and drug coverage (if applicable) disclosed agent and product specific information and disclaimers (e.g., compensation) and that the consumer has agreed to proceed with enrollment. In addition to all other federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules, the following guidelines apply:

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: The agent must determine if the consumer has a valid election period and indicate the election period on the enrollment application and reason code, if applicable.
- Individual must live in the United States.
- Individual must be a United States citizen or national, or be lawfully present in the United States.
- Individual must not be incarcerated.

Pre-Enrollment, Point-of-Sale, and Post Sale Requirements

You Must:

- Comply with all consent and application accuracy confirmation documentation requirements.
- Conduct a thorough needs analysis, prior to enrolling the consumer, to determine the plan that will best meet the consumer’s needs.
- Cover plan benefits, costs, drug coverage, providers, networks, plan limitations, additional benefits, and required disclaimers.
- Cover plan eligibility and confirm the consumer’s eligibility.
- Cover what plan type and plan metal category type.
- Explain any impact enrollment into a new plan will have on a consumer’s existing coverage.
- Provide required enrollment materials or information and/or where to obtain the information (e.g., UnitedHealthcare IFP plan options and costs for the enrollee, plan benefit details, government subsidies available to the enrollee, Open Enrollment Period (OEP) deadlines and coverage start dates, and other resources available on UHC.com for shopping purposes (Frequently asked questions (FAQs), sample medical policy, etc.)
- Obtain and document consumer consent prior to assisting with or facilitating an enrollment for coverage through the Federally-facilitated Exchanges, State-based Exchange using the Federal Platform, or Classic Direct Enrollment (DE)/Enhanced Direct

Enrollment (EDE) website, or assisting with applying for Advance Payment Tax Credit (APTC) or Cost-Sharing Reduction (CSR). Examples of situations where prior consumer consent must be obtained and documented, include but are not limited to:
  - Collecting or using any consumer Personally Identifiable Information (PII)
  - Conducting a person search for consumer eligibility applications using an approved Classic Direct Enrollment (Classic DE) or Enhanced Direct Enrollment (EDE) website
  - Actively helping a consumer apply for Marketplace coverage or financial assistance by completing an eligibility application on their behalf
  - Actively enrolling a consumer in a Marketplace QHP
  - Making updates to a consumer's eligibility application throughout the year via an approved Classic DE or EDE website
  - Checking the status of a consumer's coverage or their eligibility application, including their eligibility for financial assistance
- Compliantly document the consumer consent. The consumer consent documentation must:
  - Have the consumer or authorized representative take an action to produce the documentation (i.e. provide a signature or record a verbal confirmation).
  - Contain, at a minimum, the following information:
    - ~ A description of the scope, purpose, and duration of the consent provided by the consumer or their authorized representative;
    - ~ The date the consent was given;
    - ~ The name of the consumer or their authorized representative;
    - ~ The name(s) of the agent, broker, web-broker, or agency being granted consent (note: all individuals who assist with or facilitate the consumer's enrollment must be granted consent); and
    - ~ The process through which the consumer or authorized representative may rescind the consent.
  - Be retained and made available upon request for a minimum of 10 years
- Accurately and completely fill in the enrollment application.
- Provide complete and accurate information related to the consumer's plan options and the plan in which the consumer enrolls.
- When submitting household income projections used by the exchange to determine a consumer's eligibility for APTC and CSR in accordance with regulations, Agents must only enter consumer's household income projections that the consumer or authorized legal representative has designated is compliant with regulations, knowingly authorized, and confirmed is accurate. Household income must be calculated and attested to by the consumer.
- Obtain and document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or their authorized representative prior to application submission (including any updates or changes to existing ones) through the Federally-facilitated Exchanges, State-based Exchange using the Federal Platform, or Classic Direct Enrollment (DE)/Enhanced Direct Enrollment (EDE) website. The application accuracy documentation must:
  - Have the consumer or authorized representative take an action to produce the documentation (i.e. provide a signature or record a verbal confirmation).
  - Contain, at a minimum, the following information:
    - ~ The date the information was reviewed;
    - ~ The name of the consumer or their authorized representative;

    - ~ An explanation of the attestations at the end of the eligibility application; and
    - ~ The name(s) of the assisting agent, broker, web-broker, or agency
  - o Be retained and made available upon request for a minimum of 10 years.
- Comply with all applicable state and federal laws and regulations and all UnitedHealthcare policies related to the disclosure of compensation to consumers. Agents must disclose the total amount of direct (e.g., commissions payment) and indirect compensation (e.g., bonus contests) you may receive associated with the enrollment. Compensation must be disclosed before the consumer makes a final plan selection and can be provided verbally. UnitedHealthcare has talking points available with the required compensation information on the Jarvis agent portal for agent use. Failure to disclosure compensation is subject to corrective and disciplinary actions. Note: UnitedHealthOne call center licensed agent employees are not subject to these compensation disclosure requirements.
- Explain that subsidy calculations are based off household income for the entire year and inform consumers of the importance of reporting any changes to household income to the exchange as soon as possible so that any subsidy can be adjusted accordingly.
- Only enroll consumers who request to be enrolled and understand the purpose of the enrollment application.
- Ensure that required consumer information is provided during an enrollment.
  - o Primary contact information including permanent home address, contact information, consumer contact information, and verification of identify must be completed.
  - o Household information including who is applying for coverage and tax information must be completed.
  - o Additional information including other relationships must be completed.
  - o Applicant information must be completed.
  - o Household income must be completed.
  - o Additional information including existing coverage, employer coverage, and upcoming and recent changes must be completed.
  - o Finalization information including review of details, agreements, attestations, and signature must be completed.
- Effective 11/1/2025, you must use your own assigned National Producer Number (NPN) for all UnitedHealthcare IFP plan enrollments. Failure to comply with this NPN requirement is subject to corrective and disciplinary action up to and including termination.
- Submit the enrollment application timely (i.e. immediately) to ensure the consumer obtains the desired effective date.
- Ensure the consumer understands that they cannot access plan benefits, medical, prescription drug, or other covered services prior to approval and the plan’s effective date.
- Provide your contact information.
- Cover when and how a member may end their plan. When and how to end a plan may depend on:
  - o The reason the member is ending coverage (e.g., eligible for new coverage or want to end coverage)
  - o Cancelling a plan for everyone covered or just select individuals.
- Explain that a member can terminate their coverage voluntarily at any time, however, they will not be able to enroll in another plan outside of the Open Enrollment Period

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unless they qualify for a special enrollment period. Consumers may be eligible for a special enrollment period if they experience certain life events like getting married, having a baby, moving their permanent residence, or loss of qualifying health coverage.
- Ensure that the consumer understands that it is recommended not to end their Marketplace plan until they know for sure when their new coverage starts.

You may:
- Answer questions posed by the consumer related to household income projection, such as helping the consumer determine what qualifies as income.
- Use secure screensharing applications (e.g., Zoom) to assist a consumer through the enrollment process.

You must not:
- Submit enrollment applications that contain inaccurate information provided by either the consumer or you (e.g., inaccurate household income).
- Alter the enrollment application without consumer authorization or falsify business documents.
- Enter your own personal, professional, or company telephone number, email address, or mailing address on a consumer's application or an application for APTC or CSR for QHPs.
- Create or use a dummy telephone number or address in place of the consumer's telephone number, email address, or mailing address.

Enrollment Mechanism
You must follow established processes for the enrollment mechanism. In addition to all federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules, the following guidelines apply:

- Electronic Enrollments
  - UnitedHealthcare Enrollment Platform (HealthSherpa)
    You must use your own login credentials.

- Marketplace Exchange Enrollments (FFM or SBM)
  - You must use your own exchange login credentials.
  - You must not obtain credentials (username and password) for a consumer/member's exchange account.
  - You must not withhold access to a consumer/member's exchange account and login information.

