Direct to Consumer (DTC) Sales Agent Guide

United Healthcare®

Proprietary and confidential to UnitedHealth Group.

The materials comprising this Direct to Consumer (DTC) Sales agent Guide ("Guide") are provided by UnitedHealthcare ("Company") as a service to its agents on an "as-is, as-available" basis for informational purposes only. The Company assumes no responsibility for any errors or omissions in these materials. While the Company endeavors to keep the information up to date and correct, the Company makes no representations or warranties about the completeness, accuracy, or reliability of the information, products, or services contained in the Guide for any purpose.

This Guide is intended for Direct to Consumer (DTC) Sales agent use only.

Version 12.7 Release Date – April 01, 2026

Table of Contents

Table of Contents

Section 1: Introduction

Welcome to UnitedHealthcare!

Using this Guide

Welcome to UnitedHealthcare!

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

Here to help you succeed

We are committed to providing you with tools that help you succeed. *Direct to Consumer (DTC) Sales Agent Guide* is a comprehensive 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. To help, compliance guidelines are integrated into each section of this guide. Your partnership in adhering to our compliance guidelines is deeply valued and supports our goal of being the most trusted, capable, reliable partner to our consumers, members and the federal government.

Easy access

An electronic version of this guide is available on Knowledge Central and is updated regularly. Your comments, suggestions, and recommendations for additional content are encouraged. Please submit feedback to your supervisor/sales manager.

You play a crucial role in serving our consumers and being a trusted advisor. Thank you for your commitment to ensuring the best possible experience on every call.

Sincerely,

James B. Assali, MBA, CLU I Vice President
DTC Sales Team & Producer Help Desk
UnitedHealthcare Medicare & Retirement

Using this Guide

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

The *Direct to Consumer (DTC) Sales Agent Guide* has been developed for use by all Direct to Consumer (DTC) Sales agents. Throughout the guide the words “agent” and “you” are used to refer to any Direct to Consumer (DTC) Sales agent.

- Direct to Consumer (DTC) Sales agent: An appropriately licensed, certified, and appointed (as required by the state) representative of UnitedHealthcare who markets and sells UnitedHealthcare products telephonically.

Section 2: How do I Get Started?

Employee Individuals

Certification Program

Certification Requirements

Training Resources

Agent Profile

Employee Individuals

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

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

Direct to Consumer (DTC) Sales Agents – Employee and Vendor

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

You must also have an active insurance license in Life, Accident and Health (or similar as determined by the state) with appropriate lines of authority for your state of residence, plus non-resident licenses for any other states where you will market or sell UnitedHealthcare products.

You must be appointed (as required by the state) in any state where you will be active in marketing or sales.

You must be appropriately certified.

Direct to Consumer (DTC) Sales management or the vendor contact must submit required information determined by ALM for you.

Upon receipt of all required agent information, ALM reviews the information, confirms you have not been flagged Review Before Contracting (RBC) in the contracting system or is not active in another sales channel, assigns the Party ID (if applicable), and emails you a Party ID Notification Letter.

If at the time of hire, you do not have a current resident state license, UnitedHealthcare assists you through the resident state licensing application and exam process. You must attend all required pre-license education and pass the resident state license exam. Failure to obtain a license within 90 days of hire is grounds for termination from a sales and marketing position.

UnitedHealthcare will assist you with non-resident state license application requests as applicable.

When you have received your resident state license, your manager or vendor contact must send notification to ALM. ALM requests appointment in the resident state and initiate the non-resident state license application process in all other designated non-resident states for which you will be

active in marketing/sales activities. Note: Direct to Consumer (DTC) Sales agents will be licensed in non-resident states based on business need and assignment.

ALM will submit appointment requests for the resident state once they are notified you have received your resident state license. In JIT states, you may be appointed after your first enrollment utilizing state-authorized appointment backdating allowances. 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.

Once the appointment request is submitted you are activated in the contracting system and a writing number is issued. A Welcome Letter, which contains your writing number, is e-mailed to you with a copy sent to your supervisor or vendor contact.

ALM verifies non-resident license status using NIPR. When a new state license is issued, ALM submits the appointment request for you in that state. Note: Direct to Consumer (DTC) Sales agents will be appointed in non-resident states based on business need and assignment.

If a request to appoint is denied, you are responsible for addressing and meeting all state requirements within the timeframe prescribed by the state. If you do not meet the state requirements within the prescribed timeframe, you will not be appointed in that state and are not allowed to market and/or sell in that state.

If you have a current resident state license, ALM validates the resident state license on NIPR and requests appointment in the resident state and initiates the non-resident state license application process in all other designated non-resident states that you will be active in marketing/sales activities.

If you have a current resident state license and are licensed in all states in which you will be active in marketing/sales activities, ALM validates the resident and non-resident state license on NIPR and submits the appointment requests for all applicable states.

You are responsible for all educational requirements to maintain an active resident state license. ALM verifies license status using NIPR. Failure to pass the resident state license exam, maintain valid licensing, or loss of licensing is grounds for termination from sales and marketing position.

UnitedHealthcare will assist you with the renewal application process and costs in both resident and non-resident states. Access to online continuing education is provided. UnitedHealthcare covers CE and resident state license costs for employee Direct to Consumer (DTC) Sales agents. Vendors and/or agents are responsible for covering CE and resident state license costs for vendor agents.

Prescription Drug Plan Education and Enrollment Representatives
Prescription Drug Plan Education and Enrollment Representatives (PDP E&E) may conduct enrollment activities that do not require an insurance license. Activities cannot extend beyond the scope of their role and training. Marketing UnitedHealthcare Medicare plans is prohibited.

On an annual basis, Direct to Consumer (DTC) Sales management and Legal will collaborate to identify states that prohibit the use of PDP E&Es to conduct enrollment activities.

Direct to Consumer (DTC) Sales management or the vendor contact must submit required information determined by ALM for each PDP E&E.

Upon receipt of all required representative information, ALM:

- Reviews the information and confirms the representative has not been flagged RBC in the contracting system
- Assigns a Party ID (if applicable) and emails a Party ID Notification Letter to the representative and the applicable representative contact.
- Assigns a writing number (Agent ID) and emails a Welcome Letter containing the writing number to the representative and the applicable representative contact. Note: ALM does not verify completion of required certification to issue a writing number.

Certification Program

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

Certification materials, which consist of a study guide for all certifications topics (one for the field channel and one for the DTC Sales channel) and assessments. Once upcoming plan year certification materials are posted, current year certification materials are unavailable; therefore, an individual who is not certified for the current year, must become certified in the product for the upcoming plan year in order to market and sell the current year's product.

Certification consists of the following elements:

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

Agents must read What's New and Industry Update, complete required attestations, and successfully pass or receive credit for all Base Level assessments or pass the Fast Track assessment in order to be certified in non-special needs MA plans, PDPs, and Medicare Supplement Insurance plans. In order to be certified in other products, agents must also pass the applicable Next Level assessment. Note: Agents transferring a third party certification credit are given credit for the Medicare Basics assessment. Agents must still complete the remaining Base Level assessments (i.e. Ethics and Compliance and AARP) in order to sell non-special needs MA plans, PDPs, and Medicare Supplement Insurance plans.

Section 2: How do I Get Started?

When an individual passes or is given credit for the field Medicare Basics assessment, the individual must pass the remaining Base Level assessments (i.e. Ethics and Compliance and AARP) in order to be able to sell non-special needs MA plans, stand-alone PDPs and Medicare Supplement Insurance plans.

An individual is considered portfolio certified when they are product certified in MA plans, PDP, Medicare Supplement Insurance plans, C-SNP, and D-SNP.

Medicare Basics, Ethics and Compliance, and Next Level product assessments have a minimum passing score of 85%. The AARP assessment has a minimum passing score of 70%. Six attempts are permitted to pass an assessment. If an individual fails to pass a base level assessment within the allotted six attempts, they are prohibited from marketing/selling any product in the UnitedHealthcare Medicare Plans portfolio for the applicable plan year. Next Level assessments are only accessible after passing Base Level assessments. If an individual fails to pass a product assessment within the allotted six attempts, they are prohibited from marketing/selling that product for the applicable plan year.

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

- All eligibility requirements are as of the measurement date (The measurement date for 2027 certifications will be in May of 2026). Agents must meet the following requirements:
  - Premier producers must have 12 or more months of tenure.
  - Field agents/agencies (EDC, ICA, and IMO), eAlliance agents, TA Agents, and Solicitors must have two consecutive years of selling, 20 or more approved MA plan or Medicare Supplement Insurance plan applications within the last two years (for principals and agents who have sales under both their individual writing ID and agency writing ID, agents must have a combined application production of 20 or more approved applications), and no more than one complaint point in the last year.
  - DTC Sales and URS agents must have one full sales year and no more than one complaint point.
- The Fast Track Assessment, What's New and Industry Updates, and attestations (Fast Track) will certify the agent to market/sell MA plan, PDP, and Medicare Supplement Insurance plan.
- The Fast Track Assessment has a minimum passing score of 85% within two attempts.
- If an eligible agent wants to take the Fast Track option, the Fast Track option must be attempted prior to attempting the standard option. If a standard assessment is failed, the Fast Track option is no longer available.
- If the Fast Track option is failed in two attempts, the agent may still attempt the standard option. The agent must pass all of the Base Level assessments and applicable Next Level assessments and complete required attestations in order to certify.

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

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

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

Certification Requirements

Individuals must be appropriately product certified prior to conducting any marketing/sales activities. Agents must certify annually. No commission or incentive will be paid on any enrollment application written by an individual who was not appropriately product certified at the time of sale (i.e. an unqualified sale).

Writing Agent

Direct to Consumer (DTC) Sales Agent – Employee and Vendor

- Must be certified in the product and for the plan year prior to conducting marketing/sales activities for the product.
- DTC Sales agents authorized to market/sell SNP products must be certified in SNP products for the plan year prior to conducting marketing/sales activities for SNP products.
- DTC Sales agents authorized to market/sell SCO must be SCO product certified for the plan year and complete SCO specific training prior to conducting marketing/sales activities for SCOs.
- DTC Sales agents authorized to market/sell UHC One Care must be UHC One Care and DSNP product certified for the plan year and complete UHC One Care specific training prior to conducting marketing/sales activities for UHC One Care.
- DTC Sales agents authorized to market/sell I-SNP/IE-SNP products must be certified in I-SNP/IE-SNP products for the plan year prior to conducting marketing/sales activities for I-SNP/IE-SNP products.
- Certification requirements must be met within 30 days of hire or prior to conducting marketing/sales activities whichever comes first and annually thereafter.

PDP E&E

Must be certified in the PDP product for the plan year prior to conducting enrollment activities for PDP products.

Non-Writing Individual

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

Validation, Reporting, and Monitoring

- You can verify your own certification status and history through ***Jarvis*** (via Manage Profile > Certifications), Learning Lab, or by contacting the Producer Help Desk (PHD).

- UnitedHealthcare Managers/supervisors are responsible for monitoring the certification status of assigned individuals by using applicable Power BI SMRT reports and applications.
- The learning and development and certification operations departments monitor the certification program. Quality indicators have been established and are reviewed on a quarterly basis to ensure that certifications are effective and meet company standards. Quality indicators that are measured may include:
  - ~ Receiving and soliciting feedback including ratings on content, structure, understanding, usability, and value of courses.
  - ~ Knowledge evaluations are conducted through the administration of assessments that have been developed by subject matter and learning experts to sample the key areas of knowledge necessary and required CMS elements to perform the job successfully and compliantly.
  - ~ Activity metrics (e.g., length of time, frequency of access, frequency of assessment taking attempts, average scores) may be reviewed to ensure effectiveness of instruction and measurement of achievement. These metrics are available in the learning management system (Learning Lab) report tracking system.

Requests for Certification Related Information

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

Training Resources

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

Agent Profile

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

Section 3: What Resources are Available to Help Me?

Agent Communications

Knowledge Central

Agent Communications

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

Communications Methods

The primary method of communication used by UnitedHealthcare for the Direct to Consumer (DTC) Sales channel is Knowledge Central.

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

Disclosing Proprietary Information and External Engagement

- Confidential and/or proprietary data about UnitedHealthcare must not be released to anyone outside the company without first securing approval from the Chief Distribution Officer, Compliance, or Legal.
- You must comply with the UnitedHealth Group External Engagement policy and Non-Endorsement policy. Refer to the UnitedHealth Group corporate policies or contact your UnitedHealthcare sales leader for details.
- You must not use any UnitedHealth Group name, logo or trademark for advertising, publicity, or to suggest any endorsement, affiliation or sponsorship of any third-party product or service without prior approval from UnitedHealth Group.
- Prior to accepting an external engagement opportunity, you must follow the UnitedHealth Group approval process. External opportunities include conferences, events, panels, media requests, webinars, interviews, podcasts, statements for public policy organizations and research firms, published material for industry expertise (books, research papers, health care policy papers) and self-promoted content.
- You must engage your UnitedHealthcare sales leader for all external engagement opportunities that may include any UnitedHealth Group or its affiliate's name, logo, or trademark. If the agent is 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.

Restriction on Distribution of Policies and Procedures

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

Knowledge Central

Knowledge Central is a portal that houses valuable information for you. Knowledge Central is the primary source of information and documents for the Direct to Consumer (DTC) Sales Channel.

Section 3: What Resources are Available to Help Me?

Communication may include pop-up messages, agent communications, agent guides, job aids, and other resource and tool documents.

Agents are notified of new and updated information via the “New or Changed” tab on Knowledge Central. In addition, agents are notified of significant new or updated publications via a Knowledge Alert posting.

For additional information or questions about access please contact your manager/supervisor.