- Off Exchange Enrollments (HealthSherpa)
  You must use your own login credentials.

- Other Classic Direct Enrollment (Classic DE) or Enhanced Direct Enrollment (EDE) Enrollment Platform
  - The enrollment platform must be authorized by UnitedHealthcare.
  - You must use your own login credentials.

- UnitedHealthcare Consumer Website

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You must not enroll consumers via the UnitedHealthcare consumer website. UnitedHealthcare's public websites and enrollment tools are for consumer use only and are not electronic methods for agent use.

- Telephonic Enrollments
  - UHOne Enrollment (UnitedHealthcare Call Center or Multi-Carrier Call Center)
    You must use approved enrollment mechanisms.
  - Multi-Carrier Telephonic Enrollment
    You must use approved enrollment mechanisms (e.g., HealthSherpa)

Agent Assisting a Current Member
You may make changes in Jarvis to act limitedly on a member's behalf. When requested by the member, you may update in Jarvis, the member's Primary Care Provider (PCP) and/or request member ID cards.

Plan Cancellation/Termination
- You may direct consumers to their Marketplace account or the Marketplace call center to cancel/terminate their Marketplace plan.
- You may direct off-exchange members to Member Services to cancel/terminate their plan or you may complete the required form (accessible via Jarvis).
- You are permitted to make additional contact with members or their authorized legal representatives who request cancellation/termination from the plan if you suspect the cancellation/termination relates to an unauthorized plan switch. If you confirm it was an unauthorized plan switch, you must follow all requirements in assisting the member in getting active on the original plan, including, but not limited to obtaining new consumer consent documentation, contacting the marketplace on a three-way call, and obtaining application accuracy confirmation documentation.

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Section 6: Compensation

Non-Employee Commissions

Employee Incentives

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Non-Employee Commissions

It is UnitedHealthcare policy to pay, in accordance with applicable federal and state laws and regulations, and business requirements, commission to eligible, non-employee agents for approved enrollment applications that are complete, legible, and accurate.

You must comply with all applicable federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules, including but not limited to, the disclosure of compensation to consumers at the time of plan selection.

Non-Employee Commissions

You must be licensed, appointed (as required by the state), and have completed the registration and training required by UnitedHealthcare or the applicable exchange (Federally-facilitated Marketplace (FFM) or State-based Marketplace (SBM)) at the time of the enrollment application received date. To receive commissions or renewals on an eligible enrollment, in addition to being licensed, appointed (as required by the state), and appropriately trained as of the enrollment application received date, you must be contracted with UnitedHealthcare. Agents not contracted at the time of the enrollment application received date must be contracted with UnitedHealthcare no later than the member's plan effective date, irrespective of the credentialing status of any up-line entity.

If the writing agent is eligible for a commission on the sale, then they and any up-line entity to the writing agent that is appropriately credentialed at the time of sale will be compensated. Up-line entities that are not appropriately credentialed at the time of sale are not eligible to be compensated and their commission will be paid to their direct up-line, since the direct up-line is stepping into the shoes of the down-line who was not appropriately credentialed at the time of sale. If a writing agent is not appropriately credentialed, no commissions will be paid to the writing agent or their respective up-line. It is the responsibility of the level that receives payment to administer commissions to the solicitor who made the sale. Specific credential requirements for the writing agent are outlined below in the Credential Validation Rules for the Writing Agent section.

Agent Compensation Eligibility Requirements

Credential Validation Rules for the Writing Agent

- First-year commissions
  To be eligible to receive first-year commissions, the writing agent (including solicitors) must be appropriately credentialed as of the enrollment application received date. To be appropriately credentialed to be eligible for commission, you must be licensed and appointed (as required by the state) in the state in which the consumer resides; completed registration and training required by UnitedHealthcare or the applicable exchange (FFM or SBM) as of the enrollment application received date; and contracted no later than the member's plan effective date.
- Monthly Renewals (Year Two and Subsequent Years)
  To be eligible to receive monthly renewal commissions for year two and beyond, the writing agent (or immediate up-line if writing agent was a solicitor level) must not be suspended, termed-for-cause or deceased.

Compensation Structure

- Compensation includes commissions, fees or other incentives as established in the relevant contract between a Qualified Health Plan (QHP) issuer and the agent or broker.

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- QHP issuers directly compensate agents and brokers under the terms of their QHP Issuer contracts for assisting consumers enrolling in QHPs through a Federally Facilitated Marketplace (FFM) or State-based Marketplace (SBM). The FFM and SBM do not set compensation levels or pay commissions to agents or brokers. CMS does not require QHP issuers to offer contracts to agents and brokers.
- QHP Issuers should compensate only agents and brokers that are compliant with applicable federal and state requirements, including those for registration with the FFM and/or SBM and are not required to compensate unaffiliated agents and brokers
- A QHP issuer must pay the same agent or broker compensation for QHPs offered through an FFM or SBM that it pays for similar health plans offered in the State outside an FFM or SBM.

Commission Payment Schedule for an agent/agency set up for Direct Deposit

- Effective for New Business after 10/3/2025 – Processed after the 10th of the month following the member's effective date, Per Member Per Month, upon effectuation (i.e. the member has paid their binder or first month premium payment).
- Renewals - paid monthly, Per Member Per Month, the fourth weekend of the month.

Commission Payment Schedule for an agent/agency not set up for Direct Deposit

For an agent/agency not set up for Direct Deposit, UnitedHealthcare reserves the right to issue paper check payments no less than annually, or as otherwise required by applicable state or federal law.

Direct Deposit

You may follow the instructions below to request direct deposit.

- Access Jarvis
- Under "Manage Profile" tab, access "Edit Direct Deposit Info".
- Enter the direct deposit information.
- An email confirmation is sent to the email address on file.
- The updated direct deposit change is effective immediately for the next commission cycle.
- For any issues, contact the Producer Help Desk (PHD) at 866-235-4095 or via Jarvis.

Commission Sharing

Commission payments may only be shared within a hierarchy when otherwise not restricted by state and federal laws and regulations.

Tax Information

- Commissions paid are reported on the 1099 in the year they are paid. Payments issued in one year and then voided and reissued in the next year will be reported on the 1099 for the year in which the original payment was issued.
- An assignee receives the 1099 for any payments received on behalf of the assignor.
- Garnished payments are reported on the 1099 of the garnished agent in the year the payment was originally processed.

Assignment of Commission

- Agent Assignment to an Individual or Entity
    - The assignee, an individual or an entity represented by a principal, must be actively contracted, and completed registration and training required by

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UnitedHealthcare or the applicable exchange (FFM or SBM) for the sale of Individual and Family ACA Marketplace plans and licensed and appointed as required in the state in which the consumer resides.
  - The assignor and the assignee must belong to the same line of business. For example, an IFP Writing ID (WID) cannot assign to a Medicare & Retirement WID or an IFP agent cannot assign to an agent only selling Medicare products.
  - Assignment to an estate, widow(er), or heir: under the Agent Agreement, death of the agent is an automatic termination. UnitedHealthcare shall cease paying compensation to the agent and no further payment shall be due.
  - Assignment of commissions can only occur to one individual or entity at 100%.

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

Termination of Authorization to Assign Commissions
The authorization to assign commissions will be terminated if any of the following conditions exist:

- Termination of the assignee.
- Termination for cause or death of the assignor.
- The assignee does not have the proper state and/or federal licensing and appointment requirements.
- The assignor submits a written request to terminate authorization to assign commissions. Note: The assignee has no right to revoke a request to terminate an authorization provided by the assignor.

Held Commission Process
Commissions are paid to eligible, non-employee agents for enrollment applications that are complete, legible, and accurate. Commission will be held if the writing agent fails any of the credential validation checks, is in suspended status, as well as, if an invalid National Producer Number (NPN) is entered on the enrollment application.

Reporting and Communication Process
You and your up-line or manager/supervisor can review commission status and statements under the Commissions tab on Jarvis. If a commission is held, the reason(s) for payment ineligibility is provided.

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

- Appeals Process: The communication outlines a clear appeal process that you may use if you feel a transaction has been held inappropriately.
  - You have 30 days from receipt of the communication to submit an appeal to the PHD at acabrokersupport@uhc.com.
  - The Agent Lifecycle Management (ALM) and/or Commissions team reviews the appeal and approves or denies it.

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    - For appeals that specifically relate to agent licensing, information available through the Department of Insurance or National Insurance Producer Registry (NIPR) will be used to validate licensing claims.
- Analyst Review
    - Appeals are forwarded to an ALM analyst for review. Results of analyst review, on a per application basis, will fall into one of three categories:
        - System(s) will be updated to reflect the necessary change(s) for you and the commission will be paid systematically.
        - Commission payment remains ineligible due to reason(s) stated.
        - Appeal could not be evaluated based on currently approved rules (i.e. guidelines or published rules do not exist for the scenario under evaluation).
    - The transaction record and the Producer Contact Log (PCL) will be updated to reflect the final decision.
        - Approved appeals: System records are corrected and payment will be systematically processed during the next commission cycle.
        - Denied appeals: The transaction record will be updated to reflect a “forfeit” status indicating no further appeal is available.
    - The appeals process can take up to 14 business days, and you are contacted via email, phone, or letter with the final decision on the appeal.

Agent of Record (AOR)
UnitedHealthcare assigns Agent of Record (AOR) based on data received from the federal or state marketplaces or via the enrollment application for off exchange enrollments. AOR data will be associated to the member record based on information received from the enrollment system. This data includes the agent/agency name and identifier (e.g., NPN or license number). If the agent/agency is also contracted with UnitedHealthcare as an IFP agent as of the file received date, their UnitedHealthcare assigned Writing ID (WID) and Party ID (PID) will also be associated with the member.

AOR changes or removals may only be initiated by a member.

AOR Change or Removal
- Federal Marketplace Exchange Members
  Members must log into the federal exchange to request an AOR change or removal.
- State-based Marketplace Exchange Members
    - Members may call the plan’s customer service or;
    - Log in to the State specific Member Portal to request an AOR change or removal.
- Off Exchange Enrolled Members
    - Members must mail or fax a written request to UnitedHealthcare in order to change or remove an AOR.

Commission Payments
- Commissions will cease for the original writing agent when the AOR is changed or removed.
- New AOR that are commission eligible and pass credential validation will receive commissions for an eligible enrollment.

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Plan Changes

Plan changes where the member is moving from one UnitedHealthcare IFP plan to another UnitedHealthcare IFP plan will result in a new effective date with renewal commissions processed for the plan change effective date.

Commission Payment Audit/Appeal

You or your up-line may submit an audit or appeal request when you disagree with a payment amount, including instances when you have not been paid, but feels they should have been. Audit/appeal requests related to commissions for new enrollments may be submitted for policies effective in the current plan year or prior plan year. Appeals related to renewal commissions may be filed for transactions in question from the current plan year or prior plan year. However, appeals for the prior plan year payments must be filed by November 30 of the current plan year. The request must be in writing and must detail the specific applications the agent is questioning. If an issue with the commission payment system is identified, it will be corrected and the commission will be processed systematically. A follow-up communication will be sent to the agent. Decisions made by the Commissions Audit department are final. Note: This rule will be waived if required due to a CMS audit, DOI audit, or legal proceeding.

- You must email PHD at acabrokersupport@uhc.com and include supporting documentation to open a Service Request to process a commission payment audit request. If there are more than 10 members, the PHD Inquiry Form (available on Jarvis) must be filled out and emailed to the PHD.
- PHD will verify that the agent requesting payment is active at the time of payment being appealed. If the preceding criteria is met, the Service Request will be escalated to the Commissions Audit department for additional research.
- Results of the audit of each enrollment application will be communicated to you by the Commissions Audit department.
- Responses will be stored within the PHD Service Request.
- Follow-up inquiries associated with the request from you or your up-line should be directed to the PHD at acabrokersupport@uhc.com with reference to the Service Request provided.

Debt Repayment Process

UnitedHealthcare routinely conducts commission administration audits using the certification report from Healthcare.gov to validate that agents were properly certified during the renewal year.

- When an audit process reveals an overpayment, the impacted agent is charged back accordingly. Charge backs may be applied against future payments to you or may be recovered by any other means allowed by law.
- To minimize the impact of large charge backs, you may request a debt repayment plan by submitting an appeal to the PHD via email at acabrokersupport@uhc.com. Debt repayment options are only available for charge backs in situations where large debt is created due to audits of commission payments. Debt repayment options are not available for charge back debt created as a result of day-to-day commissions processing. To request a debt repayment plan:
    - You must be in good standing (i.e. you are not the subject of an open complaint investigation and/or open corrective and/or disciplinary action outreach),
    - You must have an existing renewal book of business, **and**
    - The amount of debt must exceed 2 months of renewal payments.

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Garnishment
When a formal notification of garnishment is received commissions will be withheld based on the terms of the levy. Garnishment amounts will be paid to the appropriate agency or organization on a monthly basis unless otherwise specified. Garnishment of commission payments will continue until the total amount of the garnishment is satisfied or a notice of satisfaction is received from the garnishing agency.

Employee Incentives
It is UnitedHealthcare policy to pay, in accordance with applicable federal and state laws and regulations, and business requirements, an incentive to eligible employee agents or sales leaders when all conditions set forth within their Sales Incentive Plan in effect at the time of sale have been met.

Employee agents are paid an incentive on a commissionable enrollment based on the terms of their 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, appointed (as required by the state), and completed registration and training required by UnitedHealthcare and/or the Federally-facilitated Marketplace (FFM)/State-based Marketplace (SBM)) at the time of sale.
  - Inter-Segment Telesales agents must meet all requirements set forth within their agreement with their Inter-Segment Telesales organization.
- 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 enrollment must be effectuated (e.g., the premium has been paid by the enrollee).
  - The company must receive revenue for the enrollment from the applicable entity (e.g., 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
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 you 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. You should refer to your SIP for eligibility specifics.

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Inter-Segment Telesales Organization (UHOne)
UnitedHealthcare will pay a vendor employee Telesales organization in accordance with the Inter-Segment Agreement (ISA). Enrollments eligible for incentive payment may vary by plan year and sales role. You should refer to your SIP for eligibility specifics.

Chargeback Calculation
Chargebacks generally are the result of a member's disenrollment but can occur for other reasons. Not all instances of disenrollment result in a chargeback (e.g., member death).

- Amounts are deducted from your incentive payment for previously paid advances on sales that are not earned.
- Chargebacks due to 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 chargeback is calculated and taken in February.

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Section 7: Compliance

Compliance and Expectations

Compliance and Oversight Monitoring

Complaints

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Compliance and Expectations

You must comply with federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules. You must complete assigned corrective or remediation actions within the required timeframe. In addition, you must comply with the investigative process and must not contact the consumer/member during the investigation with the purpose of discussing the complaint.

Failure to comply with federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules may result in corrective and/or disciplinary action up to and including contract termination.