Section 4: How do I Conduct Educational and Marketing/Sales Activities?

RSVP Consumers for Events

Direct to Consumer (DTC) Sales agents do not create or report marketing/sales events into Mira. However, Direct to Consumer (DTC) Sales agents can RSVP consumers to events in Mira.

Community Meeting (Formal Marketing/Sales Events) RSVP

You may register a RSVP for a consumer who contacts UnitedHealthcare requesting to attend a community meeting (formal marketing/sales event). A consumer may contact UnitedHealthcare with general questions after receiving a meeting postcard or a flyer. You may suggest that the consumer attends a community meeting (formal marketing/sales event) as an alternate source of information.

You must check Mira to identify if there are any Consumer Engagement Strategy (CES) messages or priority notifications.

- CES Priority Ranking – a notification pop-up in Mira based off of various criteria (i.e. market, geography).
- Events can be located on the Meeting Tab in Mira.

Note: you should avoid sending existing members to sales events.

In-Home (Personal/Individual) Appointment RSVP

You may schedule in-home (personal/individual) appointments for a consumer. There are two ways to schedule the appointment. The Direct to Consumer (DTC) Sales agent may:

- Submit a request for an appointment while the consumer is on the line (soft-set appointment). Direct to Consumer (DTC) Sales agents do not assign a field agent nor contact a specific agent while the consumer is the line. Field agents are responsible for following up with the consumer to confirm the date, time, and location of all soft appointments.
- Find an agent in Mira (who pre-loaded information) and set the specific appointment for that agent in Mira (hard-set appointment). This is the non-preferred method as it does not inquire into the agent's schedule nor does it take into account the proximity of the agent's scheduled meetings.

You should review the Mira job aid in Knowledge Central for additional information on scheduling community meetings formal marketing/sales event or in-home, personal/individual appointments.

Telesales Co-Browse Tool

The telesales co-browse tool allows UnitedHealthcare Direct to Consumer (DTC) Sales agents to engage in a live screen sharing session with a consumer on the following websites: www.UHC.com/medicare, www.AARPMedicarePlans.com, or www.UHCCommunityPlan.com. No other website, program, documents, or information on the consumer's computer or device will be visible to the Direct to Consumer (DTC) Sales agent. The consumer will continue to have control of their computer screen throughout the co-browse session and may end the session at any time. The following telesales co-browse guidelines apply:

- The co-browse session must be used through the LivePerson agent console.

- The consumer must click the “Accept” button to acknowledge that they have read and agree to the terms and conditions of the co-browsing session prior to the sharing of screens.
- You may assist the consumer with the navigation of information on the website, engage in marketing activities, review plan information, and view information the consumer enters.

Educational and Marketing/Sales Activities and Events

The information provided in this topic is meant to be written for a “field” agent. This topic does not apply to telesales but it does give the Direct to Consumer (DTC) Sales agent a summary of the “Characteristics of Activities and Events” in case they need to explain them.

Educational Events

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

Marketing/Sales Event

Marketing/sales events are designed to steer, or attempt to steer members or consumers toward a specific plan or a limited set of plans or for plan retention activities. Plan materials can only be distributed during eligible marketing periods and enrollment applications can only be collected during eligible election periods. Marketing and/or selling outside of eligible periods (e.g., marketing for a new plan year prior to October 1) is prohibited and is subject to corrective and/or disciplinary action up to and including termination. An SOA agreement is not required for consumers attending a marketing/sales event. The following are types of marketing/sales events:

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

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

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

Online Events and Appointments
Field agents are allowed to conduct online formal educational and marketing/sales events. In addition, field agents may conduct online one-on-one marketing/sales appointments. Field agents must abide by all regulations, rules, policies, and procedures.

Marketing/Sales Event Reporting

Direct to Consumer (DTC) Sales agents do not report marketing/sales events into Mira nor can they create events in Mira. The information provided in this section is for educational purposes only.

UnitedHealthcare requires all marketing/sales events, formal and informal, in-person and online be reported. Educational events do not need to be reported to UnitedHealthcare.

New Event Reporting*
All marketing/sales events must be received into UnitedHealthcare's event reporting application prior to advertising and no less than seven calendar days prior to the date of the event.

Event Reporting Exception Request
There is a process available when extenuating circumstances require a new event to be reported less than seven calendar days before the desired event date. The agent must follow the exception request process for approval on the exception request.

Changes to Reported Marketing/Sales Event
A change includes modification to any aspect of the previously reported event. Change requests must be submitted to UnitedHealthcare at least one business day prior to the scheduled date of the event. When a change occurs to the venue location, date, start time and/or end time of an event, it is considered a cancellation and requires cancellation of the event and entry of a new event (new event reporting and cancellation notification rules apply).

Cancellation of a Reported Marketing/Sales Event
Every effort should be made to avoid cancelling a reported event. If possible, another qualified agent should be utilized to conduct the event. Cancelling an event less than one business day before the scheduled start time is prohibited except in the case of inclement weather. In such cases, the agent is expected to exercise appropriate discretion when deciding a course of action.

Notification of Change/Cancellation
Consumer notification of a changed/cancelled marketing/sales event should be made, whenever possible, more than seven calendar days prior to the originally scheduled date and time. Changes requiring consumer notification do not include change of presenting agent.

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

- The agent is responsible for ensuring notification to all consumers that RSVP to an event that has been cancelled (or the venue location, date, or time changed). Only consumers who provided Permission to Call (PTC) can be contacted by telephone.
- All steps taken to notify consumers must be documented (noting date, time, and method of notification). All cancellation notification documentation must be made available upon request.
- If the change/cancellation is reported to UnitedHealthcare less than seven calendar days before the original schedule date, a representative of the plan must be at the venue at the scheduled start time. The representative must remain at the venue of a formal marketing/sales event for at least thirty minutes after the scheduled start time to advise anyone arriving for the event of the change/cancellation and redirect attendees to another meeting in the area or provide a sales agent's business card. For informal events, a representative must remain for the entire scheduled time of the event. (Note: This requirement does not apply in cases of cancellation due to inclement weather; however, the agent must attempt to notify the venue and request a sign/notice be posted.)
- If the change/cancellation is reported and RSVPs have been notified seven calendar days or more before the original date of the event, then there is no expectation that a representative of the plan should be present at the site of the event.

Request for a Sign Language Interpreter

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

Sign Language interpreter Requests

- Requests (new or change) for a sign language interpreter must be submitted 14 or more calendar days prior to the event or marketing appointment. Urgent requests within 14 calendar days should be limited to rare and exceptional circumstances. UnitedHealthcare may attempt to accommodate urgent requests but fulfillment may not be feasible.
- Agents with access to Mira must enter the requests in Mira according to established process.
- Agents without access to Mira must submit a Sign Language Interpreter Request Form (accessible via ***Jarvis***) via email to the Producer Help Desk at asl@uhc.com.
- Direct to Consumer (DTC) sales agents will request an interpreter through ASL Services, Inc. (a national vendor used to conduct interpreter services) when confirming the consumer's RSVP hard-set appointment to a formal marketing/sales event.
- Within three business days after the request has been made, ASL services, Inc. will contact the agent, at the number on record, to confirm the interpreter request and event/appointment logistics.
- To cancel an interpreter request, agents with Mira access must close the contact in Mira. Agents without access to Mira must contact the PHD to cancel the appointment.
- Cancellations with less than three business days' notice will be billable for the scheduled event/appointment duration or a two-hour minimum.

- Using a third party individual who is not an employee of UnitedHealth Group or an approved ASL interpreter vendor is prohibited.

Marketing to Consumers with Impairments or Disabilities

Agents serving the Medicare eligible population must be aware of and sensitive to the needs that might reasonably be expected within the defined population. Upon request or becoming aware of a situation requiring special accommodations, you must take appropriate actions based on the consumer's linguistic barrier, disability or impairment (e.g., obtaining language translation services, access to venue, or rescheduling an appointment to ensure the consumer's authorized legal representative is present).

Section 1557 of the Patient Protection and Affordable Care Act prohibits discrimination in certain health programs or activities and extends nondiscrimination protection to consumers. You must not discriminate based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, or geographic location.

You may not target consumers from higher income areas or state/imply that plans are only available to seniors rather than to all Medicare beneficiaries. Special Needs Plans (SNP) may limit enrollments to consumers meeting eligibility requirements based on health and/or other status. Basic services and information must be made available to consumers with disabilities, upon request.

Consumers with Linguistic Barriers

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

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

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

Translation / Interpreter Services

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

- The consumer may be accompanied by and/or authorize an individual, of their choosing, to translate/interpret the information and/or materials. You should make sure the individual assisting the consumer is capable and competent, which generally means the individual is an adult and is capable of translating/interpreting the appropriate meaning of the content from English to the non-English language and vice versa.
- Other options:

- ~ Direct to Consumer (DTC) Sales 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.

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

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

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

Vision Disability or Impairment
A visually impaired consumer may request materials in alternate formats through Customer Service. If you encounter a visually impaired consumer, you may:
- Read the materials verbatim to the consumer.
- Allow the consumer to be accompanied by an individual, of the consumer's choosing, who can read/interpret the information and/or materials.
- If the consumer has an authorized legal representative, provide a complete enrollment guide directly to the consumer's authorized legal representative for review and enrollment purposes.

- Direct the consumer to Customer Service to request materials in an alternative format. The requested material is provided at no charge to the consumer.

Cognitive Disability or Impairment
You must be aware and sensitive to the needs of cognitively impaired consumers. You must be aware that cognitively impaired consumers may or may not have an authorized legal representative (e.g., Power of Attorney) and/or may still make health care decisions themselves. You must be aware that cognitively impaired consumers may live independently or within a residential facility. If there is any question about the consumer's cognitive ability, you should ask whether the consumer has an authorized representative. If the consumer has an authorized legal representative, you should reschedule the appointment for a time when the consumer's authorized legal representative can be present.

Permission to Contact (PTC)

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

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

- PTC only applies to the entity/indivdual from which the individual requested contact, the duration and topic requested; is limited to the method of contact (e.g., permission to call or text) in the PTC mechanism (e.g., business reply card); and must be given by the individual requesting contact and cannot be given on behalf of another individual (e.g., a husband cannot grant permission on behalf of his wife as each spouse must provide individual PTC). The PTC mechanism may include statements or options that would lead a consumer to reasonably understand they will be contacted to discuss Medicare insurance options or include the exact individual product types to be discussed such as Medicare Advantage, Part D Plans, or Medicare Supplement Insurance or refers to options collectively (e.g., Medicare insurance options).
- Agents are responsible for ensuring PTC is valid and not expired prior to use.
- PTC Expiration
  - ~ Permission to contact expires 12 months from the date of the consumer signature date or the date of their initial request for information or when the consumer requests no future contact, whichever comes first, unless an exception applies.
  - ~ Exceptions include but are not limited to, consumers on the Do-Not-Call registry, consumers requesting information on Medicare Supplement insurance plans, or on a Medicaid list. For consumers on the Do-Not-Call registry or requesting information on Medicare Supplement insurance plans, PTC expires 90 days after the date of the consumer signature date or the date of their initial request for information.
  - ~ If agents are receiving PTC from UnitedHealthcare, their up-line, or other third-party sources, the date of the consumer signature or the date of their initial request for information may be prior to the date the agent obtains the PTC.
- PTC must be documented (in Mira if available to the agent) and PTC documentation (e.g., lead source/business reply card) must be retained for ten years and made available to UnitedHealthcare upon request.

Section 4: How do I Conduct Educational and Marketing/Sales Activities?

Prohibited Unsolicited Direct Contact

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

- Contacting a consumer through telephonic means, including manual or automated dialing, voice messaging, or text messaging, or through electronic means, including proximity/push marketing, and smart phone applications or social media interactive functionality (e.g., direct messaging). Prohibited scenarios include, but are not limited to:
  - ~ Any contact with a consumer when the consumer did not provide PTC through a compliant mean to be contacted in that manner.
  - ~ Contacting a consumer without valid PTC that attended an event or to whom material was mailed under the guise of following up.
  - ~ Contacting a referred consumer without valid PTC.
  - ~ Contacting a UnitedHealthcare member for whom you are not the Agent of Record and you did not receive delegated PTC from UnitedHealthcare.
  - ~ Using lead contact information received from UnitedHealthcare to market any non-UnitedHealthcare product.
  - ~ Using lead contact information obtained from Mira for a consumer with whom you do not have a relationship unless UnitedHealthcare has delegated PTC and authorized an outbound call as part of a marketing campaign.
  - ~ Engaging in any “bait-and-switch” tactics (e.g., marketing a product that does not require PTC in order to convert the marketing effort to a product that does require PTC). PTC requests must not include requests for permission to engage in door-to-door solicitation and having an address does not provide permission to engage in door-to-door solicitation.
  - ~ Contacting a former member who voluntarily disenrolled or a current member in the process of voluntarily disenrolling to market a product or plan, dissuade them from disenrolling, or to participate in any type of survey. In addition, you must not ask a disenrolling member for PTC to market plans in the future.

Permitted Direct Contact

PTC must be obtained prior to making direct contact with the consumer, except when using postal mail (e.g., advertisements, direct mail) or email. You must follow PTC guidelines described above. When contacting consumers, the contact and content of the contact must comply with all federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules. For telephonic contact, agents must comply with applicable state and federal telemarketing laws and regulations, including but not limited to, the National Do-Not-Call Registry, the Telephonic Consumer Protection Act (TCPA), federal and state calling hours, and the recording of all telephonic conversations with consumers/members as prescribed by CMS. Contact by email and other electronic means must comply with applicable state and federal laws and regulations, including but not limited to, applicable CAN-SPAM requirements.

- Agents may contact consumers when prior valid permission to contact has been obtained. The contact must be in the method identified in the permission to contact.

- Telephonic contact requires prior permission to contact via telephonic method(s) (e.g., call or text). Both the act of contacting telephonically and the content of the contact must comply with all federal and state laws and regulations, including but not limited to, Do-Not-Call, federal and state calling hours, TCPA requirements, and TPMO call recording and disclaimer requirements.
- Agents may send unsolicited postal mail.
- Agents may send unsolicited emails. Unsolicited emails must not appear to be coming from or on behalf of UnitedHealthcare and must not contain any UnitedHealthcare brand name or elements (except as required to comply with CMS requirements to identify carriers in multi-carrier marketing materials). DTC Sales Agents who are direct employees of UnitedHealthcare are permitted to send unsolicited emails that appear to be coming from or on behalf of UnitedHealthcare when using the permitted email functionality within Mira and/or Salesforce Marketing Cloud. All material rules and requirements apply. Emails must have an opt-out/unsubscribe function and must comply with all federal and state laws and regulations, including but not limited to CAN-SPAM requirements.
- Permitted PTC mechanisms include the following:
  - A consumer requests a return call from the agent or UnitedHealthcare.
  - A compliant Business Reply Card (BRC) or lead card submitted by the consumer.
  - A compliant online contact form/electronic BRC submitted by the consumer.
  - An email sent by the consumer to you requesting contact.
  - A text sent by the consumer to the agent requesting contact.
  - During permitted contact with the consumer, you request to renew PTC and the consumer consents to a future contact.

Delegated Permission to Contact - UnitedHealthcare

UnitedHealthcare may contact any existing UnitedHealthcare member who meets the criteria listed below. If you are not the Agent of Record, you may only call an existing member in one of the following categories if PTC has been delegated by UnitedHealthcare to you. Delegation of PTC occurs when UnitedHealthcare provides the member's contact information (i.e., name and phone number) to you. You may only use the member's Protected Health Information (PHI), Electronic Protected Health Information (ePHI), or Personally Identifiable Information (PII) to the extent necessary to conduct business on behalf of UnitedHealthcare. Any other use of PHI/ePHI/PII obtained through delegated PTC is prohibited.

- A current UnitedHealthcare Commercial member aging-in to Medicare to discuss UnitedHealthcare Medicare products, including benefits, or to inform them of general plan information.
- A current UnitedHealthcare MA plan, PDP, or Medicare supplement plan member to discuss other UnitedHealthcare Medicare products, including benefits, or to inform them of general plan information.
- A current UnitedHealthcare Medicaid member to discuss UnitedHealthcare Medicare products, including benefits, or to inform them of general plan information.
- A consumer who submitted an enrollment application in order to conduct business related to the enrollment.

UnitedHealthcare Book of Business

UnitedHealthcare at its discretion may provide an agency or agent access to their Book of Business member information. Provided member information must only be used to the extent necessary to conduct business (e.g., servicing members and member retention activities) on

behalf of UnitedHealthcare. Any other use of provided member information is prohibited. Book of Business reports are confidential and proprietary information of UnitedHealth Group. Do not distribute or reproduce any portion without the express permission of UnitedHealth Group. All federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules apply. Please note that provided member information may not be reflective of all Book of Business or AOR information and does not impact incentives or renewal payments.

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

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

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

Lead Generation Guidelines

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

Actionable Lead

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

Lead Validation

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

Compliant means include, but are not limited to:

- Consumer submitted a compliant BRC (paper or electronic) or lead card.
- Consumer placed an inbound call, email, or voice message requesting to discuss Medicare insurance products. Based on the method of consumer outreach, you may respond accordingly, unless the consumer requests another preferred method of contact.

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

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

Lead Referral Programs

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

Compensation in Exchange for Lead

- You are not permitted to provide anything of value (e.g., gift card, flowers) to a consumer/member in exchange for a referral (i.e. contact information including name and telephone number/email).

Scope of Appointment

You must obtain a Scope of Appointment agreement through compliant methods from each Medicare-eligible consumer (including any unexpected Medicare-eligible individuals present) within the prescribed timeframe of a personal/individual marketing appointment (e.g., telephonic) when a Medicare Advantage and/or Prescription Drug Plan may be discussed. When the SOA is recorded telephonically, each Medicare-eligible individual on the call must consent to the SOA.
Scope of Appointment Agreements

- An SOA agreement must be obtained 48 hours prior to the scheduled marketing appointment, except for:
  - The last four days during a valid election period for the consumer; or
  - Inbound consumer-initiated calls.
- UnitedHealthcare Direct to Consumer (DTC) Sales agents obtain a Scope of Appointment on inbound via the Interactive Voice Recording (IVR).
  - For consumer-initiated inbound calls to the DTC Sales, the SOA requirement is satisfied via Interactive Voice Recording (IVR).
  - DTC Sales agents must follow departmental protocols for obtaining an SOA when making outbound calls.

Telephonic Scope of Appointment Recording Retention Requirements
UnitedHealthcare will retain Scope of Appointments obtained via IVR.

Interacting with the Field

If you have any questions regarding markets or any other information in which you would need to interact with the field, please contact your supervisor/manager to facilitate any interaction.

Section 5: Direct to Consumer (DTC) Sales Interactions

Inbound Calls

Outbound Calls

Digital Messages

Enrollment Methods

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

Customer Service Resources

Section 5: Direct to Consumer (DTC) Sales Interactions

You must adhere to all federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules when interacting with consumers/members via inbound or outbound calls or via digital messages. Additionally, you must be appropriately licensed, appointed (as required by the state), and certified (refer to the Certification Requirements section for details). If you do not meet licensing, appointment, and certification requirements for the particular call, you must transfer the call to a qualified Direct to Consumer (DTC) Sales agent or provide the lead to a qualified TS Advisor or field agent. If you are a DTC Sales non-licensed representative, your activity must be solely limited to acting in a non-licensed capacity, such as entering an application for a Prescription Drug Plan (PDP) without any steering or recommendation except in those states identified annually by Legal and Direct to Consumer (DTC) Sales management where it has been determined that a state-licensed agent must be used to enroll the consumer in a stand-alone PDP.

Inbound Calls

Overview

You must comply with all federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules when handling an inbound call. Inbound calls to the Direct to Consumer (DTC) Sales call center are routed to the next available Direct to Consumer (DTC) Sales agent based on call routing and skill based criteria. On-screen and audio identifiers may assist you in choosing and delivering the correct greeting to the consumer. You must disposition the call in Mira or other contact database according to established processes outlined in Knowledge Central job aids.

Member calls

A member enrolled in any UnitedHealthcare product initiates an inbound call for the purpose of discussing an issue related to the plan in which they are currently enrolled.

- Customer Service Related
  - ~ You must handle the call using appropriate customer service tools. The call may be transferred to Customer Service if you are unable to handle the request or as call volumes dictate.

- Disenrollment
  - ~ The member must have a valid election period to disenroll from a Medicare Advantage (MA) and/or Prescription Drug Plan (PDP). In most cases, the member is automatically disenrolled from their current MA plan and/or PDP when they enroll in a new MA and/or PDP. You must handle the member or their authorized representative's verbal request to disenroll according to established processes outlined in Knowledge Central job aids. After you verify the member's active enrollment status using internal systems (e.g., member household located in GPS), the member is transferred to Customer Service to obtain appropriate termination processes in accordance with CMS guidelines.

Consumer Calls

A consumer call is an inbound call from consumers interested in UnitedHealthcare or its plans and/or products. Consumer calls may include calls from members interested in a different plan or product or consumers who wish to withdraw/cancel their enrollment application.

- Educational
  You must handle requests for educational material and information according to established processes that may include mailing or emailing requested information and answering general Medicare program related questions.

- Fulfillment
  The consumer requested and is sent marketing materials electronically or via postal mail. You process the request for marketing material by capturing, verifying, and/or updating the consumer's address and/or email address, and permission to contact, and submitting the order through Mira or applicable Customer Relationship Management (CRM) tool.

- Positive Outcomes
  The consumer is interested in UnitedHealthcare Medicare products. You may assist in plan and/or product selection by conducting a needs analysis and determining eligibility. Positive call outcomes include:
  - ~ Telephonic Enrollment Call
    You must handle telephonic enrollments according to established processes using an enrollment script and conducting post-call activities. The call recording is archived and retained according to CMS retention guidelines.
  - ~ Personal/Individual Marketing Appointment
    When the consumer prefers to meet in-person or telephonically at a future time with an agent for a personal/individual marketing appointment to review plan details and/or enroll in a plan, you will capture, verify, and/or update the consumer's contact information in Mira or applicable CRM tool and submit the request via the applicable CRM tool. You may inform the consumer that another agent will contact them to schedule an appointment. You must update or capture the consumer's permission to contact in MIRA or applicable CRM tool accordingly with the consumer's permission to contact, and the call recording is archived and retained according to CMS retention guidelines.
  - ~ Marketing/Sales Event
    When the consumer is interested in attending a marketing/sales event in their area, you will provide information on upcoming events. If the consumer selects an event that suits their needs, you may enter the RSVP in Mira or applicable CRM tool.

- Withdrawal/Cancellation
  Prior to the consumer's plan effective date, you must handle the consumer or their authorized representative's verbal request to withdraw or cancel their enrollment application according to established processes outlined in Knowledge Central job aids.

Other Calls
You must handle calls that are identified as a non-lead according to established processes. Calls may include complaints, misdirected calls and provider calls.

Outbound Calls

Overview
All outbound call campaigns must be approved by UnitedHealthcare and, if applicable, the Centers for Medicare & Medicaid Services (CMS), prior to initiating the campaign. Campaigns must comply with applicable federal and state laws and regulations and UnitedHealthcare rules, policies, and procedures, including, but not limited to permission to contact, scope of product, Scope of Appointment (SOA), TCPA, state calling hours, and Do-Not-Call requests (federal and internal). You must be appropriately licensed, appointed (as required by the state), and certified based on the campaign.

Section 5: Direct to Consumer (DTC) Sales Interactions

Outbound Campaign Types

- Business Reply Card (BRC) – Follow up to a paper or electronic BRC from the consumer. You may only discuss the product(s) as described in the returned BRC.
- Personal/Individual Marketing Appointment: Follow-up outreach to consumer who requested a follow-up appointment and provided permission to contact for a personal/individual marketing appointment. DTC Sales agents obtain Scope of Appointment (SOA) according to established processes.
- Migration efforts – Proactive outreach campaigns to Medicare and Retirement members to inform them of products in their county that provide both medical and prescription drug coverage.
- Commercial Age In – Proactive outreach campaigns to UnitedHealthcare Commercial members who will be Medicare eligible.
- Community and State Medicaid – Prescheduled outbound campaign to current and active Community and State Medicaid members to inform them of other product opportunities in their county or other products that they may qualify for due to a change in their Medicaid or LIS status.
- ISNP Migration efforts – Proactive outreach campaign to Medicare and Retirement UnitedHealthcare family of products members who reside in a UnitedHealthcare contracted nursing home to inform them of the Institutional Nursing Home Plan or Assisted Living Plan.
- ISNP Member Retention – Proactive outreach campaigns to ISNP members to retain plan membership.
- Other – Proactive outreach campaigns to consumers with active PTC in Mira or applicable CRM tool to refresh and maintain PTC.
- Fulfillment Follow up – Follow up to a consumer who requested to receive marketing materials and provided PTC for a follow-up to review and answer questions after receipt of the requested material.

Outbound Call Handling

You must disposition the call in Mira or other contact database according to established processes outlined in Knowledge Central job aids. The following outcomes may result from an outbound call:

- Fulfillment
  The consumer requests and is sent marketing material electronically or via postal mail. You may process the request for marketing materials by capturing, verifying, and/or updating the consumer's or member's address and/or email address, and/or permission to contact, and submitting the order through Mira or applicable CRM tool.
- Positive Outcomes
  The consumer is interesting in UnitedHealthcare Medicare products. You may assist in plan and/or product selection by conducting a needs analysis and determining eligibility. Positive call outcomes include:
  - ~ Telephonic Enrollment
    - o Telephonic enrollments that result in an outbound call campaign must meet requirement in the Enrollment Methods section prior to completion.
  - ~ Personal/Individual Marketing Appointment
    - o When the consumer prefers to meet in-person or telephonically at a future time with an agent, you will capture, verify, and/or update the consumer's contact information in Mira or applicable CRM tool; submit the request via the applicable CRM tool; inform the consumer that an agent will contact them to schedule an appointment;

update or capture the consumer's permission to contact; and update Mira or applicable CRM tool accordingly. The call recording is archived and retained according to CMS retention guidelines.

- ~ Marketing/Sales Event
  - When the consumer is interested in attending a marketing/sales event, you will provide information on upcoming events and enter the RSVP in Mira or applicable CRM tool, if applicable.

- Other Calls
  - ~ You must handle calls that are identified as non-lead according to established processes.

Quality Monitoring
Quality monitoring is conducted on enrollments.

Digital Messages

Digital agents assisting consumers/members in acquiring a UnitedHealthcare plan must be appropriately licensed, appointed (as required by the state), and portfolio certified. You must handle digital messages, such as click to chat, in accordance with established processes and all federal and state laws and regulations, and UnitedHealthcare policies, procedures, and rules. You must use Liveperson as the digital messaging tool and must disposition the conversation in MIRA or other contact database according to established processes.

When interacting with a consumer/member via digital messaging, you may access the messaging/chat history (if applicable) of the consumer/member. Digital message interactions may include co-browse (e.g., screen sharing) sessions.