Compliance and Oversight Monitoring

Manager/Supervisor/Up-lines Oversight Responsibilities (Applicable to managers/supervisors/up-lines)
UnitedHealthcare requires all internal and external sales leaders and up-line managers/supervisors to communicate compliance, quality, and performance standards to the individuals in their hierarchy, monitoring performance against those standards using available tools and resources and ensure any remedial training or corrective action plan is completed. Up-line managers/supervisors must ensure each agent in their hierarchy has the skills and/or training necessary to successfully and compliantly perform the requirements of the position and maintains required licensure, appointment (as required by the state), and registration and training required by UnitedHealthcare and the applicable exchange (FFM or SBM). In addition, external up-line entities must supervise and monitor compliance of the individuals in their hierarchy, as follows:

Field Agents (applicable to managers/supervisors/up-lines)

- Ensuring all agents complete all UnitedHealthcare required training.
- Ensuring that agents participate in any UnitedHealthcare required remedial training.
- Communicating all product and regulatory information from UnitedHealthcare.
- Monitoring compliance with UnitedHealthcare's established processes, policies, and guidelines across all methods of consumer interaction (e.g., telephonic, email, and chat).
- Allowing UnitedHealthcare to conduct compliance audit and oversight activities.
- Ensuring any corrective action plan is completed and reported back to UnitedHealthcare.

eAlliance/UnitedHealthOne Telesales (applicable to managers/supervisors/up-lines)

- Ensuring all agents complete all UnitedHealthcare required training.
- Ensuring that agents participate in any UnitedHealthcare required remedial training.
- Communicating all product and regulatory information from UnitedHealthcare.
- Ensuring any corrective action plan is completed and reported back to UnitedHealthcare.
- Allowing UnitedHealthcare to conduct compliance audit and oversight activities.
- Ensuring any corrective action plan is completed and reported back to UnitedHealthcare.
- Upon request, produce a list and recordings of UnitedHealthcare telephonic enrollments by call center agents for a given time period, to include any recordings where the plan or its networks or benefits were discussed leading to the enrollment.

UnitedHealthOne Telesales (applicable to UHOne)
UnitedHealthOne sales management is responsible for managing and communicating the compliance and quality requirements for UnitedHealthOne telesales agents pursuant to

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applicable UnitedHealthOne policies and procedures. UnitedHealthcare may at its discretion assign progressive disciplinary action for identified issues or compliance risk.

Override Agencies Oversight Program (applicable to up-lines)
UnitedHealthcare may monitor an IFP Override Agency's compliance, quality, and performance at the entity level. UnitedHealthcare may at its discretion assign progressive disciplinary action for identified issues or compliance risk. UnitedHealthcare may terminate an IFP Override Agency at any time and for any reason with 30 day written notice.

- Performance measures that may result in Progressive Disciplinary Engagement
  - Activity that initiates a IFP DAC review; and
  - Health Insurance Casework System (HICS)/1,000 enrollments > channel average
- Progressive Disciplinary Engagement Process
  - Verbal warning with written documentation
  - Placed on a Business Improvement Plan (BIP) – 30 days to respond to BIP
  - Placed on a Corrective Action Plan (CAP) – 90 days
  - Final warning/notice of termination as a result of not meeting requirements of the CAP – 30 day written notice
  - Termination – Minimum of 1 year from the termination effective date before they may seek to re-contract

Performance that May Result in Immediate Termination
In some circumstances, a recommendation for immediate termination (for cause) may occur. Engaging in the following activities may result in a recommendation for immediate termination (refer to the agent termination section):

- Any occurrence of fraud, forgery, payments, inducements, deception, or coercion
- Sale of a UnitedHealthcare product when not appropriately licensed and/or have completed registration and training required by UnitedHealthcare and the applicable exchange (Federally-facilitated Marketplace (FFM) or State-based Marketplace (SBM))
- Violation of terms and conditions of Agent/Agency Agreement
- Gross violation of federal or state laws and regulations or UnitedHealthcare policies, procedures, and rules
- Failure to divest or manage a conflict-of-interest as agreed upon by the Conflict-of-Interest Committee
- Any other applicable situations deemed appropriate by UnitedHealthcare

Monitoring Programs
UnitedHealthcare has implemented a monitoring program to ensure all agents are conducting marketing, sales, and enrollment activities in accordance with federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules. UnitedHealthcare has established calculation methods and expectations for the monitoring programs. Failure to meet or exceed monitoring program expectations may result in corrective action and disciplinary action up to and including termination.

Complaint Monitoring
UnitedHealthcare monitors complaints and complaint allegations against an agent. The complaint investigation outcome or coaching or corrective action process to which the agent is referred (e.g., CEC, CAR, DAC) is tracked and monitored.

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The agent complaint monitoring program is detailed below:

- Individual Agent Complaints
    - Complaint points are assigned for all closed complaints that are actionable (does not include complaints with a final disposition of No Current Action Required, Non-Complaint, or Operational Issue/No Action Required).
    - An agent complaint monitoring infraction is when a closed complaint is referred to CEC, CEC2, CAR, or IFP DAC.
- Complaint Points

UnitedHealthcare monitors the accumulated complaint points for individual agents. Additional outreach may be conducted based on accumulated complaint points.

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 not appropriately registered and/or trained as required by UnitedHealthcare and the applicable exchange (FFM or SBM) 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. A CR will be generated and assigned to a UnitedHealthcare manager/supervisor/Agent Coaching and Policy Specialist (ACPS) to conduct agent outreach.
- 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.

Monitoring of Suspicious Sales
UnitedHealthcare may monitor and analyze an agent’s enrollment trends over time and potential incidents of suspected agent fraud and forwarded for investigation as appropriate.

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. UnitedHealthcare sales management may be involved in ensuring that agent outreach occurs appropriate for any assigned CR for agents within their hierarchy.

Outreach Engagement

- Agent outreach is generally conducted by an Agent Coaching and Policy Specialist (ACPS) or UnitedHealthcare manager/supervisor. Telephonic interactions between an ACPS and you may be recorded.) UnitedHealthcare may request a manager/supervisor/trainer at the agency conduct the outreach or attend the coaching session.
- The individual responsible for conducting the outreach to the agent should take into consideration the agent’s performance across all monitoring programs in determining the appropriate level of outreach and progressive engagement.

Contact your ACPS or UnitedHealthcare manager/supervisor for questions regarding the CR process.

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Additional Outreach and/or Documentation

- Through the Corrective Action Referral (CAR) or Disciplinary Action Committee (DAC) process, you may receive an assigned action to complete.
- For external agents, your up-line may also implement corrective action based on its internal business policy.

Agent Responsibilities

- You must comply with the investigative process and must not contact the consumer/member during the investigation or after a determination is made with the purpose of discussing the complaint.
- You must participate in any coaching, training, remediation, or corrective action outreach requests.
- You must complete assigned coaching, corrective action plan, and/or remediation activities within the required timeframe.
- If you fail to participate in and/or complete assigned coaching, corrective action plans, and/or remediation activities, you may be subject to disciplinary action up to and including termination.

Coaching Request Extension and Escalation Process

Contact your ACPS or UnitedHealthcare manager/supervisor for questions regarding the CR extension or escalation process.

Complaints

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 complaint tracking tool within 5 business days or 7 calendar 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

Internal sources complete the entry of each complaint as needed into the Broker Referral Tool in Broker Issue Application (BIA) and a case number is assigned. Each complaint is reviewed by Agent Issue Management (AIM) team to validate that it is within the scope of the agent complaint process.

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- 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, or federal or state laws, regulations, or rules
  - The basis for the complaint is due to an internal business operational issue and submitted through the agent complaint tracking tool
- If the complaint is in scope of the agent complaint process, it moves to the pre-disposition stage

Pre-Disposition
The 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 Agent Broker Investigations (ABI) for investigation and in some circumstances, directly referred to Corrective Action Referral (CAR). The status of the complaint is updated in the agent complaint tracking tool.

Complaint Education Contact Process
The Complaint Education Contact process provides two levels of engagement (i.e. CEC and CEC2) and is used as an intermediary measure to proactively address agent complaint behavior in an effort to prevent repeat infractions and/or more egregious behavior by facilitating the training and coaching of agents based upon established criteria. Throughout this guide, the term CEC is used to include the processes related to both levels, CEC and CEC2. The CEC process includes the following steps:

- The AIM team uses the applicable Referral Criteria Grid to determine appropriate outreach.
- For active agents, the AIM team creates a Coaching Request (CR) in PCL and assigns it to the appropriate Agent Coaching & Policy Specialist (ACPS) or UnitedHealthcare agent manager/supervisor. When a Telesales vendor or eAlliance is assigned a coaching that originated when the agent was not in their hierarchy, the case description provided must not include member PHI/PII unless there is a clear business purpose to do so. In which case, only the minimum necessary PHI/PII may be provided and must be transmitted securely.
- For inactive agents, a CR is not created. The AIM team updates the complaint status in the agent complaint tracking tool and notifies ALM to put a Review Before Contracting (RBC) flag on the agent, which serves as an alert in the event the agent attempts to re-contract. When an agent re-contracts and becomes active, any outstanding coaching must be completed prior to conducting any marketing/selling activities.

Agent Complaint Investigation Process
The Agent Broker Investigations (ABI) is responsible for the investigation of complaints involving agents who market and sell UnitedHealthcare products. Complaints referred to the ABI are repeat issues or severe allegations of misconduct. At any point during the investigation, the AIM team or ABI may determine by using a severity grid that a recommendation to suspend an agent's ability to market and sell UnitedHealthcare products is justified. The ABI will forward the suspension recommendation to the Director of Agent Issue Management.

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Initial Review and Assignment of Case
Upon receipt of a complaint referral from the AIM team, ABI 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 up-line or UnitedHealthcare sales leadership. 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 up-line UnitedHealthcare sales leadership, is sent a Non-Response Letter (NRL) stating that a response must be received within two business days. If no response is received within the prescribed timeframe, an administrative termination is initiated.
- Members or their authorized representatives may be interviewed during an investigation to gather required details regarding the complaint or to confirm identity of the agent and/or other pertinent facts. All contact with members is made in accordance with federal and state guidance.
- The investigator may also conduct a telephone interview of the agent. 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 (ABI investigator, ABI 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, 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, 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.

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- 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 and company policy.
- Non-Response: You failed to respond within the required timeframes to the RAR and NRL.

Refer for Disposition
Upon completion of the investigation, the Investigative Report, Investigative Findings, and Allegation Outcomes are generally documented in the agent complaint tracking tool. The case is updated as 'Refer for Disposition' in the tracking tool and is referred back to the AIM team. Supporting documentation, including exhibits, are provided to the AIM team within the BIA database. ABI may refer for disposition, cases that no longer meet the requirement for ABI 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 complaint tracking tool:
- The allegation outcome is Insufficient Information, No Allegation, or Unsubstantiated. If the investigation results in unsubstantiated outcomes for all allegations, the Agent Closure Letter is emailed to you, thanking them for their cooperation and notifying them of the investigative results.
- The allegation outcome is Inconclusive or Substantiated, you had received outreach for the same allegation or the same allegation family within the past twelve months, and the event/enrollment application for the current allegation took place before the outreach occurred.

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 IFP 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 IFP Disciplinary Action Committee (DAC) is appropriate. The following situations result in a DAC referral:

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- 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 repeated instances of lower severity complaints.
- Your behavior posed 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:

- For active agents, the AIM team creates a Coaching Request (CR) in PCL and assigns it to the appropriate Agent Coaching & Policy Specialist (ACPS) or UnitedHealthcare agent manager/supervisor. When a Telesales vendor or eAlliance is assigned a coaching that originated when the agent was not in their hierarchy, the case description provided must not include member PHI/PII unless there is a clear business purpose to do so. In which case, only the minimum necessary PHI/PII may be provided and must be transmitted securely.
- For inactive agents, a CR is not created. The AIM team updates the complaint status in the agent complaint tracking tool and notifies ALM to put a RBC flag on the agent, which serves as an alert in the event the agent attempts to re-contract. When an agent re-contracts and becomes active, any outstanding coaching must be completed prior to conducting any marketing/selling activities.

IFP Disciplinary Action Committee

The IFP 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 IFP 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 IFP 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 complaint tracking tool are updated with the meeting outcomes.

DAC Proceedings

- The IFP DAC reviews the merits of the complaint and the investigation findings, and any other pertinent information (e.g., agent complaint and compliance history).

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- If additional information is required, the IFP 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 IFP DAC determines the agent does not require additional training to address the issue presented.
- Corrective Action
  - The IFP 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 the agent and the agent's manager/supervisor notifying the appropriate manager to facilitate appropriate outreach and training to the agent or the agency if the issue is best addressed at the agency level.
- Revocation of Authority to Market or Sell a Specific Product
  - UnitedHealthcare at its discretion may revoke an agent's ability to market or sell specific UnitedHealthcare IFP products. Refer to policy IFP-113 Agent Termination Process for details.
- Termination
  - The IFP DAC terminates an agent or recommends the termination of an employee agent. In addition to the decision to terminate the agent, the IFP DAC must determine if the termination is for-cause or not-for-cause. ALM is notified to flag the agent RBC. (Refer to the Agent Termination Process section for termination process details.)

Other ABI Complaint Processes
UnitedHealthcare may at its discretion investigate agents/agencies or initiate investigation processes based on compliance risk or other factors.

Large Agency Investigation
ABI may use the Sales Agency Complaint Efficiency process to investigate agencies using NPN Override or multiple complaints tied to one ID.

- ABI may select 30 active cases affiliated with a single agency or a Broker ID will be chosen for investigation.
- The cases will be randomly assigned to an investigator.
- The remaining affiliated cases will be set aside for pending assignment.
- If the investigation identifies substantial risk, all affiliated cases will be subject to investigation according to established procedures.
- If the investigation identifies low-risk, the agency or Broker ID will be provided coaching based on the findings and the remaining affiliated cases will be closed.

Book of Business Investigation
ABI may implement the Book of Business investigation process when the amount of applications submitted in a single day would be highly improbable for an agent/broker to submit or a large

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number of enrollments appear to be suspicious, including what appears to include falsified information, and it cannot be confirmed the enrollee existed (i.e., “ghost enrollments”).

- ABI will conduct a comprehensive review of agent data, licensing, and contact information.
- The investigation may involve opening companion cases, requesting full book of business, commission details, interviewing agents, and conducting background checks.
- Investigators will analyze business trends, verify member information through CLEAR reports (a collection of public records and background information from Lexis Nexis) and interviews, compile and finalize investigative reports, report privacy concerns as needed, and refer cases for disposition.
- Connected agents will be investigated concurrently and all findings will be documented in the tracking tool.

High Complaint Review

- ABI will select on a monthly basis an Agent/Broker ID identified as an outlier from the High Complaint Volume Broker ID Dashboard. Outliers are determined through an internal analytical review, including but not limited to, complaint volumes in comparison to their peers.
- The agent/broker will be referred upon the first offence directly to IFP DAC for review and potential remediation.
- The IFP DAC presentation will be based on complaint metrics and relevant sales metrics from the ABI internal systems.

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. 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.

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Section 8: Termination

Suspension of Marketing/Sales Activities

Revocation of Authority to Market or Sell UnitedHealthcare IFP Products

Disciplinary Action Termination

UHOne Disciplinary Termination

Administrative Termination

Discretionary Termination Without Cause

Termination Process

State and CMS Notification Process

Request for Reconsideration – Employee Individual

Request for Reconsideration – Non-Employee Individual

Request to Re-contract after Denial – Non-Employee Individual

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Suspension of 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 IFP products.

- If a determination to suspend an individual's ability to market and sell is made, a suspension notification letter will be sent via email to you with a copy sent to your UnitedHealthcare manager/supervisor or immediate up-line.
- The suspension is effective immediately as of the date of the letter of notice and shall continue until the investigation is completed 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 IFP 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 commissions and/or Sales Incentive Plan (SIP) payments, while on suspension status.