Message Source

- A consumer/member initiates a digital message from a UnitedHealthcare acquisition website.
- A member enrolled in any UnitedHealthcare plan initiates a digital message for the purpose of discussing their current plan with member services. If the discussion involves interest in other UnitedHealthcare products, member services may transfer the message/chat to a digital agent. It must be made clear that the member is being transferred to or interacting with a licensed sales representative.

Interaction Types

- Educational
  You must handle requests for educational material and information according to established processes that may include mailing or emailing requested information and answering general Medicare program related questions. When If a consumer initiates a marketing/sales discussion, you may proceed with providing plan/product information including benefits and cost sharing related to a specific plan and may obtain permission to contact (including scope of product), capture a lead for a follow-up, or complete an enrollment.
- Fulfillment
  The consumer requested and is sent marketing materials electronically or via postal mail. You process the request for marketing material by capturing, verifying, and/or updating the consumer's address and/or email address, and/or permission to contact, and submitting the order through MIRA or applicable CRM tool.

- ~ Positive Outcome
  The consumer is interested in UnitedHealthcare products. You may assist in selecting a plan (e.g., conducting a needs assessment, determining eligibility, presenting a plan), scheduling a personal/individual appointment or marketing/sales event, or completing an enrollment.
- ~ Enrollment
  You must handle enrollments according to established processes.
  - Digital Enrollment
    You may assist a consumer with questions during their Online Enrollment (OLE). You must not attach or provide your Writing ID when assisting a consumer with an OLE.
  - You may complete an enrollment via remote signature by email or text using the applicable enrollment tool.
    - Personal/Individual Marketing Appointment or Marketing/Sales Event
      - If the consumer prefers to meet in-person or telephonically at a future time with an agent, you will capture, verify, and/or update the consumer's contact information in MIRA or applicable CRM tool; and schedule or conduct an appointment. You will update or capture the consumer's permission to contact in MIRA or applicable CRM tool and obtain SOA according to established processes.
      - If the consumer is interested in attending a marketing/sales event, you will provide information on upcoming events and enter the RSVP in MIRA or applicable CRM tool, if applicable.
    - Telephonic Interaction
      You may transition the interaction to a telephonic interaction that could lead to a Telephonic Enrollment (refer to the inbound or outbound calls section).

- Disenrollment/Withdrawal/Cancellation Requests
  Prior to the consumer's plan effective date, you must handle the consumer or their authorized representative's request to disenroll, withdraw or cancel their enrollment application according to established processes outlined in Knowledge Central job aids.
- Other Digital Messages
  You must handle chats that are identified as a non-lead according to established processes. Digital messages may include complaints, misdirected messages, and provider messages.

Enrollment Methods

UnitedHealthcare has a number of enrollment tools and solutions for enrolling consumers. Electronic enrollment methods have been designed to create an excellent enrollment experience for both the agent and the consumer.

The best practice is to utilize Knowledge Central for the enrollment process. There is a telephonic enrollment system toolkit available through Mira.

Refer to Knowledge Central for the appropriate enrollment method based upon plan selected.

Online Self Service: All information need is located within Knowledge Central.

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

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

- Review consumer specific information, such as:
  - ~ Review the kind of health plan the consumer wants to enroll in.
  - ~ For network-based plans, verify (if applicable) all of the consumer's Primary Care Provider (PCP), specialist, and providers (e.g., doctors, hospitals, pharmacies, and facilities) are in the network. If the PCP, specialist, and/or providers are not in network, agents must explain that the consumer would need to choose a new in-network PCP, specialist and/or provider or may have to pay a higher cost share for benefits and services. Agents must explain that if the consumer uses an out-of-network provider, that except in emergency or urgent situations, non-contracted providers may deny care. Agents must explain that the plan does not pay for non-covered benefits and services. Agents must not steer or attempt to steer a consumer/member toward a particular provider or toward a limited number of providers, offered by either the plan sponsor or another plan sponsor, based on the financial interest of the provider or agent. Agents must not enter into arrangements with providers to steer a consumer/member into a UnitedHealthcare Medicare Plans plan based on financial or any other interest of the provider.
  - ~ Review the selection of a Primary Care Provider (PCP) if required by the plan and any referral requirements.
  - ~ If prescription drug coverage is included, verify (if applicable) all of the consumer's current prescription medications are on the formulary, in what tier, and if the consumer's pharmacy is in network. If the consumer's prescription(s) are not on the formulary, agents must explain that alternative drugs may be available and that the consumer may be responsible for the full price of the prescription(s) not covered by the plan. Agents must explain that if the consumer uses an out-of-network pharmacy, the plan may not pay for the consumer's prescription(s) or the consumer may pay more than at a network pharmacy.
  - ~ Determine if the consumer requires hearing, dental, and/or vision coverage?
  - ~ Determine if the consumer has any other health care needs (e.g., durable medical equipment or physical therapy)?
  - ~ Determine if the consumer has any other specific health care needs?
  - ~ Review the cancellation, withdrawal, and disenrollment processes and timeframes.
- Review plan benefits.
- Review premiums, including Part B premium, [insert dollar amount] per month/quarter/year. [This only applies if there is a premium greater than $0]. If applicable, review current premium vs another plan premium.
- If the plan has prescription drug coverage, review the formulary, drug tiers, step therapy, prior authorization, quantity limits, exception requests, coverage stages (including the coverage gap), and Late Enrollment Penalty (LEP).
- Review cost sharing including deductible, coinsurance, and copayments. Go over deductible cost, PCP copay, specialist copay, inpatient hospital copay, and any other copays for services or items the consumer needs.
- Review costs and limitations on dental, vision, and hearing.

- Review in-network and out-of-network coverage for providers and services (e.g., explain that except in emergency or urgent situations, the plan does not cover services by out-of-network providers (i.e. doctors who are not listed in the provider directory).
- Review coverage outside of the United States.
- Explain the potential effect that enrolling in a plan will have on other current coverage, which may in some cases mean that the consumer is disenrolled from their current health coverage (e.g., another MA plan or PDP).
- Explain that the plan is not a hearing, dental, or vision rider but a full plan.
- Explain that the plan operates on a calendar year basis, so benefits may change on January 1 of the following year.
- Explain that the Evidence of Coverage ("Certificate of Insurance" for Medicare Supplement plans and "Policy" for Standalone Dental, Vision, Hearing plans (Standalone Dental, Vision, Hearing plans are no longer sold as of October 1, 2025)) provides all of the costs, benefits, and rules for the plan.
- Review how to file a complaint.
- Review items only applicable to certain plan types.
  - ~ Review PPO or PFFS out-of-network coverage.
  - ~ Review chronic/disabling condition qualifying requirements for CSNP.
  - ~ Review the requirement to have Medicaid to qualify for a DSNP.
  - ~ Review the need to remain in an institutional skilled nursing facility in order to qualify for ISNP.
- Review election period and effective date for enrollment.
- Review plan eligibility requirements.
- Review the Star Rating for the Medicare Advantage (MA) plan or Prescription Drug Plan (PDP) presented, including where to find the rating in the Enrollment Guide, provide Star Rating updates as they are communicated during the year and explain where to obtain additional information about Star Ratings on the www.medicare.gov website.
- Advise the consumer that no-cost interpreter services are available, as applicable.
- Advise where the consumer can find contact information for the plan.
- Explain the appeals and grievance process, as applicable.
- If the sales presentation turns into an enrollment, the agent must inform the consumer they are transitioning to the enrollment phase.

Telephonic Enrollment

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

Telephonic Enrollment Based on Call Type

- Consumer-Initiated Inbound
  - ~ The following calls are characterized as consumer-initiated inbound calls:
    - o Consumer directly dials a telesales call center.
    - o The consumer intended to reach telesales, but reached another department (e.g., Customer Service). The consumer is transferred to telesales. The internally transferred call is considered a consumer-initiated in-bound call.
    - o Consumer directly dials a telesales call center. Due to high call volume or lengthy estimated hold time, the consumer is offered to be placed on 'virtual hold', which enables the consumer to receive a system-generated return call rather than remain

on hold. The system-generated return call is considered a consumer-initiated inbound call.
    - Consumer directly dials a telesales call center. If the call is accidently disconnected or dropped once the telephonic enrollment application has begun, the telesales agent may immediately initiate an outbound call to the consumer to complete the in-progress enrollment application provided permission to call was received prior to the call disconnect/drop.
    - A consumer uses a third-party routing system (e.g., Oracle) to facilitate a call to a telesales call center.
  - Telephonic enrollment into an MA plan (including SNP), PDP, or Medicare Supplement plan may occur as a result of a consumer-initiated inbound call.
- Telesales Agent-Initiated Outbound
  - The following calls are characterized as agent-initiated outbound calls:
    - Telesales agent directly dials (includes calls made through a dialer) an existing UnitedHealthcare member or a consumer from whom permission to call has been obtained.
    - Consumer uses a click-to-call feature on a UnitedHealthcare or multi-carrier call center web page and enters their telephone number requesting a call from a telesales agent.
    - Consumer receives a call via an automated message delivery system and indicates (by pressing the button as directed) their desire to speak with a telesales agent and is connected automatically to a call center.
  - Agent-initiated outbound calls must comply with all applicable Permission to Contact (PTC) (refer to the Permission to Contact section) and Scope of Appointment (SOA) requirements (refer to the Scope of Appointment section).
  - For agent-initiated outbound call enrollments, an existing business relationship, as defined by CMS, includes a consumer who leaves a message wishing for a call back, fills out a business reply card, or other way in which a consumer might initiate the relationship with UnitedHealthcare.
  - For agent-initiated outbound call enrollments, an existing business relationship, as defined by the TCPA, includes when a consumer initiates an inbound call within the previous three months.
  - Telephonic enrollment into an MA plan (including SNP) or PDP may only occur during an agent-initiated outbound call if:
    - DTC Sales Agents and DTC Sales Vendor Agents
      - The consumer is a current member of any UnitedHealthcare plan (e.g., commercial, Medicaid, MA Plan, PDP, or Medicare Supplement).
      - There is an existing business relationship, as defined by CMS or the Federal Trade Commission (FTC), and the consumer expresses desire to enroll.
  - Telephonic enrollment into a Medicare Supplement plan may occur on an agent initiated outbound call if the agent has valid and applicable PTC and the consumer is an AARP member.
  - The agent is responsible for determining if an enrollment may take place on a call characterized as an agent-initiated outbound call. If telephonic enrollment is not permitted on the agent-initiated outbound call, the agent must provide the consumer with instructions on placing a consumer-initiated inbound call in order to facilitate the telephonic enrollment.

- ~ If a telephonic enrollment is completed non-compliantly on an agent-initiated outbound call, and it is discovered prior to the effective date, the enrollment application should be withdrawn and a new application completed on a consumer-initiated inbound call.

Telephonic Enrollment Requirements

In addition to all other applicable requirements that apply to enrolling a consumer, an agent conducting a telephonic enrollment must comply with the following guidelines.

- All telephonic enrollment scripts must be approved by UnitedHealthcare and accepted or approved by CMS, if applicable, prior to use.
- The telephonic enrollment conversation must be recorded in its entirety, including the telephonic voice signature, archived, and retained for a minimum of 10 years from the plan effective date.
- You must determine if an enrollment may be completed based on the call type (i.e. consumer-initiated inbound, agent-initiated outbound).
- Prior to initiating a telephonic Medicare Supplement plan enrollment, you must verify that the consumer has received an Enrollment Kit or has reviewed plan information (including rates) on-line prior to the request to enroll.
- All elements of the enrollment request must be provided solely by the consumer or their authorized legal representative, though they may receive assistance from an individual of their choosing (e.g., family member or friend). You must determine the relationship of the caller to the individual enrolling in the plan and follow the authorized legal representative or witness process if applicable.
- You must follow and read verbatim the current accepted or approved telephonic enrollment script for the applicable plan.
- If the enrollment application contains a field(s) for the applicant's email address, you must not enter your own email address or a dummy email address. If the applicant does not have an email address or refuses to provide one, the you must leave it blank. For MA plans and PDP, an email address must not be required. For Medicare Supplement Insurance plans, if the signature method requires an email address and the applicant does not have an email address or refuses to provide one, you must choose a different signature method.
- The consumer must be provided with the agent's contact information. DTC Sales Agents who do not work a book of business will provide the consumer with a customer service number.
- When using JarvisEnroll, you must follow established process for obtaining a remote signature.
- When using JarvisEnroll, you must follow established processes for obtaining a voice signature.

Force Majeure Resilience Program

The Chief Distribution Officer or their delegate may invoke at their discretion the force majeure resilience program when requirements are met in order to provide reasonable alternative enrollment resources on behalf of the field sales channels (i.e. EDC and ICA/IMO). The force majeure resilience program must not be invoked in situations in which CMS provides relief to consumers in a particular geography who may have difficulty submitting an enrollment application by the end of the Election Period (e.g., Annual Election Period (AEP), Initial Coverage Election Period (ICEP), Initial Enrollment Period for Part D (IEP for Part D), Medicare Advantage Open Enrollment Period (MA OEP), Open Enrollment Period for Institutionalize Individuals (OEPI), or Special Election Period (SEP)) deadline.

A force majeure event means an act of God, riot, civil disorder, or any other similar event beyond the reasonable control of the field sales channels, if a field sales channel does not cause the event, directly or indirectly. A force majeure event affects travel and a field agent's ability to meet with a consumer for a prescheduled marketing/sales event or appointment, which has the potential to affect a field agent and/or consumer's ability to submit an MA plan, PDP, or AARP Medicare Supplement Insurance plan enrollment application by the applicable Election Period deadline.

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

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

Withdrawal of Enrollment Application
Requests to withdraw an enrollment application occur prior to the effective date and prior to UnitedHealthcare submission of the enrollment data to CMS.

- You must handle withdrawal requests according to established processes which may include utilizing a change/withdrawal form.

Cancellation of Enrollment Application
A request to cancel an enrollment application occurs prior to the effective date, but after UnitedHealthcare has submitted the enrollment data to CMS. You must handle cancellation requests according to established processes.

Request to Disenroll
A voluntary disenrollment occurs after the effective date.

- A member may request disenrollment only during a valid election period.
- The member may disenroll by:
  - Enrolling in another plan (during a valid election period)
  - Providing a written (signed) notice to UnitedHealthcare
  - Calling 1-800-MEDICARE.
  - Completing an online disenrollment request via the consumer portal.
- If the member verbally request disenrollment, you must instruct the member to make the request in one of the ways described above.

Agent Assisted Health Assessment (HA) Process **(excludes standalone PDP, Medicare Supplement Insurance, and Standalone Dental, Vision, Hearing plans (Standalone Dental, Vision, Hearing plans are no longer sold as of October 1, 2025))**

You (includes internal and UnitedHealthcare vendor) may assist a consumer in completing a Health Assessment (HA) at the time of the sale. Direct to Consumer (DTC) Sales agents are not

eligible to receive compensation for completing an HA (refer to the Compensation section for HA payment program details).

You may only complete an HA for a consumer enrolling in a DSNP or CSNP.

General Guidelines

- The HA must not be completed prior to an enrollment or more than three calendar days after the consumer signature date on the enrollment application.
- You must not require or pressure a consumer to complete an HA.
- When completing an HA immediately after completing an enrollment application, the agent must make the consumer aware that the enrollment application is complete and the HA process is beginning.
- The agent must advise the consumer that answers provided for the HA do not impact the consumer's enrollment.
- HA completed telephonically (i.e. not in-home) are exempt from the in-home requirement to disclose at least two prescription drug safe disposal locations in the consumer's area.
- You must complete the enrollment application and the HA in JarvisEnroll.
- You must not share their log-on credentials with another individual.

Customer Service Resources

For customer service needs of the member, you should refer the member to the contact information on the back of their membership identification (ID) card as phone numbers and hours of service availability differ by plan.

Please see the listing of appropriate customer service phone numbers found in Knowledge Central.

Section 6: How am I Paid?

Compensation Overview

Compensation Overview

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

Incentive Eligibility Requirements

To be eligible for an incentive:

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

For an enrollment application to be eligible:

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

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

Incentive payments are calculated monthly, and, if earned, are processed for payment in your 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. The SIP participant should refer to their SIP for eligibility specifics.

UnitedHealthcare Government Programs Employee Agent

- The enrollment application is validated for eligibility.
- You are validated for eligibility. If you do not pass credential validation, the enrollment is not incentive-eligible.
- If the enrollment application and you are eligible, incentive payment is calculated based on information reported in the applicable Consumer Relationship Management (CRM) tool. Applicable CRM records are validated against membership data to determine if a Direct to Consumer (DTC) Sales agent is associated with a field lead appointment and a corresponding accreted enrollment application.
- The Sales Employee Incentive Compensation team will make available to you a monthly enrollment data report.
  - ~ You are responsible for reviewing your enrollment data report each month on a timely basis.

- ~ If you find a discrepancy, you must submit an adjustment request using the Agent Enrollment Tracker (AET) tool. Adjustment requests submitted after the deadline will be processed during the next incentive payment cycle.
- ~ The adjustment request is reviewed by the Sales Employee Incentive Compensation team and the requestor is notified of the request's approval or denial (with explanation).

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

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

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

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

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

Chargeback Calculation for Medicare Supplement Products
For employee Direct to Consumer (DTC) Sales agents, the AARP Connector Model Medicare Supplement Insurance incentives do not have chargebacks applied.

Health Assessment (HA) Payment Program (excludes standalone PDP and Medicare Supplement Insurance Products)
Direct to Consumer (DTC) Sales agents are not eligible for an HA payment for completing a qualifying HA.

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

Section 7: What are Expected Performance Standards?

Compliance and Ethics

Agent Performance Standards

Performance that may result in Immediate Termination

Monitoring Programs

Agent Complaint Process

Suspension of Agent Marketing and Sales Activities

Termination – Disciplinary Action

Termination – Due to Unqualified Sale

Termination Due to Quality

Termination Process

Request for Reconsideration

Compliance and Ethics

Code of Conduct
Our Code of Conduct provides essential guidelines that help us achieve the highest standards of ethical and compliant behavior. At UnitedHealthcare and UnitedHealth Group, we hold ourselves to the highest standards of personal and organizational integrity in our interactions with consumers, employees, contractors and other stakeholders, including the Centers for Medicare & Medicaid Services (CMS).

Act with integrity
- Recognize and address conflicts of interest.

Be Accountable
- Hold yourself accountable for your decisions and actions. Remember, we are all responsible for compliance.

Protect Privacy. Ensure Security
- Fulfill the privacy and security obligations of your job. When accessing or using protected information, take care of it!

Your Role and Responsibilities
- To fulfill your Compliance Responsibilities.

Stop. Think. Ask.
- Speak up about your concerns
- Address any mistakes, especially when a consumer may be effected
- Do the right thing – the first time and every time

If you encounter what you believe to be a potential Code of Conduct or policy violation, speak up! Speaking up is not only the right thing to do, it is required by Company policy.

UnitedHealth Group expressly prohibits retaliation against employees and agents who, in good faith, report or participate in the investigation of compliance concerns.

Compliance Reporting Resources
- Compliance Question compliance_questions@uhc.com
- Privacy & Security incidents psmg_privacy@uhc.com
- The UnitedHealth Group Compliance & Ethics HelpCenter 800-455-4521 or www.uhghelpcenter.ethicspoint.com (available 24 hours a day, 7 days a week.)

The complete Code of Conduct can be accessed on www.unitedhealthgroup.com > Corporate Governance.

Conflict-of-Interest

Individuals representing UnitedHealthcare (including but not limited to agents (including active, servicing, and solicitors), agency principals, contractors, employees, and sales leaders) must not engage in any activity that conflicts with, or gives the appearance of conflicting with, their responsibility to UnitedHealthcare or competes with, or gives the appearance of competing with

the interests of UnitedHealthcare or its consumer/members unless approved by management and in accordance with the Conflict of Interest policy.

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 Conflict
Most conflicts covered by this 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 with an Organization that Interacts with Medicare Beneficiaries

- An individual representing UnitedHealthcare has a direct or indirect ownership interest in AND/OR is an employee, contractor, or consultant of AND/OR holds a position of influence with an organization* that has any interaction with Medicare beneficiaries. * No conflict exists for non-employee agents when the organization is their insurance 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 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 Medicare insurance products. * Does not include employees in a sales role selling the product(s) they are authorized to sell.

Conflict-of-Interest Disclosure and Attestation 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.

Section 7: What are Expected Performance Standards?

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

- Individuals must complete the disclosure and attestation process in Sircon.
- Failure to complete the disclosure and attestation process by the due date or failing to disclose a conflict during the process may result in a 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 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 an outcome for each, which may include developing a management plan, requiring the individual to divest the conflict, or referring the individual for termination. Failing to agree to or comply with a management plan or failing to divest of a conflict may result in corrective and/or disciplinary action up to and including termination.

Privacy and Security Incidents
You are required to act in compliance with all of the Centers for Medicare & Medicaid Services (CMS) regulations and guidelines and other applicable federal and state laws.

UnitedHealthcare expects agents to act with the highest degree of ethics and integrity and in the best interest of its consumers and members.

UnitedHealthcare does not tolerate unethical behavior and our policies and procedures strictly prohibit activities that are not in the best interest of those we serve. Federal law requires Medicare plan sponsors to implement and maintain a Compliance Program that incorporates, measures to detect, prevent, and correct compliance related issues that include fraud, waste, and/or abuse.
The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides requirements for the protection of health information. There are two pertinent provisions that guide the use of member/consumer information:

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

Section 7: What are Expected Performance Standards?

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

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

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

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

- Incidents should be reported to one of the following:
  - The UnitedHealthcare Privacy Office at UHC_Privacy_Office@uhc.com
  - Your supervisor or manager
  - The Segment Compliance Officer/Compliance Lead
- The UnitedHealth Group Compliance & Ethics HelpCenter 800-455-4521 or www.uhghelpcenter.ethicspoint.com (available 24 hours a day, 7 days a week.)
- Security incidents (unauthorized access of UHG data/systems, laptop theft) must be ***immediately*** reported to the UHG Support Center at 888-848-3375 (24 hours a day, 7 days a week)
- UnitedHealthcare prohibits retaliatory action against any individual for raising concerns or questions regarding ethics and compliance matters or for reporting suspected violations in good faith.

Privacy and Security

You must protect the privacy and security of consumer/member Protected Health Information (PHI) and/or Personally Identifiable Information (PII) at all times. When conducting educational and/or marketing/sales activities and events, you must remember the safeguards below to ensure proper handling of PHI/ePHI/PII and maintenance of consumer privacy. Agents who fail to protect consumer/member PHI/ePHI/PII may be subject to financial responsibility for the payment of identity theft protection (e.g., LifeLock) for impacted members resulting from the loss of a device containing PHI/PII (e.g., laptop, mobile/smart phone, or other portable electronic device) and to corrective and/or disciplinary action up to and including termination.

Protected Health Information (PHI)

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

Section 7: What are Expected Performance Standards?

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

Personally Identifiable Information (PII)
PII is a person's first name or first initial and last name in combination with one or more of the following: Social Security Number, Driver's License number or other State or Federal issued ID, credit card number or debit card number, unique biometric data (e.g., fingerprint, retina or iris image, DNA profile), or Account Number, user name, unique identifier, phone number, or email address in combination with a password, one time password, access code, or security question and answers that would permit access to an online account.

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

Agents Must:

- Protect the privacy and security of consumer/member PHI/ePHI/PII at all times.
- Carry only the minimum amount of hard copy documents with consumer/member PHI or PII necessary to complete the day's activities.
- Keep documents containing PHI/PII with them at all times while on marketing/sales activities, placing document in a folder or locked briefcase.
- Keep documents in a secure locked area (e.g., file cabinet).
- Encrypt all laptops, computers, smart phones, mobile phones, or other portable electronic devices in a manner so PHI/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 secure-encrypted program.
- Use a fax cover sheet containing the HIPAA Privacy Statement when faxing PHI or PII.
- Include the HIPAA Privacy Statement when emailing PHI/ePHI/PII.
- Dispose of documents containing PHI/PII in a secure manner (e.g., cross-cut shred).
- Report suspected privacy incidents to UnitedHealthcare Privacy Office at uhc_privacy_office@uhc.com, UnitedHealthcare sales leader/leadership, Segment Compliance Lead, UnitedHealth Group Ethics & Compliance Help Center at 1-800-455-4521, or compliance_questions@uhc.com.

Agents must not:

- Leave hard copy documents unattended in an area where the documents could be viewed by others (e.g., desk, vehicle, table, or booth)
- Discuss consumer/member information in public spaces, including halls, elevators, lobbies, lunchrooms, cafeterias, restaurants, lavatories, parking lots or other unsecured public places where the conversation could be overheard. You must be cognizant of eavesdroppers and others who may appear to be interested in your business.
- Leave laptops and/or documents containing PHI/ePHI/PII unattended or unsecured outside the workplace (e.g., at home, at a hotel, while traveling, unattended in a vehicle).
- Share, store, or use consumer/member information inappropriately.

- 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) and enable a technical control to restrict use of such devices. Formally documented business justification is needed if portable storage is necessary to conduct business and the device must be enabled with a minimum of 256 bit encryption.
- Scan or store paper enrollment applications or business reply cards (BRC) electronically, except when employee agents use UnitedHealthcare approved applications/platforms (e.g., Blackberry Work or employee's home directory) or when appropriate encryption software is in place to ensure the protection of private data transmission.
- Throw hard copy documents containing PHI/PII in the garbage, unless they have been shredded.

Direct to Consumer (DTC) Sales Agents
In addition to the guidelines above, the following privacy and security guidelines apply:

Agents 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, commission/telephonic enrollment, in-home appointments, and community meetings.

Employee agents only
- May use an electronic method when tracking commission/telephonic enrollments, in-home appointments, and community meetings. 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).

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

Fraud is intentionally obtaining something of value through misrepresentation or concealment of facts. The complete definition of fraud has many components including:
- Intentional dishonest actions or misrepresentation of fact,
- Committed by a person or entity, and
- With knowledge the dishonest action of misrepresentation could result in an inappropriate gain or benefit.

This definition applies to all persons and all entities.
Waste and abuse are generally broader concepts than fraud. Waste includes inaccurate payments for services, such as unintentional duplicate payments, and can include inappropriate utilization and/or inefficient use of resources. Abuse describes practices that, either directly or

indirectly, result in unnecessary costs to health care benefit programs. This includes any practice that is not consistent with the goals of providing services that:

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

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

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

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

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

Ethics and Integrity

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

Merriam-Webster's Dictionary defines ethics as:

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

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

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

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

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

Disclosure

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

- You must inform consumers of the advantages, as well as, the limitations of the products you present
- Disclose all true out-of-pocket costs including, but not limited to, the fact that the consumer must keep paying their Medicare Part B premium
- Disclose the annual maximum out-of-pocket limit
- Take the time to answer the consumer's questions

Competency
- You have an obligation to fully comprehend the products you are selling
- Product comprehension protects against placing a consumer into a non-suitable product

Suitability
- You have an obligation to recommend a product that best meets the consumer's needs, goals, and financial resources
- Selling the right product, to the right consumer, at the right time should be your goal

You can report potential misconduct or policy violations to:
- Your Manager or Supervisor
- Compliance_Question@uhc.com
- The UnitedHealth Group Compliance & Ethics HelpCenter 800-455-4521 or www.uhghelpcenter.ethicspoint.com (available 24 hours a day, 7 days a week.)