Revocation of Authority to Market or Sell UnitedHealthcare IFP Products

UnitedHealthcare at its discretion may revoke a contracted non-employee individual representing UnitedHealthcare ability to market or sell specific UnitedHealthcare IFP products. Authority to market or sell specific IFP products is defined within the Agent Agreement. When your authority to market or sell a specific IFP product is revoked, you will receive a contract amendment.

Revocation of Authority Process

- You will receive an amendment to your Agent Agreement. The effective date will be 30 days from the date of the amendment or based on the terms of the Agent Agreement.
- Commission will not be paid on any enrollment application written for the applicable product after the revocation of authority effective date.
- You will continue to receive commission renewals, if eligible, for business written prior to the revocation effective date.

Revocation of Authority Appeal Process

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

- An appeal can be filed when you are notified of the revocation for the current sales year or in the future for a new sales year.
- All appeals must be in writing, include your name and address, and be submitted via email to business_monitoring@uhc.com.
- In the written appeal, you must clarify and provide detail, or explain mitigating circumstances, regarding the complaint and/or rapid disenrollment findings, including correction of errors or share extenuating circumstances.
- Written notification of the IFP DAC's decision is sent to you via email, with a read receipt, to your email address in ICM. A copy of the notification is sent to your up-line.
- The decision of the IFP DAC is final. You must wait a minimum of six months after notification of a denial to submit a request for reauthorization to market or sell a product.

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Disciplinary Action Termination

- The IFP DAC terminates a contracted and appointed (if applicable) non-employee individual or recommends the termination of an employee. In addition to the decision to terminate the individual, the IFP DAC must determine if the termination is for-cause or not-for-cause (refer to the termination process section). Refer to the Complaints Section for termination determinations made by the IFP DAC.
- The IFP DAC will review for determination IFP appointed agents who are termed not-for-cause by other UnitedHealth Group lines of businesses.

UHOne Disciplinary Termination

In order to promote alignment across UnitedHealthcare lines of businesses, any IFP appointed agent who is disciplinary termed by the UHOne DAC for-cause, will automatically have their IFP appointment terminated not-for-cause by the AIM team.

Administrative Termination

Administrative Termination – Contracted and Appointed (if applicable) Non-Employee Individual

Administrative terminations are disciplinary, not-for-cause terminations initiated by the AIM team in certain circumstances including:

- **Administrative Termination – Agent Broker Investigations (ABI)**
  If you fail to respond within the prescribed timeframes to the Request for Agent Response (RAR) and Non-Response Letter (NRL) sent by an investigator during a complaint investigation. (Refer to the Complaints section for details.)
    - The AIM team sends you a notification of termination letter detailing the reason for termination, the termination effective date, and the appeal process via email, with a read receipt, to your email address in ICM. A copy of the notification is sent to your up-line or UnitedHealthcare manager/supervisor and to Agent Lifecycle Management (ALM).
    - ALM will process the termination 30 days from the termination notification date and add a Review Before Contracting (RBC) to your file.
        - If within 30 days from the date of the letter you provide a sufficient RAR/NRL response to the investigator, the investigator will alert the AIM team and a retraction to the notification of termination letter will be sent via email with a read receipt. A copy is sent to your up-line or UnitedHealthcare manager/supervisor and to ALM.
        - If the termination becomes effective, you may request a reconsideration of an administrative termination. (See the Request for Reconsideration section.)

- **Administrative Termination – Agent Coaching and Policy Specialist (ACPS)**
  If you fail to complete required training/coaching resulting from a Complaint Education Contact (CEC/CEC2), Corrective Action Referral (CAR), or DAC referral or any required compliance monitoring program coaching. (Refer to the Complaint section for details.)
    - The AIM team sends you a notification of termination letter detailing the reason for termination, the termination effective date, and the appeal process via email, with a read receipt, to your email address in ICM. A copy of the notification is sent your up-line or UnitedHealthcare sales leader and to ALM.

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  - ALM will process the termination 30 days from the termination notification letter and add a RBC flag to your file.
    - If within 30 days from the date of the letter, your UnitedHealthcare manager or ACPS provides notice that you have completed all coaching or corrective action requirements, your UnitedHealthcare manager or ACPS will alert the AIM team and a retraction to the notification of termination letter will be sent via email with a read receipt. A copy is sent to your up-line or UnitedHealthcare manager/supervisor and to ALM.
    - If the termination becomes effective, the individual may request a reconsideration of an administrative termination. (See the Request for Reconsideration section.)

Discretionary Termination Without Cause

You may be discretionarily terminated at will and without cause by UnitedHealthcare upon 30 days prior written notice.

Termination Process

Terminations

All terminations must be classified for-cause or not-for-cause. If an individual's IFP contract is terminated, UnitedHealthcare will review the individual's contract in other UnitedHealth Group lines of business to determine if a contract termination is necessary for those products and vice versa.

For-Cause

UnitedHealthcare may initiate a for-cause termination. If you are terminated for-cause, you will be flagged RBC in the contracting system. UnitedHealthcare will report for-cause terminations to other UnitedHealth Group lines of business. UnitedHealthcare will report for-cause terminations to the appropriate state Department of Insurance and CMS. (See the State and CMS Notification Process section.)

Not-for-Cause

A not-for-cause termination may be initiated for you by UnitedHealthcare or requested for any reason by you or your up-line. For non-employee individuals, the termination notification period is 30 days or per your Agent Agreement unless immediately effective as requested by you. Depending on the reason for termination, you may be flagged RBC in the contracting system. UnitedHealthcare will report not-for-cause terminations to other UnitedHealth Group lines of business.

- **Non-Employee Individual**
  - For-Cause Termination Process
    - A for-cause termination letter, detailing the reason for termination, the termination effective date, and the appeal process, is sent to you via email, with a read receipt, to your email address in ICM. A copy of the letter is sent to your up-line or UnitedHealthcare sales leader and is uploaded to your file.
    - ALM is notified of the termination request by the AIM team via a database referral to PCL.

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        - ALM processes the for-cause state appointment termination with the same termination date as indicated in the individual's termination notification letter.
        - If you have down-line agents, the entire down-line is reassigned to the next hierarchy as of your termination effective date. Any solicitors in the down-line are terminated as of the terminated individual's termination effective date.
        - You are flagged RBC in the contracting system.
        - If you are terminated for disciplinary or administrative termination, you may request a reconsideration of a termination. (See the Request for Reconsideration section.)
    - Not-for-Cause Termination Process
        - When UnitedHealthcare initiates a not-for-cause termination, a not-for-cause termination letter, detailing the reason for termination, the termination effective date, and the appeal process (if applicable), may be sent to you via email, with a read receipt if applicable, to your email address in ICM.
        - When the IFP DAC initiates a disciplinary action not-for-cause termination, a not-for-cause termination letter, detailing the reason for termination, the termination effective date, and the appeal process (if applicable), is sent to you via email, with a read receipt, to your address in the contracting system.
        - You and/or up-line-initiated not-for-cause termination requests are submitted for processing to ALM via email to exchangescontracting@uhc.com with the subject "Termination".
        - Upon receipt of a not-for-cause termination request, ALM updates the contracting system with the appropriate termination effective date.
        - The appointment termination is processed by ALM based on the termination effective date.
        - If you have down-line agents and the termination is requested by UnitedHealthcare, the entire down-line is reassigned to the next hierarchy as of your termination effective date. Any solicitors in the down-line are terminated as of the termination effective date.
        - If you have down-line agents and the termination is requested by the up-line, the entire down-line is terminated or reassigned to the next hierarchy.
        - You are flagged RBC in the contracting system upon the DAC referral for disciplinary termination, directed by Legal, the AIM team (for administrative terminations), or Regional Sales Leadership.
        - If you are terminated for disciplinary or administrative termination, you may request a reconsideration of termination. (See the Request for Reconsideration section.)