UnitedHealthcare expressly prohibits retaliation against employees or contractors who, in good faith, report or participate in the investigation of compliance concerns.

Agent Performance Standards

UnitedHealthcare has developed performance standards and oversight programs to monitor agents and agencies that market and sell UnitedHealthcare Medicare and ensure all agents are conducting marketing, selling, and enrollment activities compliantly. Agents must adhere to all federal and state laws and regulations and Centers for Medicare & Medicaid Services (CMS) and UnitedHealthcare ethical and business standards, policies, procedures, and rules.

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

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

UnitedHealthcare Direct to Consumer (DTC) Sales Agent, DTC Sales Vendor, and Non-Licensed Representatives

Your Direct to Consumer (DTC) Sales management will manage and monitor your performance by:
- Ensuring you complete and pass all required training.
- Providing annual training to communicate company, product, and regulatory information.
- Ensuring that you have a fundamental understanding of UnitedHealthcare.
- Requiring that you participate in any remedial training assigned by UnitedHealthcare.

- DTC Sales agents authorized to sell UHC Senior Care Option and/or Massachusetts UHC One Care (HMO DSNP) plans will be monitored by their DTC sales leadership.

Employee Performance Management – UnitedHealthcare Direct to Consumer (DTC) Sales Employee Agents

It is your UnitedHealthcare DTC Sales manager's responsibility to manage and communicate the performance expectations for DTC Sales agents to you. Quality telephonic and digital interaction monitoring performance is evaluated monthly with an expectation of an average score of 90% or higher. The performance expectations apply to all active Direct to Consumer (DTC) sales agents and becomes effective upon individuals completing the new hire Supported Practical Application (SPA) phase.

Contact your Direct to Consumer (DTC) Sales supervisor/manager for additional questions.

Activities that may result in Immediate Termination

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

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

- Any occurrence of fraud, forgery, payments, inducements, deception, or coercion
- Creating a hostile work environment by employee agent
- Sale of a non-UnitedHealthcare product by an employee agent
- Sale of a UnitedHealthcare product when not appropriately licensed
- Violation of terms and conditions of Agent/Agency Agreement
- Gross violation of UnitedHealthcare policy and procedures or CMS regulations or guidelines
- Failure to divest or manage a conflict of interest as agreed upon by the Conflict of Interest Committee (see Conflict of Interest section)
- Any other applicable situations deemed appropriate by UnitedHealthcare

Monitoring Programs

UnitedHealthcare has implemented a variety of monitoring programs to ensure all agents are conducting sales, marketing, and enrollment activity in accordance with federal and state laws and regulations and UnitedHealthcare policies, procedures, and rules. Calculation methods and thresholds have been established for all compliance monitoring programs and are periodically reviewed. Deficient performance is categorized as Yellow (Complaint Monitoring only) or Red depending upon severity and patterns of performance. Monitoring programs reported within Power BI Sales Management Reporting Tool (SMRT) Agent Oversight include:

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

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

- Unqualified Sales
- Suspicious Sales

- Telephonic and Digital Interaction Monitoring Reporting
- Quality-Related Metrics
- Telephonic Sales Compliance Mystery Shopping

UnitedHealthcare reserves the authority to monitor additional issues and circumstances as deemed warranted. At its discretion, UnitedHealthcare may discontinue or suspend CR creation and required coaching requirements for monitoring programs. Agents (including solicitors) and up-lines must not interfere with any UnitedHealthcare-initiated monitoring program or efforts. Failure to meet or exceed monitoring program thresholds may result in corrective action and disciplinary action up to and including termination.

For questions regarding the compliance monitoring program and thresholds, contact your UnitedHealthcare sales leader.

Telephonic and Digital Interaction Monitoring
Telephonic and digital interaction monitoring program evaluates consumer and Telesales (Direct to Consumer (DTC) Sales, and DTC Sales vendor, and external call center partners) telephonic and digital interactions that resulted in an enrollment to ensure compliance with CMS guidelines for the following product types; Medicare Advantage (MA), Prescription Drug Plan (PDP), and/or Medicare Supplement.

Monitoring Methods
MA Plan and Prescription Drug Plan monitoring methods include:

- Voice Analytics Automated Dashboard and LivePerson Chat Dashboard to monitor adherence to CMS filed scripting, demographics, and medication/copay/provider conversations. Data from Automated Dashboard and LivePerson Chat Dashboard will be utilized to identify trends and additional coaching opportunities by site, supervisor and/or agent.
- Voice Analytics Member Experience Dashboard to monitor percent of conversations involving providers, medications, and additional benefits. This will be utilized to identify trends that require deep dive analysis to determine coaching opportunities by site, supervisor, and/or agent (DTC Sales internal only).
- MA Plan and PDP Accuracy Evaluation Form that captures required elements and other identified measures (DTC Sales vendor only).

Medicare Supplement Insurance Enrollment monitoring methods include:

- Medicare Supplement Insurance Accuracy Evaluation that captures required elements and other identified measures.
- Accuracy Evaluations will be randomly selected and completed by a UnitedHealthcare Quality Analyst (QA).

Telephonic Interaction Selection Process for Accuracy Evaluations
Telephonic recordings are randomly selected by TRIO/QAT to evaluate according to criteria established to ensure an adequate sample based on completed enrollment applications and previous agent compliance evaluation outcomes. For these types of evaluations, agents receive a weighted score. A score of 96% or higher (with no rounding) on an accuracy evaluation is considered passing. The following guidelines are used to determine the number of telephonic enrollment conversations that will be evaluated by a QA during a specified time period by agent type. When the minimum number of evaluations cannot be completed, a pro-rated number of

evaluations will be completed. The minimum number of evaluations on top-performing DTC Sales agents (e.g., agents that have historical quality telephonic interaction evaluation scores of 100%) may be reduced in order to redirect focus, support, and resources on new DTC Sales agents.

DTC Sales Agent:
Monthly Medicare Supplement accuracy evaluation goals are based on a statistically valid sample size of telephonic enrollments completed by DTC Sales Agents.

DTC Sales Vendor Telesales Agent:
Accuracy evaluation goals are based on a statistically valid sample size, requiring the DTC Sales Vendor Quality Teams to complete these evaluations on 66% of the weekly average number of agents each vendor is required to have (a.k.a. Agent Requirements) each month.

Evaluation Elements
Automated Dashboard Evaluation Elements - Voice Analytics software will monitor all internal and vendor telephonic enrollment conversations to ensure the DTC Sales agent cover the following elements.

- MA plan and PDP
  - ~ HIPAA
  - ~ Ask for Telephone number
  - ~ Ask for email
  - ~ Conversation about medications
  - ~ Plan Stages Verbiage
  - ~ Conversation about providers
  - ~ Conversation about copays
  - ~ Understand Benefits
  - ~ Consent to Call
  - ~ Who will complete enrollment
  - ~ Permission to text
  - ~ Language/plan materials
  - ~ Plan name and effective date
  - ~ Not a Rider
  - ~ Confirmation of enrollment of rider
  - ~ Not a Medicare Supplement Plan
  - ~ Plan specific disclaimers
  - ~ Other insurance disclaimers
  - ~ Chronic Special Needs Plan (CSNP) (if applicable)
  - ~ Premium in addition to Part B Premium
  - ~ Late Enrollment Penalty (LEP)/Income-Related Monthly Adjustment Amount (IRMAA)
  - ~ Payment Options
  - ~ Signature Statements
  - ~ Customer Service Information

- MA plan and PDP Accuracy Evaluation Elements – The VQA will evaluate the telephonic enrollment conversation on a Qfiniti Form to ensure the agent covers the following elements with the consumer:
  - ~ Provider of Choice (offer to lookup and/or provide accurate information if looking up)

- ~ Copay/Coinsurance and Referral
- ~ Medical Deductible Information
- ~ Prescription Coverage
- ~ Pharmacy and Medications of Choice (offer to lookup and/or provide accurate information if looking up)
- ~ Utilization Management Restrictions (if applicable)
- ~ Additional Benefits
- ~ Premium Amount Disclaimer
- ~ Enrollment Processes
- ~ Customer Experience

- Medicare Supplement Evaluation Form – The QA will evaluate the telephonic enrollment conversation in Qfiniti to ensure the Direct to Consumer (DTC) Sales agent covers the following elements:
  - ~ HIPAA
  - ~ Demographics
  - ~ Rate Quote & Disclaimer
  - ~ AARP Membership
  - ~ Plan Benefits
  - ~ Ancillary Benefits
  - ~ Authorized Representative/Witness Process
  - ~ Plan name and effective date
  - ~ Enrollment Process
  - ~ Enrollment type (Scope)
  - ~ Required scripting and disclaimers
  - ~ Consumer Experience

- LivePerson Chat Agent Compliance Tracking Dashboard – Chat interaction software that will monitor all internal digital enrollment interactions to ensure the DTC Sales agent covers the following elements:
  - ~ HIPAA
  - ~ Phone Number
  - ~ Conversation Covering Provider Lookup
  - ~ Conversation Covering Prescription Copays
  - ~ Addressing the Consumer's Questions and Concerns
  - ~ Consumer Experience

<u>DTC Sales UnitedHealthcare Agent and DTC Sales Vendor Agent Scores</u>

- An Accuracy Evaluation or Medicare Supplement Evaluation – A Quality Telephonic or digital Interaction Monitor score is determined by a weighted measurement system in Qfiniti and is based on selections made by the QRS.
- A score is communicated via auto-generated email from TRIO/QAT directly to your supervisor within 24 business hours from when the quality telephonic or digital interaction monitoring occurred. A score less than 96% is considered a failed evaluation and prompts immediate DTC Sales agent or DTC Sales Vendor agent coaching by your supervisor to take place within 24 hours of any areas of opportunity demonstrated in a Quality Telephonic or digital Interaction Monitor evaluation. This can include, but is not limited to, focused monitoring, side by sides, coaching sessions, additional evaluations, and one-on-

ones. Additionally, for multiple failed evaluations related to a compliance issue, the DTC Sales or DTC Sales Vendor management team will meet with you to determine the appropriate disciplinary action, which may include additional quality monitoring, performance, or corrective action plans.
- During increased seasonal volume (i.e. AEP), immediate coaching of a failed evaluation by your supervisor may occur prior to the CR being generated. Therefore, to accommodate the time lag, Sales Oversight provides the completed attestations directly to you with a copy to your site manager/agent supervisor, which will prompt the closing of the outstanding CR.
- Digital Chat Scoring – anything less than 96% on a digital chat evaluation is considered a fail.

Documentation

A QRS will evaluate and score the telephonic or digital interaction on the evaluation form from Qfiniti. As part of this MA/PDP Accuracy Evaluation or Medicare Supplement Evaluation, the QRS will document a strength(s) demonstrated by a Direct to Consumer (DTC) Sales agent during the call and identify an area(s) of opportunity.

DTC Sales and DTC Vendor Communication Process

- MA and PDP Evaluations – You and your supervisor will listen to the recording, review the evaluation, and if needed, request clarification. Your supervisor will coach you on the scorecard detail error. You will either agree with or refute the results. If you disagree with the results, you will initiate an internal escalation.
- Medicare Supplement – The evaluation will be emailed to the vendor quality manager and coordinator upon completion.

DTC Sales and DTC Vendor Escalation Process

A DTC Sales or DTC Sales Vendor agent can listen to the recorded interaction and comment on an MA/PDP or Medicare Supplement accuracy evaluation. Agents have three business days to escalate, with allowances up to 30 days. If the agent's supervisor and site director agree, the supervisor will complete the intake form on the Quality Review Escalation SharePoint, explaining why the error(s) should be overturned. The UnitedHealthcare Quality Team will review the escalation. If the score changes, the new score is entered into Qfiniti. Whether the score is overturned or upheld, the individual who submitted the original intake will be notified of the decision via email. This process does not apply to calls scored by the XM Discover automated quality dashboard.

Cancelled Enrollment Applications

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

Complaints

The complaint investigation outcome or process to which you are referred (e.g., CEC, CAR, DAC) determines the threshold reported in Power BI SMRT Agent Oversight (see the Agent Complaint Process section for details). If you are assigned a CEC or CEC2, you must participate in assigned outreach and complete all assigned coaching. If you are referred to the CAR process, you must participate in assigned outreach and successfully complete the assigned sales remediation training course(s) and corresponding assessment, with a minimum

score of 80% within six attempts, by the indicated due date. Additional outreach is conducted based on accumulated complaint points.

Your Responsibilities

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

Late Enrollment Applications

Late Enrollment Applications monitors the timely submission of enrollment applications.

Rapid Disenrollment

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

Unqualified Sales and Corrective/Disciplinary Action

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

- For the first two instances of an unqualified sale in a rolling 12-month period, you will be assigned a CAR and two complaint points.
- You will be terminated not-for-cause when a third unqualified sale is validated within a rolling 12-month period subsequent to completed corrective actions for the first two instances on the same type of unqualified sale. (Refer to the Termination Process section for termination details.)

Suspicious Sales Monitoring

Two reports are used to monitor enrollment activity that is potentially fraudulent. The suspicious agent report looks for enrollment trends based on an agent's activities over time. The deceased enrollee report compares enrollment application receipt date to the consumer's reported death date. Potential incidents of suspected agent fraud are analyzed and forwarded for investigation as appropriate.