- **Non-Employee (Vendor Telesales)**
  Contact your up-line for process details.

- **Employee**
  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:

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- If the IFP DAC makes a recommendation to terminate your 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 by you through HRDirect, unless required by state law, in which case your notification is automatic. It is the responsibility of your UnitedHealthcare management to notify ALM of your termination. 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 notification. (See the State and CMS Notification Process section.)
- UnitedHealthcare reserves the right to suspend you from marketing and sales activities until the termination becomes effective.
- You may request a reconsideration of termination. (See the 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 individuals. Contact your up-line or UnitedHealthcare Sales Leader for details.

Request for Reconsideration – Employee Individual

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 UnitedHealthcare management must notify ALM to reappoint the employee to the appropriate entities.

Request for Reconsideration – Non-Employee Individual

If your contract and/or appointment was terminated as a result of a disciplinary termination or an administrative termination, you may request a reconsideration of that decision.

- You must request, complete, and email a Request for Reconsideration of Appointment form and all supporting documentation to the AIM team via business_monitoring@uhc.com within 90 days of the termination effective date. If an initial request is received after 90 days of the termination effective date, the request will be addressed on a case-by-case basis by the AIM team and Sales Operations Leadership.
- The IFP DAC will review the reconsideration request at a future IFP DAC meeting.
- If you are approved for reinstatement after the IFP DAC determination, you must begin the re-contracting process by submitting a new contracting packet. All contracting requirements apply, including a background check and certification. Any open complaints or previously assigned corrective action must be processed and completed by the individual upon on-boarding.
- If you are denied reinstatement after the IFP DAC determination, the RBC status remains indefinitely.

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Request to Re-contract after Denial – Non-Employee Individual

Under certain circumstances, an individual denied reinstatement through the process outlined in the Request for Reconsideration section is permitted to re-contract. The following guidelines apply to disciplinary and administrative terminations:

IFP DAC For-Cause Termination

- A minimum waiting period of 36 months from your termination effective date is required before your re-contract request is considered.
- You must request, complete, and email a Request for Reconsideration of Appointment form and all supporting documentation to the AIM team via business_monitoring@uhc.com.
- The AIM team will review the individual's complaint history. If you have unaddressed complaints received after termination that have substantiated allegation outcomes for allegations within the Risk to Consumers/Organization allegation family, you will be denied a re-contracting request unless an exception is granted by IFP Sales Operations Senior leadership.
- The IFP DAC reviews the re-contracting request, sales behavior changes made by you, and a detailed future action plan by the Regional Sales Leader or up-line in order to make a determination. The DAC may amend your action plan or deny re-contracting based on an insufficient action plan.
- If the IFP DAC approves the re-contracting request, the Chief Distribution Officer will cast the final approval/rejection vote and may consult with the Regional Sales Leader and/or request additional information to make their decision.
- The RBC flag will be removed and you must address any outstanding member complaints following the reappointment.
- If the IFP DAC denies the re-contracting request, the RBC flag will remain and you are prohibited from future contracting opportunities.

IFP DAC Not-for-Cause Termination

- A minimum waiting period of 24 months from your termination effective date is required.
- You must request, complete, and email a Request for Reconsideration of Appointment form and all supporting documentation to the AIM team via business_monitoring@uhc.com.
- The AIM team will review your complaint history. If the individual has unaddressed complaints received after termination that have substantiated allegation outcomes for allegations within the Risk to Consumers/Organization family, you will be denied a re-contracting request unless an exception is granted by IFP Sales Operations Senior leadership.
- The IFP DAC reviews the re-contracting request, sales behavior changes made by you, and a detailed future action plan by the Regional Sales Leader or up-line to make a determination. The IFP DAC may amend your action plan or deny re-contracting based on an insufficient action plan.
- If the IFP DAC approves the re-contracting request, the RBC flag will be removed and you must address any outstanding member complaints following the reappointment.
- If the IFP DAC denies the re-contracting request, the RBC flag will remain and you are prohibited from future contracting opportunities.

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Administrative Termination – ABI

- A minimum waiting period of 12 months from your termination effective date is required.
- You must request, complete, and email a Request for Reconsideration of Appointment form and all supporting documentation to the AIM team via business_monitoring@uhc.com.
- The AIM team will review the individual's complaint history and open a request to address any outstanding investigation.
- You must respond and cooperate with the ABI until the outstanding investigation is completed. Note: If the initial complaint receipt date exceeds 24 months prior to the request for reconsideration, the reconsideration request must be heard by the IFP DAC prior to completion of the investigation.
  - If you fail to respond and cooperate with the investigation a second time, the re-contracting request will be denied and you will be prohibited from future contracting opportunities.
  - If unaddressed complaints received after termination have substantiated allegation outcomes for allegations within the Risk to Consumers/Organization allegation family, the re-contracting request will be denied, unless an exception is granted by IFP Sales Operations Senior leadership.
- The IFP DAC reviews the re-contracting request, sales behavior changes made by you, and a future action plan.
- If the IFP DAC approves the re-contracting request, the RBC flag will be removed, the AIM team will disposition the investigation findings following the reappointment,
- If the IFP DAC denies the re-contracting request, the RBC flag will remain and you are prohibited from future contracting opportunities.

Administrative Termination – ACPS

- A minimum waiting period of 12 months from your termination effective date is required.
- You must have the approval and support of a Regional Sales Leader in order to submit a request to re-contract.
- You and the Regional Sales Leader must request, complete, and email a Request for Reconsideration of Appointment form and all supporting documentation to the AIM team via business_monitoring@uhc.com.
- The AIM team will review your complaint history. Re-contracting requests are denied when you received complaints after termination that have an allegation within the Risk to Consumers/Organization allegation family with a substantiated allegation outcome, unless an exception is granted by IFP Sales Operations Senior leadership.
- If the AIM team approves the re-contracting request, the RBC flag will be removed, previous corrective action will be re-opened and referred for completion following the reappointment. If you fail to complete the previous corrective action, you will be terminated and are prohibited from future contracting opportunities.
- If the AIM team denies the re-contracting request, the RBC flag will remain and you are prohibited from future contracting opportunities.

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Section 9: Glossary of Terms

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Glossary of Terms

This glossary is not a complete glossary of terms and should not be copied, used for other documents, distributed and/or reproduced.

Term	Definition
A	
Advance Premium Tax Credit (APTC)	A tax credit an individual can take in advance to lower their monthly health insurance payment (or "premium"). When they apply for coverage in the Health Insurance Marketplace®, they estimate their expected income for the year. If they qualify for a premium tax credit based on their estimate, they can use any amount of the credit in advance to lower their premium
Agency	A global term to refer to the entity level contracted with UnitedHealthcare to market and sell UnitedHealthcare IFP products. Agencies may include a network of down-line contracted, licensed, appointed (as required by the state), and have completed registration and training required by UnitedHealthcare or the applicable exchange (Federally-facilitated Marketplace (FFM) or State-based Marketplace (SBM)) agents and/or solicitors.
Agent	A global term to refer to any contracted (if applicable), licensed, appointed (as required by the state), and have completed registration and training required by UnitedHealthcare or the applicable exchange (Federally-facilitated Marketplace (FFM) or State-based Marketplace (SBM)) individual marketing and selling UnitedHealthcare IFP 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 Coaching and Policy Specialist (ACPS)	The UnitedHealthcare individual that conducts outreach and coaching for agent complaints and allegations.
Agent Issue Management (AIM)	The team that manages the intake, review, and disposition of agent related complaints.
Agent Lifecycle Management (ALM)	The functional area within UnitedHealthcare that manages the centralized contracting and appointment data required to ensure sales agent file information is compliant with CMS and applicable state Department of Insurance (DOI) guidelines.
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.
Anti-Kickback Statute	The primary purpose of the federal anti-kickback statutes or laws is to restrict the corrupting influence of money on health care decisions – including knowingly and willingly offering payment or gifts to induce referrals of items or services covered by Medicare, Medicaid, or other federally funded program. *(See 42 U.S.C. 1320a–7b)*

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	Examples of activities that may be prohibited under the statute: • Offering cash reimbursement in exchange for an enrollment or referral. • Offering gifts or services greater than a nominal amount permitted by federal guidelines. • Offering gifts or services dependent on enrollment or referral. A violation of the federal anti-kickback law is a felony offense that carries criminal fines of up to $25,000 per violation, imprisonment for up to five years and exclusion from government health care programs
Appointment (agent)	A procedure required by states that grants limited authority to an individual to market and sell UnitedHealthcare insurance products within that state.
B	
Broker	See Agent
C	
Classic Direct Enrollment (DE)	Agents begin on a QHP issuer or CMS approved agency website, redirect to Healthcare.gov for the application and eligibility determination, and then are redirected back to the private partner's website to complete plan selection and enrollment.
Coaching Request (CR)	The documentation in PCL of all coaching interaction between the agent/agency and the UnitedHealthcare manager/supervisor or ACPS.
Commission	Commission is a form of compensation given to an agent for new enrollments of consumers into a plan or membership renewals.
Agent Broker Investigations (ABI)	A unit within UnitedHealthcare Government Programs responsible for the investigation of complaints regarding agents selling UnitedHealthcare products. Complaints referred to the ABI are severe allegations of misconduct or repeated complaints of lower severity.
Cost Sharing Reduction (CSR)	A discount that lowers the amount you have to pay for deductibles, copayments, and coinsurance. In the Health Insurance Marketplace®. If an individual qualifies, they must enroll in a plan in the Silver category to get the extra savings.
Corrective Action Plan (CAP)	A step-by-step plan of necessary actions to achieve targeted outcomes for the resolution of the identified issues.
Credentialed	The status of an individual or entity in meeting the contracting, appointment (as required by the state), licensing, and having completed registration and training required by UnitedHealthcare and/or the FFM or SBM requirements in order to market, sell, and/or receive commission or incentive on UnitedHealthcare IFP products.
D	
Direct Entity	An entity that is contracted with UnitedHealthcare to only market and sell UnitedHealthcare insurance products through its hierarchy of down-line contracted agents and solicitors.
Down-line	The hierarchy structure where an individual or entity aligns under a higher contracted level entity.
E	

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Term	Definition
eAlliance	A contracted entity approved by UnitedHealthcare to operate a telephonic enrollment call center and/or electronic enrollment capability.
Effective Date	The date that a member's plan coverage begins.
Enhanced Direct Enrollment (EDE)	CMS approved partner's website that offers enhanced functionality that includes fully integrated platforms that provide a range of custom enrollment and client management features and capabilities. The marketplace remains responsible for making eligibility determinations.
Exchange	See Marketplace
F	
Federally-facilitated Marketplace (FFM)	A health insurance shopping and enrollment service operated by the federal government.
Field Marketing Organization (FMO)	An entity that is contracted with UnitedHealthcare to market and sell UnitedHealthcare insurance products through its hierarchy of down-line contracted agents and solicitors.
H	
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.
Hierarchy	The structure of the highest level of a contracted external organization and their down-line.
HIPAA Privacy Statement	A message addressed to the fax recipient that states the information is confidential and may contain Protected Health Information (PHI) and/or Personally Identifying Information (PII). A HIPAA Privacy Statement must always be included on a fax cover sheet when sending PHI/PII via fax machine or electronic/desktop fax. Sample HIPAA Privacy Statement: *CONFIDENTIALITY NOTICE: Information accompanying this facsimile is considered to be UnitedHealthcare's confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it is addressed. Such recipient shall be liable for using and protecting UnitedHealthcare's information from further disclosure or misuse, consistent with applicable contract and/or law. The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including, but not limited to HIPAA. Individuals who misuse such information may be subject to both civil and criminal penalties. If you believe you received this information in error, please contact the sender immediately.*
I	
IFP Disciplinary Action Committee (IFP DAC)	A committee responsible for determining appropriate disciplinary and/or correction action up to and including agent termination.
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).

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Incentive Compensation Management (ICM)	The system is responsible for the calculation of external broker commissions for the IFP lines of business.
J	
Jarvis	The agent portal that provides access to agent tools, product, commission, and resources information.
K	
Key FMO	An entity that is contracted with UnitedHealthcare to market and sell UnitedHealthcare insurance products through its hierarchy of down-line contracted agents and solicitors.
L	
Lead	The name and contact information of a consumer who might be contacted to market UnitedHealthcare IFP products.
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.
M	
Marketplace	A health insurance shopping and enrollment service operated by federal government or state that is accessible through websites, call centers, and in-person assistance.
N	
National Insurance Producer Registry (NIPR)	A database which contains information about insurance agents and brokers provided by state Departments of Insurance (DOI).
National Producer Number (NPN)	A unique identifier assigned through the National Association of Insurance Commissioner's (NAIC's) licensing application process. The NPN is used to track individuals and business entities on a national basis
New Commission	The compensation given to an agent for the first month the member is enrolled in a plan and upon effectuation (i.e. the member has made their binder or first month premium payment).
O	
Off-Exchange Plans	Option for consumers to purchase commercial health insurance plans directly from an insurance carrier rather than through an FFM or SBM.
Open Enrollment Period (OEP)	The annual period when eligible individuals can enroll in a Marketplace health insurance plan. OEP runs from November 1 through January 15.
P	
Party ID	A UnitedHealthcare generated number that provides primary identification of an individual to UnitedHealthcare and links all subsequent issued Writing IDs to the individual. Individuals will only be assigned one Party ID for their lifetime with UnitedHealthcare.
Permission to Contact (PTC)	Permission given by a consumer to be contacted by a representative of UnitedHealthcare for the purposes of marketing/selling a UnitedHealthcare IFP product or plan.
Principal	The individual that is contracted with UnitedHealthcare as the responsible party for an agency/entity.

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Producer Contact Log (PCL)	A system used to document agent/agency Complaint Requests (CR) and outreach.
Producer Help Desk (PHD)	UnitedHealthcare contact center that provides support pertaining to the agent experience.
Q	
Qualified Health Plan (QHP)	A health insurance plan that has in effect a certification that it meets the Health and Human Services (HHS) standards or is recognized by the Exchange.
R	
Renewal Income	The compensation given to an agent for any month following the initial enrollment month the member remains in the same plan or moved to another renewal commission eligible UnitedHealthcare IFP plan via eligible plan change.
Renewal Month	All months following the initial enrollment month the member remains in the same plan or moved to another renewal commission eligible UnitedHealthcare IFP plan via eligible plan change.
S	
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.
Service Request	The documentation in PCL of all contacts between the PHD and an agent.
Solicitor	An agent who is licensed, appointed (as required by the state), and has completed registration and training required by UnitedHealthcare or the applicable exchange (Federally-facilitated Marketplace (FFM) or State-based Marketplace (SBM)) who markets and sells UnitedHealthcare IFP products through a contract with an agency or eAlliance. There is no contractual relationship between the solicitor and UnitedHealthcare.
Special Enrollment Period (SEP)	A period outside of the annual OEP when eligible individuals who meet defined qualifying life changes can enroll in a Marketplace health insurance plan.
State-Based Marketplace (SBM)	A health insurance shopping and enrollment service operated by a state.
Successor Agent	The active agent who becomes the Agent of Record (AOR) for the original agent's book of business.
U	
UnitedHealthOne® (UHOne)	A UnitedHealthcare company that is contracted to market and sell UnitedHealthcare Individual and Family Plans telephonically.
Up-line	The contracted entities that are above a specific individual or entity.
W	
Writing ID	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.

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