Quality-Related Metrics Monitoring

UnitedHealthcare may monitor and use quality-related metrics to assess agent/agency performance and recommend the agent/agency for termination when applicable.

- Agents (including solicitors) will be terminated if they have 10 or more CTMs and a ratio of 10 CTMs per 1000 applications or higher within a rolling 12-month period.
- Agents (including solicitors) and agencies may be submitted for review and potential termination if their up-line identifies and reports quality concerns to UnitedHealthcare or based on other factors deemed material by UnitedHealthcare.
- Agencies may be submitted for review and potential termination based on overall compliance performance, including, but not limited to CTM rate per 1000 applications and other criteria at UnitedHealthcare's discretion.

Agent Complaint Process

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

Sources of Complaints

Complaints and allegations of misconduct can originate from both internal and external sources. All complaints against agents must be forwarded to the Agent Issue Management (AIM) team via the agent issue management tool within 5 business days or 7 calendar days (whichever occurs first) of initial receipt.

Sources of Complaints and Allegations of Misconduct:

- Internal sources include, but are not limited to, UnitedHealthcare Government Programs, Appeals and Grievances, Sales and Marketing, Service Integrity and Member Support, Provider Services, Care Coordination, Producer Help Desk (PHD), UnitedHealth Group Ethics and Compliance (Ethics Point), and other UnitedHealth Group lines of business.
- External sources include, but are not limited to, the Centers for Medicare & Medicaid Services (CMS), state Departments of Insurance (DOI) or Departments of Health or Public Welfare, state Attorneys General, providers, state or federal law enforcement, and other state or federal regulatory agencies.

Initial Review and Pre-Disposition

Review Process

The AIM team will complete the entry of each complaint as needed into the agent issue management tool and a case number is assigned. Each complaint is reviewed to validate that it is within the scope of the agent complaint process.

- A complaint is closed and the case documented accordingly if any of the following conditions exist:
  - No UnitedHealthcare sales agent is involved in the complaint
  - The product identified in the complaint is not a UnitedHealthcare product
  - The issue in question is not a violation of UnitedHealthcare policies, CMS guidelines, or federal or state rules or laws
  - The basis for the complaint is due to an internal business operational issue and submitted through the agent issue management tool
- If the complaint is in scope of the agent complaint process, it moves to the pre-disposition stage

Pre-Disposition

The AIM team reviews each complaint using the Complaint Education Contact (CEC) – CEC 2 – Corrective Action Referral (CAR) – Disciplinary Action Committee (DAC) Referral Criteria Grid to determine if the complaint is referred to the CEC process or Agent Broker Investigations (ABI) process for investigation and in some circumstances, directly referred to the Corrective Action Referral (CAR) process. The status of the complaint is updated in the agent issue management tool.

Complaint Education Contact Process

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

- The AIM team uses the applicable Referral Criteria Grid to determine appropriate outreach.
- If you are an active agent, the AIM team creates a Coaching Request (CR) in the Producer Contact Log (PCL) and assigns it to your UnitedHealthcare sales leader/supervisor.
- If you are an inactive agent, a CR is not created. The AIM team updates the complaint status in the agent issue management tool and notifies ALM to flag you Review Before Contracting (RBC), which serves as an alert in the event you attempt to re-contract. When you re-contract and become active, any outstanding coaching must be completed prior to conducting any marketing/selling activities.

Agent Complaint Investigation Process

Agent Broker Investigations (ABI) is responsible for the investigation of complaints involving agents who market and sell UnitedHealthcare products. Complaints referred to 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. ABI will forward the suspension recommendation to the Director or Agent Issue Management.

Initial Review and Assignment of Case

Upon receipt of a complaint referral from the AIM team, 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 UnitedHealthcare sales management hierarchy. The RAR requests that you provide specific detailed responses to each allegation as well as other pertinent questions, facts, and circumstances. You must submit your own RAR statements with an Agent Attestation of Signature. A written response to the RAR is required within five business days. If a response is not received by the date requested, you, along with your UnitedHealthcare sales management hierarchy, are sent a Non-Response Letter (NRL) stating that a response must be received within two business days. If no response is received within the prescribed timeframe, an administrative termination is initiated.
- Members or their authorized representatives may be interviewed during an investigation to gather required details regarding the complaint or to confirm identity of the agent and/or other pertinent facts. All contact with members is made in accordance with CMS guidance.
- The investigator may also conduct a telephone interview with you. These interviews may occur prior to or as a follow-up to the RAR or NRL when the investigator needs more information or clarification of details.

- Interviews of other witnesses relevant to the investigation are also conducted as determined appropriate.
- System research is conducted to obtain information regarding claims, customer service notes, lead generation, and other details as determined in reviewing the case (ABI investigator and 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, CMS Medicare Communications and Marketing Guidelines (MCMGs), UnitedHealthcare policies, procedures, and rules, or other authority, a reasonable person would conclude that the allegation is true.
- Unsubstantiated: Based on the evidence and facts that existed at the time the investigation was conducted and applicable federal and state laws and regulations, MCMGs, UnitedHealthcare policies, procedures, and rules, or other authority, a reasonable person would conclude that the allegation is unfounded. Inconclusive: There was insufficient evidence, facts, or corroborating evidence that existed at the time the investigation was conducted that would lead a reasonable person to conclude the allegation is neither substantiated nor unsubstantiated.
- Insufficient Information: The complaint lacked the minimum amount of information necessary to determine the identity of the agent, member, or other information necessary to conduct a complex investigation.
- No Allegation: The complaint is determined not to have been a complaint against the agent for sales or marketing misconduct in accordance with federal and state laws and regulations, MCMGs and UnitedHealthcare policies, procedures, and rules.
- Non-Response: You failed to respond within the required timeframes to the RAR and NRL.

Refer for Disposition
Upon completion of the investigation, the Investigative Report, Investigative Findings, and Allegation Outcomes are generally documented in the agent issue management tool. The case is updated as 'Refer for Disposition' in the tracking tool and is referred back to the AIM team. Supporting documentation, including exhibits, are provided to the AIM team within the tracking tool. Effective 05/05/2021, 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 issue management tool:

- The allegation outcome is Insufficient Information, No Allegation, or Unsubstantiated. If the investigation results in unsubstantiated outcomes for all allegations, the Agent Closure

Letter is emailed to you, thanking you for your cooperation and notifying you of the investigative results.
- The allegation outcome is Inconclusive or Substantiated, you have received outreach for the same allegation or the same allegation family within the past twelve months, and the event/enrollment application for the current allegation took place before the outreach occurred.

Referral to the Corrective Action Referral Process
For allegation outcomes of Inconclusive or Substantiated, the AIM team uses the CEC-CEC 2-CAR-DAC Referral Criteria Grid to determine if a referral to the Corrective Action Referral (CAR) process is appropriate. The following situations result in a CAR process referral:
- You **have not** had outreach for the same allegation(s) within the past twelve months and the CEC-CEC 2-CAR-DAC Referral Criteria Grid recommends referral to the CAR process.
- You have exhausted all CEC/CEC2 opportunities for the same allegation family (-ies) within the past twelve months and the event/enrollment application for the current allegation took place after those previous CEC/CEC 2 outreaches occurred.

Referral to the Disciplinary Action Committee
For allegation outcomes of Inconclusive or Substantiated, the AIM team will use the CEC-CEC 2-CAR-DAC Referral Criteria Grid to determine if a referral to the Disciplinary Action Committee (DAC) is appropriate. The following situations result in a DAC referral:
- You **have not** had outreach for the same allegation(s) in the past twelve-months and the CEC-CEC 2-CAR-DAC Referral Criteria Grid recommends referral to the DAC.
- You have had outreach for a non-CEC eligible allegation (i.e. high-risk) through either the CAR or DAC process within the past twelve months and the event/enrollment application for the current allegation took place after that previous CAR or DAC outreach occurred.
- You have had repeated instances of lower severity complaints.
- Your behavior poses a continuing risk to company reputation or harm to members.
- You have been terminated for cause from another UnitedHealth Group line of business (e.g., Employer and Individual (E&I)).

Corrective Action Referral Process
The Corrective Action Referral (CAR) process supports the progressive disciplinary process and is a proactive measure intended to address egregious agent behavior. The retraining efforts through the CAR process are delivered in a prompt manner intending to correct the underlying problem that resulted in program violation and to prevent future noncompliance. The following steps are taken when a referral is made to the CAR process:
- If you are an active agent, the AIM team creates a Coaching Request (CR) in PCL and assigns it to the appropriate UnitedHealthcare sales leader/supervisor and submits a request to certification operations to assign the applicable sales remediation module(s) to you.
- If you are an inactive agent, a CR is not created. The AIM team updates the complaint status in the agent issue management tool and notifies ALM to flag you RBC, which serves as an alert in the event you attempt to re-contract. When you re-contract and becomes active, any outstanding coaching must be completed prior to conducting any marketing/selling activities.

Section 7: What are Expected Performance Standards?

Disciplinary Action Committee
The Disciplinary Action Committee (DAC) is responsible for determining appropriate disciplinary and/or corrective action up to and including agent termination.

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

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

DAC Outcomes
The following outcomes are available to the DAC:
- No Action Required
  - The DAC determines you do not require additional training to address the issue presented.
- Corrective Action
  - The DAC recommends appropriate corrective action tailored to address the complaint or issue of noncompliance and timelines for completion. In such cases, the AIM team opens a Coaching Request in PCL, in addition to drafting and sending a formal corrective action letter that is sent to you and your manager/supervisor notifying the appropriate manager to facilitate appropriate outreach and training to you or the agency if the issue is best addressed at the agency level.
- Deauthorization of Sales and Marketing Activity
  - The DAC deauthorizes you from performing sales and marketing activity of a particular product until assigned corrective action is completed. The DAC chairperson is responsible for notifying your manager of the deauthorization and required training. Your manager is responsible for monitoring the completion of the assigned training.
- Termination
  - The DAC recommends the termination of an employee agent. In addition to the decision to terminate you, the DAC must determine if the termination is for-cause or not-for-cause. ALM is notified to flag you RBC. (Refer to the Agent Termination Process section for termination process details.)

Complaint point System
Points will be assessed to actionable complaints (i.e. Inconclusive or Substantiated outcomes) based on the outcome of the complaint with point accumulation over a rolling 12 months. A CEC or CEC2 is accessed 1 point, a CAR 2 points, and a DAC with actionable outcomes 3 points. Effective 06/01/2021, complaint points will not be assigned to CAR cases that meet eligibility criteria. An agent will receive training/outreach or escalated disciplinary action when their accumulated points meet or exceed a threshold.

Coaching Request Extension Process
Under certain circumstances, a UnitedHealthcare sales leader may request from AIM an extension to the required CR completion date. Contact your UnitedHealthcare sales leader for process details.

Suspension of Agent Marketing/Sales Activities

At any time should UnitedHealthcare believe your performance or actions pose a potential threat to consumers/members, threaten or damage the reputation of UnitedHealthcare, or do not meet company and compliance standards, UnitedHealthcare can initiate the suspension of your ability to market and sell UnitedHealthcare products.

- If a determination to suspend your ability to market or sell is made, you will receive a suspension notification letter. The suspension letter will be sent via email to you with a copy sent to your UnitedHealthcare manager/supervisor.
- The suspension is effective immediately as of the date of the letter of notice and shall continue until the investigation is complete and a final disciplinary recommendation has been made and completed or as indicated in the notification letter.
- You are not to market or sell UnitedHealthcare products while on a suspension status.
- New business written during the suspension period will not be eligible for commission. UnitedHealthcare reserves the right to hold any or all Sales Incentive Plan (SIP) payments, while on suspension status.
- Contact your UnitedHealthcare sales leadership for additional details regarding a suspension of marketing and sales activities.

Termination – Disciplinary Action

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

Termination – Due to Unqualified Sale

An unqualified sale is a sale by an agent who, at the time the enrollment application was written, was not appropriately licensed and/or appointed (as required by state) and/or certified (refer to the Certification Requirements section for details).

- An unqualified sale does not necessarily affect the member's enrollment in the plan, but the member may request to make a plan change.
- UnitedHealthcare will not pay an incentive on any enrollment application determined to be an unqualified sale.
- Termination due to Certification or Appointment Issue or License Issue
  You will be terminated not-for-cause when a third unqualified sale is validated within a rolling 12-month period subsequent to completed corrective action for the first two instances on the same type of unqualified sale. (See the Termination Process section.)

- You may submit an appeal during the termination notification period (typically 30 days or based on the terms of your agent agreement) by providing documentation that includes proof of an active license, state appointment, and/or product certification at the time of sale.
- You must wait a minimum of 12 months from the date of the unqualified sale that initiated the termination process before you can seek to re-contract.
- You may request a reconsideration of a termination.

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

Termination Due to Quality

UnitedHealthcare may, at its discretion, initiate a not-for-cause termination of any agent/agency operating within a non-employee distribution channel (e.g., EDC/eAlliance, ICA/IMO, and Direct to UnitedHealthcare) for quality-related issues. Termination may be based on quality-related metrics, such as the volume/ratio of Complaints to Medicare (CTMs) within a rolling 12-month period, issues reported to UnitedHealthcare by the upline of an agent/agency identifying quality concerns, or other factors deemed material by UnitedHealthcare. (Refer to the Compliance and Quality Assurance section for details.)

Discretionary Termination without Cause

Agents, agencies, and solicitors may be terminated at will and without cause at the discretion of UnitedHealthcare sales management. Agent/agency termination will be effective upon 30-days written notice and solicitor termination will be effective immediately upon written notice. (See the Not-for-Cause Termination Process section.)

Termination Process

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

Not-for-Cause Termination

A not-for-cause termination may be recommended for you by UnitedHealthcare or requested for any reason by an agent. For solicitors, the termination may be effective immediately upon written notification. Depending on the reason for termination, you may be flagged Review Before Contracting (RBC) in the contracting system.

For-Cause Termination

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

Termination Process

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

- If the DAC makes a recommendation to terminate 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 through MyHR, unless required by state law, in which case agent notification is automatic. You will be flagged RBC in the contracting system.
- A written notification of appointment termination will be sent to you when the appointment is terminated for-cause.
- ALM processes the employee not-for-cause or for-cause appointment termination and appropriate state Department(s) of Insurance (DOI) notification. (See the State and CMS Notification Process section).
- UnitedHealthcare reserves the right to suspend you from marketing and sales activities until the termination becomes effective.
- You may request a reconsideration of termination. (See Agent Request for Reconsideration section).

Non-employee (Vendor Direct to Consumer (DTC) Sales)

- For-Cause Termination Process
  - ~ DAC-initiated for-cause termination notification is sent by the AIM team to your vendor.
  - ~ Contact your manager/supervisor for additional details.
- Not-for-Cause Termination Process
  - ~ UnitedHealthcare-initiated termination notification is sent to your vendor.
  - ~ DAC-initiated not-for-cause termination notification is sent by the AIM team to your vendor.
  - ~ Vendor-initiated termination notification of the agent is submitted in TRIO.
  - ~ Contact your manager/supervisor for additional details.
- Transfer from Direct to Consumer (DTC) Sales to UnitedHealthcare Service role (temporary)
  - ~ Vendor submits your transfer information in TRIO.
  - ~ Contact your manager/supervisor for additional details.

Non-Employee Non-Licensed Representatives

- For-Cause Termination Process
  - ~ DAC initiated for-cause termination notification is sent by the AIM team to the vendor.
  - ~ Contact your manager/supervisor for additional details.
- Not-for-Cause Termination Process
  - ~ UnitedHealthcare-initiated termination notification is sent to the vendor and the vendor submits the representative's termination information in TRIO.
  - ~ DAC-initiated termination notification is sent to the vendor by the AIM team. The vendor submits the representative's termination information in TRIO.
  - ~ Vendor-initiated termination notification of the representative is submitted in TRIO.
  - ~ Contact your manager/supervisor for additional details.

Employee Non-Licensed Representative

When your writing number is deactivated (i.e. you cannot perform the duties of a non-licensed representative) it may necessitate a termination of your employment as well. Therefore, when

deactivated a representative's writing number is under consideration, the following steps must be followed:

- If the DAC makes a recommendation to deactivate an employee representative's writing number or recommends termination, the representative's UnitedHealthcare management must consult with Human Capital. Human Capital will confer with your UnitedHealthcare management to discuss the next steps.
- You will be sent a notification of the deactivation of writing number. If you are terminated for-cause, you will be sent a notification and will be flagged RBC in the contracting system.
- ALM will process the deactivation of your writing number.
- You may request a reconsideration of the deactivation of your writing number if employment is terminated. (See the Agent Request for Reconsideration – Employee Agents section).

State and CMS Notification Process

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

- Contact your UnitedHealthcare sales leader/supervisor for additional details.

Request for Reconsideration

Agent Request for Reconsideration - Employee Agent

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

Section 8: Glossary of Terms

Glossary of Terms

This glossary is not a complete glossary of terms and should not be copied, used for other documents, distributed and/or reproduced. The entire glossary was updated on 04/01/2024.

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

Section 8: Glossary of Terms

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

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

Section 8: Glossary of Terms

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

Channel (EDC)	contracted entities, agencies, agents, and solicitors (there is no contractual relationship between a solicitor and UnitedHealthcare). EDC entities, agencies, agents, and solicitors are not employees of UnitedHealth Group and are not captive to UnitedHealthcare.
External Vendor Certification Courses	Third-party certification programs (e.g., America's Health Insurance Plans (AHIP) and National Association of Benefits and Insurance Professionals (NABIP)) that satisfies the requirement for UnitedHealthcare Medicare Basics Assessment.
F	
Fast Track Assessment	Part of the UnitedHealthcare certification program that upon successful completion certifies an agent to market/sell MA plan, PDP, Medicare Supplement Insurance plan, Standalone Dental, Vision, Hearing plan (Standalone Dental, Vision, Hearing plans are no longer sold as of October 1, 2025), DSNP, CSNP, and report and conduct events
Field Agent	A global term referring to any licensed, appointed (as required by the state), contracted (as applicable), and certified agent that market/sell UnitedHealthcare products that is not in a call center environment.
Field Marketing Organization (FMO)	An entity that is contracted with UnitedHealthcare to market and sell UnitedHealthcare insurance products through its hierarchy of downline contracted agents and solicitors. Not the highest contract level in the EDC hierarchy structure.
Field-Based Channel	A global term to describe agents/agencies that market and/or sell UnitedHealthcare products not in a call center environment. Consists of EDC and IMO/ICAs.
First Tier, Downstream, or Related Entities (FDRs)	First Tier entity means any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program. Downstream entity means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. Related entity means any entity that is related to the MA organization by common ownership or control and (1) Performs some of the MA organization's management functions under contract or delegation; (2) Furnishes services to Medicare enrollees under an oral or written agreement; or (3) Leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.
First Year Commissions	The compensation given to an agent for the first-year a member is enrolled in a UnitedHealthcare plan. A plan year ends on December 31 regardless of the effective date of the enrollment and the first year may not mean the first 12 months.

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

Section 8: Glossary of Terms

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

LeaderNav	An intranet-based site used to communicate with UnitedHealthcare Sales Leaders.
Learning Lab	The training platform where individuals access certifications and other learning and development resources.
Level, Alignment, or Channel Change	Requests to change contract level, hierarchy, or channel with UnitedHealthcare.
Licensed	An individual that has a license granted by a governmental entity authorizing them to act as an agent and sell insurance products within that state.
LivePerson	The agent console that allows DTC Sales agents to conduct co-browse live screen sharing sessions.
M	
Master General Agency (MGA)	An entity that is contracted with UnitedHealthcare to market and sell UnitedHealthcare insurance products through its hierarchy of downline contracted agents and solicitors. Not the highest contract level in the EDC hierarchy structure.
Medicare Advantage (MA) Plan	Plans offered by private insurance companies that contract with the federal government to provide Medicare coverage. Medicare Advantage Plans may be available both with and without Medicare Part D prescription drug benefits.
Medicare Beneficiary	An individual who is entitled to Medicare Part A and eligible for Medicare Part B. Also referred to as consumer or member.
Medicare Made Clear (MMC)	A communication material produced by UnitedHealthcare that provides general information on the Medicare program.
Medicare Supplement Insurance Plan	Medicare Supplement insurance sold by private health insurance companies to help pay some of the out-of-pocket costs for services covered by Original Medicare, like copayments, coinsurance, and deductibles. Also referred to as "Medigap".
Member Retention Activities	A term used as part of UnitedHealthcare Book of Business to describe activities conducted in an effort to keep the member enrolled in their UnitedHealthcare plan.
Migration	A term used in the DTC Sales channel to describe a proactive outreach campaign to Medicare and Retirement members to inform them of products in their county that provide both medical and prescription drug coverage.
MIRA	A program that allows the creation and storing of a consumer contact record and schedule marketing/sales appointments and/or events.
Multi-Carrier Agent	An agent that is contracted to market/sell UnitedHealthcare plans and plans offered by other carriers.
Multi-Carrier Enrollment Tool	An online enrollment tool that may be used to initiate an enrollment into an MA plan or PDP. Prior to making UnitedHealthcare plans available via the multi-carrier tool, the NMA request must be approved by UnitedHealthcare and submitted to CMS.
Multi-Carrier Pre-Assessment Form	A form that must be completed as part of the application process for an eAlliance agreement or Telephonic Enrollment Capability Addendum.
Multi-Carrier Program	A program that allows participating agents to conduct informal marketing/sales events at Walmart in-store kiosks.

Section 8: Glossary of Terms

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

Section 8: Glossary of Terms

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

Producer Contact Log (PCL)	A system used to document agent/agency interaction with the PHD, UnitedHealthcare Sales Leadership, or UnitedHealthcare Agent Coaching and Policy Specialist (ACPS).
Producer Help Desk (PHD)	UnitedHealthcare contact center that provides support pertaining to the agent experience.
Q	
Quantity Limits	A limit on the quantity of a drug a member can receive at a time. Quantity limits may be set by the Plan and/or Medicare.
R	
Rapid Disenrollment	When a member voluntarily disenrolls from a MA plan or PDP within three months of the effective date.
Relationship Hierarchy Addendum (RHA)	Part of the contracting packet that documents the hierarchy structure for the applicable agent/agency.
Renewal Income	The compensation given to an agent for any year following the initial year enrollment the member remains in the same plan or a different plan that is a like plan type.
Renewal Year	All years following the initial enrollment year the member remains in the same plan or in different plan that is a like plan type as determined by CMS.
Rider	Additional coverage for specific medical benefits that may be available for consumers enrolling in an MA plan for an additional monthly premium.
S	
Sales Activity	A term to describe the activities conducted by an agent in an attempt to enroll a consumer into a UnitedHealthcare Medicare plan.
Sales Communication Team	The team that manages and distributes sales related communications to agents/agencies and UnitedHealthcare sales management.
Sales Incentive Plan (SIP)	The agreement that documents the requirements, sales goals, and conditions a UnitedHealthcare employees must meet in order to be paid an incentive.
Sales Management Personnel	A global term used to describe the UnitedHealthcare leadership hierarchy.
Senior Community Care Sales Field Agent	Employee field sales agents that are part of the Optum Sales hierarchy that market/sell only I-SNP/IE-SNP.
Senior National Marketing Alliance (SNMA)	An entity that is contracted with UnitedHealthcare to market and sell UnitedHealthcare insurance products through its hierarchy of downline contracted agents and solicitors. Can be the highest contract level in the EDC hierarchy structure.
Service Area	The geographic area approved by CMS within which an eligible consumer may enroll in a certain plan.
Service Request	The documentation in PCL of all contacts between the PHD and an agent.
Servicing Status	The UnitedHealthcare program where contracted non-employee agents terminated not-for-cause may enter into a servicing agreement in order to receive renewal commissions for MA plans and PDPs.

Solicitor	A licensed, certified, and appointed (as required by the state) agent who markets and sells UnitedHealthcare products through a contract with an EDC agency or eAlliance. There is no contractual relationship between the solicitor and UnitedHealthcare.
Special Supplemental Benefits for the Chronically Ill (SSBCI)	Supplemental benefits that are not primarily health related that may be offered by MA plans to chronically ill consumers. The benefits are not available in all plans and eligibility requirements apply.
Star Rating	ratings that are calculated annually by CMS to rate the quality and performance of a MA plan and PDP on a scale of 1 to 5, with 5 being the highest rating. Star Ratings are published annually in October.
Static URL	A term to describe a website URL that does not change.
Step Therapy	When a plan may require a member to try a lower-cost alternate drug that treats the same health condition before covering the requested drug.
Strategic Marketing Organization (SMO)	An entity that is contracted with UnitedHealthcare to market and sell UnitedHealthcare insurance products through its hierarchy of downline contracted agents and solicitors. May be the highest contract level in the EDC hierarchy structure or align under an NMA.
Sub-Contracted	A third-party organization sub-contracted to provide services to UnitedHealthcare or an entity contracted with UnitedHealthcare.
Successor Agent	The active agent who becomes the Agent of Record (AOR) for the original agent's book of business.
Successor Program	The UnitedHealthcare program where contracted non-employee agents may request UnitedHealthcare transfer their entire UnitedHealthcare book of business to a successor agent, who agrees to accept and service the original agent's book of business and oversee down-line agents, where applicable.
T	
Telephonic Addendum (TA)	An addendum to an entity's contract that permits them to operate a call center to market and sell UnitedHealthcare insurance products.
Telephonic Enrollment	Enrollment requests that are completed telephonically and are only allowed to by authorized telesales call centers (e.g., UnitedHealthcare call center, a contracted vendor call center, contracted eAlliance, or Telephonic Addendum entity)
Telephonic Enrollment Script	A script to complete a telephonic enrollment that must contain all required elements and must be submitted and approved by CMS.
Third-Party Marketing Organization (TPMO)	Any organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA plan or plans to making an enrollment decision). All entities and individuals contracted directly with UnitedHealthcare are considered first tier, downstream or related entities (FDRs) and, therefore, TPMOs. TPMOs also include any entity contracted or subcontracted by an FDR that provides services to UnitedHealthcare or UnitedHealthcare's FDR, including solicitors.

Section 8: Glossary of Terms

UnitedHealthcare Agent Toolkit	The platform that provides access to UnitedHealthcare approved materials and assets.
U	
UHC For OneCare	A Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) offered in Massachusetts. The plan combines all the benefits and coverage of Original Medicare and MassHealth under one plan
UnitedHealthcare Book of Business (BoB)	A collection of member information assigned to a particular agent/agency that is maintained by UnitedHealthcare.
Up-Line	The contracted entities within the External Channel hierarchy that are above a specific agent/agency.
W	
Writing Number	A UnitedHealthcare generated number assigned to a contracted, licensed, and appointed agent used for submitting business, to track commissions, and other agent-specific sales statistics.
X	
XM Discover	A voice analytics tool that analyzes call transcripts for keywords, topics, or emotions to help us better identify trends and understand how our organization is performing on the metrics we monitor.